

## Joint Appraisal report 2019

*The italic text in this document serves as guidance, it can be deleted when preparing the Joint Appraisal (JA) report.*

*Gavi's support to a country's immunisation programme(s) is subject to an annual performance assessment. The Joint Appraisal (JA) is a key element of this performance review. It is an annual, country-led, multi-stakeholder review by the senior leadership of the MoH and its partners of the implementation progress and performance of Gavi's support to the country, and its contribution to improved immunisation outcomes.*

**Joint Appraisals require careful preparation. This includes:**

- **By 31 March: Submission of End of year stock reporting**
- **By 15 May: Submission of the vaccine renewal request** on the country portal (including provision of updated targets, wastage rates, switch requests, if applicable, etc.)
- **4 weeks before the Joint Appraisal:**
  - **Submission** on the country portal **of reporting documentation required for renewal purposes**, in particular;
    - **Update of the grant performance framework (GPF)**
    - **Financial reports, annual financial statements and audit reports** (for all types of direct financial support received)
    - **Reporting on any campaigns/SIA conducted** (if applicable)
  - **Submission of HSS and CCEOP renewal request** (if new tranche needed), on the country portal including HSS budget for requested tranche;
  - **Gavi partners (WHO, UNICEF and others)** to report progress against their milestones on the partner portal.

**Other reporting information** to be posted on the country portal 4 weeks before the Joint Appraisal includes:

- *Immunisation financing and expenditure information (required from all countries)*
- *Data and survey requirements (required from all countries)*
- *Annual progress update on the Effective Vaccine Management (EVM) improvement plan (required from all countries)*
- *Updated CCE inventory (only from countries receiving CCEOP support)*
- *HPV specific reporting (only if applicable)*
- *HSS end of grant evaluation (only if applicable)*
- *Post Introduction Evaluation (PIE) reports (only if applicable)*
- *Gavi transition and/or polio transition plans or asset mapping information (only if applicable)*
- *Expanded Programme on Immunization (EPI) review / plan of action implementation report (if available)*
- *Post campaign coverage survey reports (only if applicable)*
- *Other information, such as information on additional 3<sup>rd</sup> party funded private sector engagements*

**Note: Failure to submit the renewal requests as well as required reporting on the country portal four weeks ahead of the Joint Appraisal meeting (except for the vaccine renewal request, which is to be submitted by 15 May) may impact the decision by Gavi to renew its support, including a possible postponement, and/or decision not to renew or disburse support.**

Country	GUINEA
Full JA or JA update <sup>1</sup>	<input checked="" type="checkbox"/> full JA <input type="checkbox"/> JA update
Date and location of Joint Appraisal meeting	25 to 30 August 2019, Conakry-Guinea
Participants / affiliation <sup>2</sup>	Ministry of Health, Ministry of Finance, Ministry of Planning and Cooperation, MATD, Governorate of the city of Conakry, Associations of Mayors of Municipalities of Guinea, Sicily Society - CNOSCG, INS, AN Health Commission, Children's Parliament of Guinea, National Polio Committee, GTCV, SG Religious Affairs, Ministry of Communication, Ministry of Social Action, Ministry of Education, WHO, UNFPA, UNICEF, USAID, JICA, Rotary, World Bank Project (PASSP), HKI, CDC, JHPIEGO, Dalberg, GAVI, BMGF, Stat View, EU, GIZ, AFD, OOAS, IOM, national and international NGOs.
Reporting period	Annual
Fiscal period <sup>3</sup>	January to 31 December 2018
Comprehensive Multi Year Plan (cMYP) duration	5 years (2016 to 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 <input checked="" type="checkbox"/>	No <input type="checkbox"/>	
Does the vaccine renewal request include a switch request?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
HSS renewal request	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	N/A <input type="checkbox"/>
CCEOP renewal request	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	N/A <input type="checkbox"/>

## 2. GAVI GRANT PORTFOLIO

Existing vaccine support (to be pre-filled by Gavi Secretariat)

Introduced / Campaign	Date	2017 Coverage (WUENIC) by dose	2018 Target		Approx. Value \$	Comment
			%	Children		
DTP-Heb-Hib	--- 2008	DTP-HepB-Hib 1: 63%	95	413,959	868,500	This amount represents 76% of the total volume of purchases. Support has respected the principle of initial self-financing (20% of the country and 80% Gavi)
		DTP-HepB-Hib 2: xx%	90	392,171		
		DTP-HepB-Hib 3: 45%	85	370,384		
VAA	--- 2002	NA	85	305,022	434,000	This amount represents 83.2% of the total volume of purchases.
IPV	November 2015	IPV 1: 45%	70	370,384	320,500	This amount represents 100% of the total volume of purchases. The state has

<sup>1</sup> Information on the differentiation between full JA and JA update can be found in the Guidelines on reporting and renewal of Gavi support, <https://www.gavi.org/support/process/apply/report-renew/>

<sup>2</sup> If taking too much space, the list of participants may also be provided as an annex.

<sup>3</sup> If the country reporting period deviates from the fiscal period, please provide a short explanation.

## Joint Appraisal (full JA)

						<i>not honoured its share of co-financing in accordance with the principle of initial self-financing</i>
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### Existing financial support (to be pre-filled by Gavi Secretariat)

Grant	Channel	Period	First disbursement	Cumulative financing status @ June 2018				Compliance	
				Comm.	Appr.	Disb.	Util.	Fin.	Audit
TCAs	UNICEF	2018	397,700	100%	397,700	397,700	397,700	Juin 2019	
	OMS	2018	??	??	??	??	??	??	
	Dalberg	2018	??	??	??	??	??	??	
HSS2	UNICEF	2017-2018	3,776,869	26,63%	18,905,807	15,128,937	5,147,242.24	2021	2021
CCEOP	UNICEF	2017	8,749,076	??	8,749,076	8,749,076	??	Juin 2019	NA
<b>Comments</b>									

### Indicative interest to introduce new vaccines or request Health System Strengthening support from Gavi in the future<sup>4</sup>

Indicative interest to introduce new vaccines or request HSS support from Gavi	Programme	Expected application year	Expected introduction year
	MenAfriVac	2019	2020
	MCV2	2018	2020
	Rota Virus <sup>7</sup>	2020	2021
	PCV-13	2020	2021
	MR <sup>8</sup>	2021	2022
	HEPATITE B		
	(Dose de naissance)	2022	2023
	HPV	2022	2023
	Ebola*	2024	2025
	Td	Not applicable	Introduced in 2017]

### Grant Performance Framework – latest reporting, for period 2018 (to be pre-filled by Gavi Secretariat)

	Intermediate results Indicator	Target	Actual
1.1a	Rate of implementation of activities planned in the Integrated Operational Action Plans (OAPs) of the 21 Health Districts	95%	

<sup>4</sup> This amount includes the sum of 3,798,328 paid to the UNICEF SD for 20% of the CCE OP co-financing and an amount of USD 11,330,609 paid directly to the country under the first three tranches of the tripartite agreement.

<sup>5</sup> Amount spent during the period from September 21, 2017 to December 31, 2018

<sup>6</sup> Providing this information does not constitute any obligation for either the country or Gavi, it merely serves for information purposes.

Countries are encouraged to highlight in subsequent sections, and particular in the Action Plan in Section 7, key activities and potentially required technical assistance for the preparation of investment cases, applications and vaccine introductions, as applicable.

<sup>7</sup> Intégrer la surveillance des diarrhées a Rota Virus dans le site sentinelle existants

<sup>8</sup> Disposer des données épidémiologiques du syndrome rubéoleux congénital

	Intermediate results Indicator	Target	Actual
1.1b	Rate of implementation of activities planned in the Integrated Operational Action Plans (OAPs) of the 38 Health Districts	95%	
<b>Ob1: Increase the functionality of health districts from 52% in 2015 to 80% in 2021, in particular the 21 target districts</b>			
1.2a	% of the 21 health districts that have carried out integrated formative supervision in the last 3 months	100%	
1.2b	% of the 38 health districts that have carried out integrated formative supervision in the last 3 months	100%	
1.3a	% of health districts that have held a Prefectural Technical Committee on Health (CTPS) during the last 6 months in the 21 health districts (D	100%	
1.3b	% of health districts having held a CTPS during the last 6 months in the 38 health districts;	100%	
<b>Ob2: Increase from 53% in 2015 to at least 80% in 2021 the coverage of fully vaccinated children in the 21 target health districts</b>			
2.1a	% of surviving infants who received Penta 3 in advanced strategy in the 38 health districts	95%	41%
2.1b	% of surviving infants who received Penta 3 in advanced strategy in the 21 districts supported by GAVI	95%	40%
2.2a	% of surviving infants who received Penta 3 as a fixed strategy in the 21 districts supported by GAVI	95%	59%
2.2b	% of surviving infants who received Penta 3 as a fixed strategy in the 38 health districts	95%	57,4%
2.3	% of advanced strategy points visited (services) per month in the 38 districts	95%	62% <sup>5</sup> .
<b>Ob3: Increase the average Effective Vaccine Management (EVM) score from 37% in 2016 to at least 80% in 2019 and maintain this performance until 2021</b>			
3.1	Effective Vaccine Management Score	80%	N/A
3.2a	Number of health facilities with at least one refrigerator with a continuous temperature recorder provided by the platform (CCEOP)	1346	226
3.2b	Number of health posts/private and religious structures that did not have cold chain equipment and that benefited from it thanks to the platform (CCOEP)	966	226
3.3	Percentage of health facilities that have a functioning solar cold chain during the last 3 months	100%	90%
<b>Ob 4: By 2021, at least 95% of the parents of the target population in the 21 selected health districts accept and request vaccination services.</b>			
4.2	Number of operational community platforms for immunisation	61	0
<b>Ob5: Reduce the gap between administrative data and Penta3 immunization coverage survey data from 30 points in 2015 to 5 points in 2021</b>			
5.1	Percentage of health districts that provided all EPI statistical reports for the last month in a timely manner	95%	87%
5.2	Completeness of reports at the district level for the last month	100%	100%
5.3	Percentage of immunization facilities whose data in primary sources correspond to those transmitted to the higher level (quality control)	95%	N/A
<b>Observations</b>			
The indicators for Objectives 1 and 2 have been achieved in a significant way. By 2018, the GEV improvement plan was in the early stages of implementation. We note that 62% of the advanced strategy points were visited (services) according to the data collected in the HSS2 2018 report. These data are already configured in the DHIS2 software. For demand generation, 49/61 contracts with CSOs have been signed and are scheduled to be operational in 2019. Although completeness and administrative coverage are above 80%, there are significant differences of up to 40 points between these coverage data and survey data. For example, in 2018, the gap between the administrative data and those of WENIC is 55 points for penta3.			

<sup>5</sup> HSS2 Report 2018

**PEF Targeted Country Assistance: Core and Expanded Partners at [insert date] (to be pre-filled by Gavi Secretariat)**

	Year	Funding (US\$m)			Staff in-post	Milestones met	Comments
		Appr.	Disb.	Util.			
<b>UNICEF</b>	2018 (TCAs)	66,096	66,096	20%	1 NoC HSS2	Reaching Every Child (ACE) approach is implemented in all health districts	The deployment of technical assistance in 2018 was dependent on the country's completeness and additional fund management measures.
	2018 (TCAs)	199,584	199,584	5%	4 NoB Immunization	Reinforcement of the EPI performance monitoring system through the DQS in certain health areas	
	2018 (HSS2)	??	??	18,189	1 NoB-	Updated cold chain mapping	
	2018	>>	??		1 G6 accountant	HACT plan implemented	

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

Comment on changes which occurred since the previous Joint Appraisal, if any, to **key contextual factors** that directly affect the performance of the immunisation programme and Gavi grants (such as natural disaster, political instability, conflict, displaced populations, inaccessible regions, etc., or macroeconomic trends, health worker industrial actions, disease outbreaks or severe and unexpected Adverse Events Following Immunisation, etc.).

For **countries facing fragility, affected by emergencies or hosting refugees**<sup>6</sup>: Please indicate if any flexibilities in grant management are being requested, and also mention in case the vaccine or HSS renewal requests were adjusted.

For countries transitioning from the **Global Polio Eradication Initiative**: Please briefly describe the impact on immunisation and primary health care services and specify whether the country has a polio transition plan in place. If such a transition plan exists, please briefly describe it with particular focus on health workforce and surveillance. If no transition plan exists, please describe actions being taken to prepare for polio transition. Please also comment on whether Gavi investments are being used/expected to be used in the polio transition.

In 2018, the country did not experience any major socio-political events that could impact the programme's performance. However, in terms of financing the health sector, the disbursement rate of the state counterpart remains low, although the budget allocated to the health sector has increased from 2.4% in 2010 to 7.4% in 2018. In addition, there are constraints related to the country's delay in implementing additional measures that have influenced the overall programming of HSS2 grant activities. Also, no disbursement was initiated in favour of the central EPI and the Office of Strategy and Development (OSD), which was delayed due to the poor completeness of the fiduciary risk management measures for the consolidation of the financial statements. In addition, other factors come into play, in particular, (i) the inadequacy of the accountability framework, (ii) the lack of transparency of the various financing measures that address the missions of the DRS/DPS, making it difficult not only to provide fragmented support but also to monitor difficult commitments and hinder performance in service delivery, (iii) the poor documentation and development of innovative strategies for reducing inequalities at the health district and community levels and (iv) the lack of qualified and sufficient human resources.

Epidemiologically, the country recorded 34 laboratory-confirmed measles outbreaks with 359 cases of IGM+ measles. Investigation sheets for positive cases in 2018 indicate that 88.6% of these cases are not vaccinated or have had an unknown vaccination status. This recurrence of measles shows the poor performance of systematic vaccination confirmed by the WEUNIC (WHO/Unicef) estimate of VAR, which

<sup>6</sup> For further information refer to <http://www.gavi.org/about/programme-policies/fragility-emergencies-and-refugees-policy/>

remained stable at 48% from 2014 to 2018. The 2018 survey of factors contributing to the persistence of measles epidemics also raised the level below the population's standards of knowledge, attitude and practices regarding immunization.

Although Guinea has been downgraded from the list of countries with polio epidemics, it remains vulnerable.

#### 4. Potential future issues (risks)

Also provide a forward-looking perspective on what else may happen over the next year (given current conditions, vulnerabilities, dependencies, trends and planned changes) and needs to be anticipated. E.g. potential security challenges due to upcoming elections, risks of vaccine hesitancy, stock-outs or vaccine expiry, or risks to a sustainable transition out of Gavi support.

Drawing on existing country risk assessments, please list a maximum of five most important risks (i.e. with a high likelihood to happen and / or a high potential impact if it did happen). Consider the need for proactive actions to prevent them from happening or to timely detect and effectively respond once they will happen. Also clarify whether these risk mitigation actions are being prioritised in the action plan (section 7 below).

1. The country is planning to hold national elections this year and next. This situation suggests a risk of unrest in an atmosphere of mistrust between political actors that could lead to the persistence of protest movements. A national contingency plan is required for this purpose.
2. The disbursement rate of funds allocated by the state to the health sector remains low. This rate of disbursement of budgets allocated to EPI activities should be improved to more than 18%.
3. The EPI in Guinea remains highly dependent on external financing. The State provides co-financing and invests in the purchase of so-called traditional vaccines. On the other hand, the operational costs of immunization are mainly covered by external funding. A strategic plan for innovative financing is being developed to take these needs into account. In addition, it should be noted that a PPP partnership was signed with the Chamber of Mines of Guinea (CMG) in August 2019 to promote vaccination activities in mining areas.
4. The weak capacity of health facilities for community-based surveillance and early warning contributes to the development of a climate conducive to the emergence and persistence of outbreaks of diseases such as measles. In addition, the possibility of cross-border transmission in relation to diseases with epidemic potential should not be overlooked. To this end, the country plans to introduce the 2nd dose of VAR into its vaccination schedule and to organize a follow-up campaign to reduce the potential risk of measles epidemics.
5. Since the introduction of the policy of free access to certain services (obstetrical care, malaria care, etc.), health centres have had difficulty bearing certain operating expenses (incompressible expenses and other expenses), resulting in a heavy dependence on external funding. Efforts are being made by the government to finance certain service costs, including vaccination by local authorities through ANAFIC (National Agency for Community Financing).
6. The planning process for fixed and advanced strategies is not very well mastered by the district management teams. Even with such detailed demographic data, the target populations of these strategies are calculated from the averages proposed by the central level, which distorts the realities of immunization service delivery at the peripheral level. The analysis of vaccination equity and the community enumeration approach are underway as part of the deployment of community health to improve this approach.

#### 5. PERFORMANCE OF THE IMMUNISATION PROGRAMME

This section is expected to capture primarily the **changes since the last Joint Appraisal** took place. It should provide a succinct analysis of the performance of the immunisation programme with a focus on the evolution / trends observed over the past two to three years and including an analysis of immunisation coverage and equity, as well as a review of key drivers of poor coverage

Information in this section will substantially draw from the recommended analysis, of coverage and equity and other relevant programme/service delivery aspects, which can be found in the Joint Appraisal Analysis Guidance (<http://www.gavi.org/support/process/apply/report-renew/>). In addition, the annual data quality desk review exercise is considered an important source of analytics that can be used for populating the Joint Appraisal report.

Countries are encouraged to present the information in tables, graphs and maps, and to reference the source of data.

### 5.1. Coverage and equity of immunisation

Please provide **national and sub-national analysis** of the situation related to coverage and equity of immunisation in the country, **focusing on newly available data & analysis, trends and changes, including outbreaks and details on outbreak responses observed since the last Joint Appraisal was conducted.**

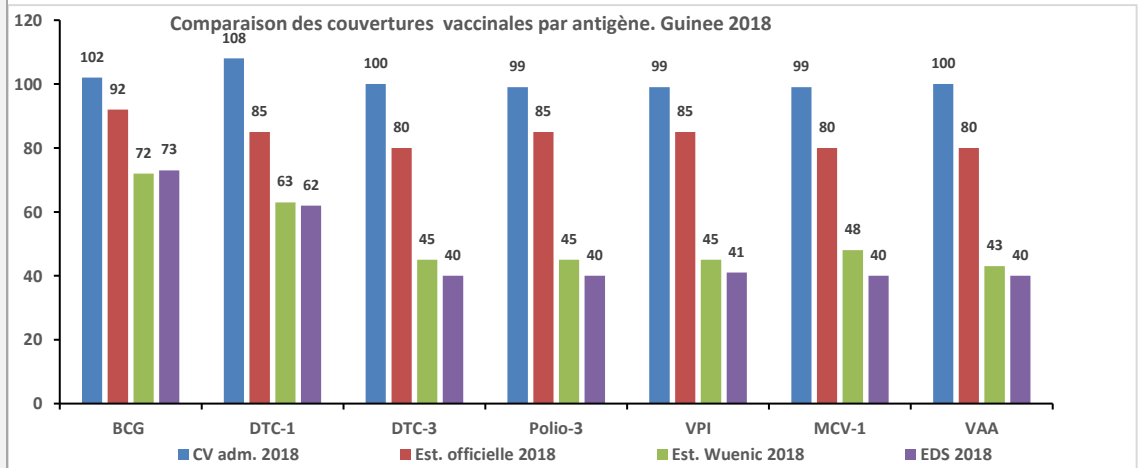
- Provide a summary of the trends in **coverage and equity**, across geographical areas, socio-economic status including gender-related barriers, populations and communities, including **urban slums, remote rural settings and conflict settings** (consider population groups under-served by health systems, such as slum dwellers, nomads, ethnic or religious minorities, refugees, internally displaced populations or other mobile and migrant groups).
- Relevant information includes: overview of districts/communities which have the lowest coverage rates, the highest number of under-vaccinated children, highest dropout rate, disease burden: number and incidence of vaccine preventable diseases (VPD) cases as reported in surveillance systems in regions/districts, etc.
- **Achievements against agreed targets**, within the country monitoring and evaluation (M&E) framework (and captured in the grant performance framework (GPF). If applicable, reasons why targets have not been achieved, identifying areas of underperformance, bottlenecks and risks.

**Coverage:**  
DTP3, MCV2, etc.

The country's situation for 2018 is as follows with harmonized data on our performance framework:

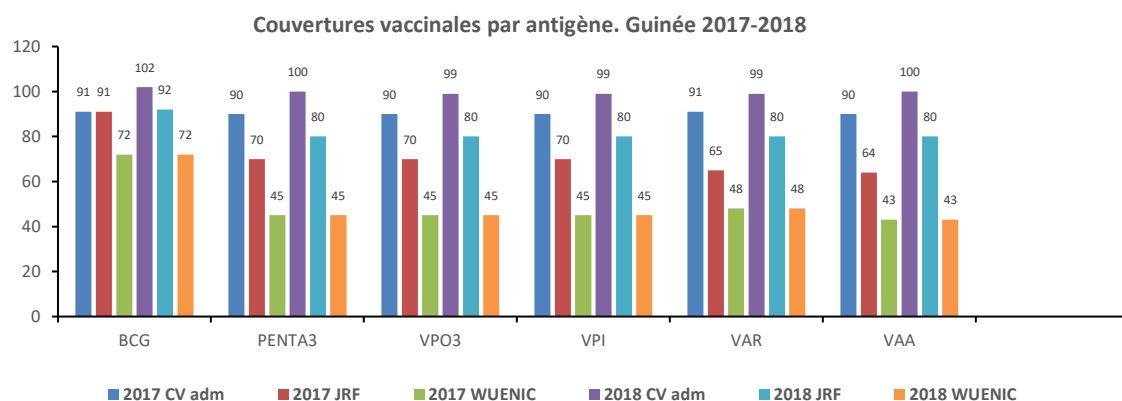


	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Estimate	63	60	57	64	63	57	50	44	45	45	45	45
Estimate GoC	•	•	•	•	•	•	•	•	•	•	•	•
Official	93	70	85	90	85	102	90	60	60	66	70	75
Administrative	93	84	85	90	95	102	103	91	89	119	90	100
Survey	NA	NA	NA	68	50	NA	NA	*	40	NA	NA	NA



At the national level, in 2018 according to the graph above, there are significant variations between administrative vaccine coverage and those estimated (JRF and WUENIC) for all antigens. The differences are observed among others for DTP-3 (100% vs. 45%), OPV-3 (99% vs. 45%), IPV (99% vs. 45%, MCV1 (99% vs 48%) and VAA ( 100% vs 43%) Also, according to the results of EDS 2018, in children aged 12-23 months, differences were observed in all DTC-3 antigens (100% vs. 40%), OPV -3 (99% vs. 40%), IPV (99% vs. 41%, MCV1 (99% vs. 40%) and VAA (100% vs. 40%).

Finally, the trends show a clear difference, falling between the survey covers and the administrative covers. It is the same between estimated and administrative coverages.



This chart shows that the administrative data improved between 2017 and 2018. For Penta3, coverage increased from 90% to 100%. According to the JRF, the blankets had a slight increase for all the antigens, but did not reach the targets. However, vaccine coverage according to the WUENIC has been stationary since 2015, despite progress in providing immunization services.

According to the 2018 DVD-MT, at the subnational level, administrative vaccination coverage varies from district to district for all antigens. It is noted that 31 districts out of 38 have reached a vaccination coverage of 90%, 5 districts have coverage between 80 and 90% (Dinguiraye, Koundara, Labe, Matam, Ratoma) and 2 districts have the lowest coverage between 50 and 80% (Dubréka 75% and Téliélé 80%). No district has less than 70% coverage.

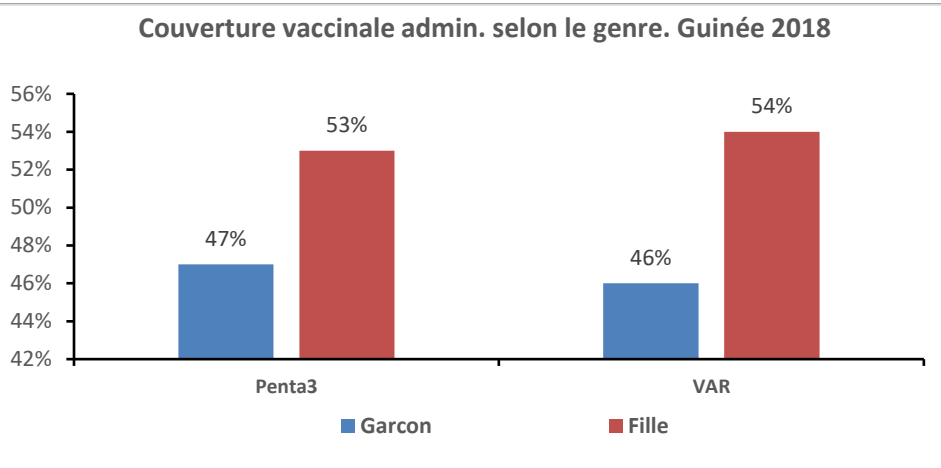
Table n ° 1: Number of unvaccinated children by district in Penta and VAR in Guinea 2018

Districts	Penta1	Penta3	VAR	Districts	Penta1	Penta3	VAR
Boffa			260	Coyah			927
Boké			1 008	Dubréka	3 606	4 420	4 152
Fria			62	Kindia	281	1 022	823
Gaoual	542	784	407	Téliélé		2 283	2 390
Koundara	319	713	573	Koubia	47	157	212
Kaloum		9		Labé	378	1 360	2 006
Matam	886	1 071	1 100	Lélouma		203	835
Ratoma	1 813	3 203	1 541	Mali		757	1 195
Dabola			260	Tougué		87	182
Dinguiraye	427	908	1 115	Mamou			218
Faranah		42	75	Pita		587	1 062
Kérouané		344		Beyla		196	923
Kouroussa		593		Lola		411	987
Mandiana		15	1 049	Macenta			55
Siguiiri		488	2 722	N'Zérékoré			501

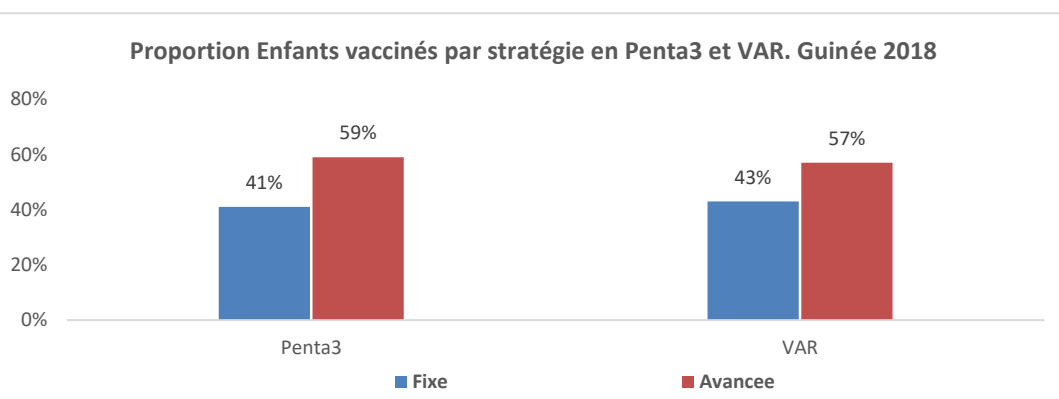
The analysis of this table indicates that the largest number of children (over 3000) unvaccinated for Penta3 are in the health districts of Ratoma and Dubréka. In these two health districts, there are the districts of Siguiiri and Téliélé, which have more than 2000 unvaccinated children at Penta3.



	For the VAR antigen, the largest number of unvaccinated children (over 3000) are in the Dubréka health district, followed by 7 other districts with more than 2000 unvaccinated children (see table below).																																																																																										
<p><b>Coverage:</b> Absolute numbers of un- or under-immunised children</p>	<p><i>E.g. at sub-national level:</i> District 1: 5M under-immunised children District 2: 1.2M under-immunised children District 3: 2M under-immunised children</p>																																																																																										
<p><b>Equity:</b></p> <ul style="list-style-type: none"> <li>• Wealth (e.g. high/low quintiles)</li> <li>• Education (e.g. un/educated)</li> <li>• Gender</li> <li>• Urban-rural</li> <li>• Cultural, other systematically marginalised groups or communities e.g. from ethnic religious minorities, children of female caretakers with low socioeconomic status, etc.</li> </ul>	<p><b>Supplementary Analysis of Equity Linked to Immunization:</b></p> <p><b>Table:</b> Sociodemographic characteristics according to EDS V-2018 for tracer indicators</p> <table border="1" data-bbox="368 595 1471 1200"> <thead> <tr> <th>Characteristiques</th> <th>Penta3</th> <th>MCV</th> <th>ECV</th> <th>No vaccine</th> </tr> </thead> <tbody> <tr> <td colspan="5"><b>Sex</b></td> </tr> <tr> <td>– Masculin</td> <td>42,2%</td> <td>41,8%</td> <td>20,3%</td> <td>22,2%</td> </tr> <tr> <td>– féminin</td> <td>37,9%</td> <td>37,0%</td> <td>17,1%</td> <td>22,4%</td> </tr> <tr> <td colspan="5"><b>Milieu de résidence</b></td> </tr> <tr> <td>– Urbain</td> <td>51,6%</td> <td>53,0%</td> <td>24,3%</td> <td>9,2%</td> </tr> <tr> <td>– Rural</td> <td>35,3%</td> <td>33,7%</td> <td>16,4%</td> <td>27,9%</td> </tr> <tr> <td colspan="5"><b>Niveau d'instruction</b></td> </tr> <tr> <td>Aucun</td> <td>36,2%</td> <td>36,8%</td> <td>17,3%</td> <td>25,9%</td> </tr> <tr> <td>Primaire</td> <td>42,8%</td> <td>40,1%</td> <td>14,8%</td> <td>19,4%</td> </tr> <tr> <td>Secondaire et plus</td> <td>57,3%</td> <td>52,0%</td> <td>28,7%</td> <td>7,7%</td> </tr> <tr> <td colspan="5"><b>Quintile de bien-être économique</b></td> </tr> <tr> <td>Plus bas</td> <td>26,2%</td> <td>27,3%</td> <td>11,1%</td> <td>37,9%</td> </tr> <tr> <td>Second</td> <td>38,6%</td> <td>31,6%</td> <td>16,6%</td> <td>25,9%</td> </tr> <tr> <td>Moyen</td> <td>38,5%</td> <td>41,9%</td> <td>19,9%</td> <td>24,0%</td> </tr> <tr> <td>Quatrième</td> <td>47,3%</td> <td>43,0%</td> <td>21,5%</td> <td>10,4%</td> </tr> <tr> <td>Plus élevé</td> <td>54,6%</td> <td>59,4%</td> <td>27,2%</td> <td>8,1%</td> </tr> <tr> <td><b>Ensemble</b></td> <td><b>40,2%</b></td> <td><b>39,5%</b></td> <td><b>18,7%</b></td> <td><b>22,3%</b></td> </tr> </tbody> </table> <p>The 2018 DHS shows that immunization coverage varies according to certain socio-demographic characteristics. The proportion of children who received all basic vaccines is higher in urban areas than in rural areas (24.3% versus 16.4%). The results by region show gaps with basic immunization coverage ranging from a minimum of 8% in Labé to a maximum of 37% in Conakry and 36% in Kankan.</p> <ul style="list-style-type: none"> <li>- For all the variables observed, the percentage of boys is higher than that of girls (20.3% of children fully vaccinated in boys compared to 17.1% in girls); with the smallest gender difference, at 8%;</li> <li>- A large number of child vaccines were observed in urban areas (24.3% compared to 16.4% in rural areas);</li> <li>- For the level of education, the proportion of children fully vaccinated varies with the parents' level of education (28.7% for secondary school and above compared to 17.3% for parents with no level of education);</li> <li>- The higher the economic level, the higher the proportion of children fully immunized (27.2% compared to 11.1% for the lowest).</li> </ul>	Characteristiques	Penta3	MCV	ECV	No vaccine	<b>Sex</b>					– Masculin	42,2%	41,8%	20,3%	22,2%	– féminin	37,9%	37,0%	17,1%	22,4%	<b>Milieu de résidence</b>					– Urbain	51,6%	53,0%	24,3%	9,2%	– Rural	35,3%	33,7%	16,4%	27,9%	<b>Niveau d'instruction</b>					Aucun	36,2%	36,8%	17,3%	25,9%	Primaire	42,8%	40,1%	14,8%	19,4%	Secondaire et plus	57,3%	52,0%	28,7%	7,7%	<b>Quintile de bien-être économique</b>					Plus bas	26,2%	27,3%	11,1%	37,9%	Second	38,6%	31,6%	16,6%	25,9%	Moyen	38,5%	41,9%	19,9%	24,0%	Quatrième	47,3%	43,0%	21,5%	10,4%	Plus élevé	54,6%	59,4%	27,2%	8,1%	<b>Ensemble</b>	<b>40,2%</b>	<b>39,5%</b>	<b>18,7%</b>	<b>22,3%</b>
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Analysis of administrative data shows that the proportion of girls vaccinated is higher than that of boys for Penta3 and VAR (53% compared to 47% for Penta3 and 54% compared to 46% for VAR) see graph above. In contrast, survey data compared to administrative data by gender indicate that the proportion of boys vaccinated is higher than that of girls.



Compared to the 2 most commonly used vaccination strategies in the country, there is a higher proportion of children vaccinated in advanced strategies for VAR and Penta3.

## 5.2. Key drivers of sustainable coverage and equity

Briefly summarize the health system and programmatic drivers of the levels of coverage and equity based on the key areas listed below, **focusing on the evolution and changes since the last Joint Appraisal**. For those districts/communities identified as lower performing, explain the evolution of key barriers to improving coverage and improving programmatic sustainability.<sup>7</sup> If there are no updates, please indicate and provide rationale.

- **Health Work Force:** availability, skill set and distribution of health work force
- **Supply chain:** integration, procurement planning and forecasting, key insights from latest EVMs and implementation of the EVM improvement plan, and progress on the five supply chain strategy fundamentals.<sup>8</sup> This subsection might be informed by available dashboards and tools, for example the Immunisation Supply Chain Management Dashboard that links EVM, Maturity Scorecard and DISC (Dashboards for immunisation Supply Chain) indicators.
- **Service delivery and demand generation<sup>9</sup>:** key insights related to service quality improvement and community engagement strategies; access, availability and readiness of primary health care/immunisation

<sup>7</sup> Relevant discussion questions on a number of the strategic areas here can be found in the programming guidance available on the Gavi website: <http://www.gavi.org/support/process/apply/additional-guidance/>

<sup>8</sup> More information can be found here: <http://www.gavi.org/support/hss/immunisation-supply-chain/>

<sup>9</sup> Programmatic guidance on demand generation <https://www.gavi.org/library/gavi-documents/guidelines-and-forms/programming-guidance---demand-generation/>

services; integration and cost-effectiveness strategies; strategies on demand generation for immunisation services; immunisation schedules, etc.

- **Gender-related barriers faced by caregivers<sup>10</sup>:** Please comment on what barriers caregivers currently face in bringing children to get vaccinated and interventions planned or implemented (through Gavi or other funds) to facilitate access to immunisation services by women for their children. (For example: flexibility of immunisation services to accommodate women's working schedules, health education for women on the importance of vaccination and social mobilisation targeting fathers, increasing the number of female health workers etc.)
- **Data / Information system:** Strengths and challenges related to the immunisation data (routine data collection and reporting system, integration within the health information system, regular surveys, targeted surveys, quality of data, use of data. Links with the surveillance system). At national and at sub-national levels.
- **Leadership, management and coordination:** leveraging the outcomes of the Programme Capacity Assessment and/or other assessments, please describe the key bottlenecks associated with management of the immunisation programme. This includes the performance of the national/regional/district EPI teams/health teams managing immunisation (e.g. challenges related to structure, staffing and capabilities); use of data for analysis, management and supervision of immunisation services; coordination of planning, forecasting and budgeting, coordination related to regulatory aspects; and broader sectoral governance issues.
- **Other critical aspects:** any other aspect identified, for example based on the cMYP, EPI review, C&E assessment, PIE, EVM or other country plans, or key findings from available independent evaluations reports<sup>11</sup>.

**Health personnel:** Over the next few years, the Ministry of Health, in collaboration with the Ministry of Public Service, plans to recruit approximately 5,000 new agents, including community relays (RECOs), to strengthen the health system, particularly at the community level. These new resources would make it possible to strengthen the system of supervision, service provision and demand and thus contribute to the development of immunization activities at the decentralized level. In addition, to ensure the sustainability of staff at the local authority level, the Ministry of Territorial Administration and Decentralization (MATD) is continuing the process of setting up the local civil service in the short term.

**The vaccine supply chain** is not integrated into the national supply chain. After an analysis, the integration factors are not met, particularly with regard to the location. Supply planning and forecasting is done in the third quarter of year n-1 through the "Forecast" tool in collaboration with partners. A supply plan is drawn up at the beginning of the year, taking into account the targets to be vaccinated, the vaccination coverage objectives and the loss rates assigned. This planning is not always respected due to interference from often postponed vaccination campaigns and the unavailability of funds in time to ensure the supply of vaccines and immunization equipment to districts and health centres.

The Effective Vaccine Management evaluation conducted in 2016 showed an overall score of 37%. Significant bottlenecks prevent the achievement of the program's supply chain objectives. These include, in particular,: a) insufficient storage capacity at all levels (central, regional, district and some health centres); b) breakdowns of some cold chain equipment; c) lack of EPI focal points at regional and health district level; d) insufficient training and supervision of staff in the context of new technologies introduced in vaccine management and the cold chain; (e) Inadequate transport facilities at the central level for vaccine distribution; (f) Limited resources for the operation of obsolete equipment; (g) Inadequate qualified personnel for maintenance, especially in health districts and regions; (h) Vaccine disruptions at the district and health centre level; (i) Weaknesses in the inventory management and reporting system. In addition, the regional level is not involved in the supply chain. To date, the supply of quality vaccines to beneficiaries and the strengthening of the cold chain are the main challenges that the programme should face.

The inventory carried out in 2016 also revealed numerous shortcomings in the functioning and quality of cold chain equipment.

<sup>10</sup> For additional programmatic guidance refer to <http://www.gavi.org/support/process/apply/additional-guidance/#gender>. Gender-related barriers are obstacles (for access and use of health services) that are related to social and cultural norms about men's and women's roles. Women often have limited access to health services and are unable to take their children to get vaccinated. Barriers include lack of education, lack of decision-making power, low socio-economic status, women unable to move freely outside their homes, inaccessibility of health facilities, negative interaction with health workers, lack of father's involvement in healthcare etc.

<sup>11</sup> If applicable, such as Full Country Evaluations (relevant for Bangladesh, Mozambique, Uganda and Zambia) and Technical Assistance evaluations (conducted for Gavi Partners' Engagement Framework tier 1 and tier 2 priority countries).

At the end of the GEV, an improvement plan was developed and implemented, the implementation rate of which is summarized in the table below.

Domaine fondamental	Activités						
	Nombre planifié	Nombre réalisé	% de réalisation	Nombre en cours de réalisation	% en cours de réalisation	Non réalisé	% Non réalisé
Remodelage/optimisation du système	11	6	55%	3	27%	2	18%
Gestionnaire du système logistique	7	4	57%	2	29%	1	14%
Données pour la gestion du système logistique	7	3	43%	2	29%	2	29%
Équipement de la chaîne de froid	21	12	57%	2	10%	7	33%
Amélioration continue du système	1	0	0%	0	0%	1	100%
<b>Total</b>	<b>47</b>	<b>25</b>	<b>53%</b>	<b>10</b>	<b>21%</b>	<b>12</b>	<b>26%</b>

The implementation rate has improved significantly, from 10 activities carried out in 2017 (21%) to 25 or 53% in 2018. Among the activities carried out, the following can be noted under the core areas:

**(i) System design:** the managerial and managerial capacities of two central level managers and eight regional level managers were strengthened. The involvement of health regions in the supply chain is being achieved through the installation of solar cold rooms. With regard to the optimization and modelling of the vaccine supply chain, the process is ongoing. The second workshop planned for November 2018 has been completed. One of the buildings housing part of the central cold rooms has been upgraded with the rehabilitation of the vaccine loading/unloading area. A Logistics Management Unit has been set up to serve as a platform for the EPI on logistics issues. The EPI input management tool (SMT) is analyzed monthly and shared with all partners.

**(ii) Cold chain equipment and maintenance:** the storage capacity of the central level has been increased by the installation of a 40m3 positive cold room. A second positive cold room of 40 m3 is in the process of being installed. In 2018, 240 solar refrigerators without batteries (SDD) were acquired to strengthen district storage capacities and replace obsolete, broken down and substandard refrigerators at health centres. The process of installing solar cold rooms at the regional level is underway. Four hundred and twelve (412) coolers were received for vaccine transport capacity building at regional and district level. Maintenance and personal protection kits have been made available to the central, regional and district levels. The central cold rooms have been secured with the installation of 4 voltage regulators. Under the CCEOP, 848 refrigerators and 5 long-life coolers (Arkteks) were received, transported and stored at the depots of the local representatives of two manufacturers and at the EPI level. To do this, 247 of the 848 refrigerators were installed in 2018. In addition, 240 large capacity solar refrigerators acquired with UNICEF funds were also received. A maintenance technician has been recruited to provide support at the central level.

**iii) Temperature monitoring:** A continuous temperature recorder (MULTiLOG2) was installed in the central cold rooms and the mapping of all the rooms carried out. Refrigerators in health district depots and health centres/posts have been equipped with Fridge-Tags2. Freezing indicators are available for monitoring the temperature of vaccines during transport. A system for analysing the temperature of cold rooms has been set up.

**(iv) Distribution:** The inventory of fixed assets of Gavi and other partners has been completed and the report is being finalized. The 6 trucks planned for the central and regional level will be ordered after receipt of the fixed asset inventory report from Gavi and other partners. The 818 motorcycles acquired in 2018 have been deployed at the operational level. The current input distribution channel does not integrate the regional level. The ongoing modelling process will redefine an appropriate circuit.

**(v) Human resources:** Nine (09) data managers were recruited, including eight (08) deployed in the health regions and one (01) at the central level. The 21 focal points have signed their contracts and will be deployed shortly in the priority districts. A maintenance technician has also been recruited to provide central support. Eight

(08) immunization doctors have been in each health region since 2018. In terms of training, health personnel have received training in effective vaccine management in all 8 health regions of the country.

**(vi) Logistics management information system:** Most of the deficiencies identified by the 2016 inventory have been corrected by the installation of efficient solar refrigerators. The central, regional and district levels have computer equipment for data management. The SMT is used for stock management at the central level, the DVD-MT is used for monitoring immunization and vaccine management data at the regional and district level. DHIS2 is also used at the district and 178 health centre levels. The timeliness and completeness of reports and data quality have been improved with the recruitment of data managers in place since March 2018. In addition, updated and validated management tools have been put in place, but their use requires capacity building.

Despite these achievements, it should be noted that financial difficulties have hampered the implementation of the improvement plan and the procurement plan. Indeed, 25 of the 47 activities planned in 2018, or 57%, were carried out, 10 or 21% were in progress and 12 or 26% were not carried out.

The level of satisfaction of the needs of the health districts is relatively low given the lack of funding and the lack of harmonisation of the needs assessment between the health districts and the central level (EPI).

Identification et synthèse des activités logistique et vaccins

Domains	Priority Issues	Possible solutions
<p><b>Installation of regional cold rooms</b></p>	<ul style="list-style-type: none"> <li>- Choice of installation scenario</li> <li>- Insufficient funding for installation work</li> </ul>	<ul style="list-style-type: none"> <li>- Formalize the choice of scenario for the installation of solar cold rooms (Hub or region?)</li> <li>- Advocate for the mobilization of financial resources for installation work;</li> <li>- Reproduce and disseminate management tools and train health workers on their use</li> </ul>
<p><b>Supply chain modeling</b></p>	<ul style="list-style-type: none"> <li>- Delay in the implementation of the supply chain modelling process</li> <li>- Financial difficulties in implementing the maintenance plan</li> </ul>	<ul style="list-style-type: none"> <li>- Implement data collection and analysis as soon as possible.</li> <li>- Facilitate procedures for disbursement of funds for the implementation of the activities of the maintenance plan</li> </ul>
<p><b>Implementation of the EVM Improvement Plan</b></p>	<ul style="list-style-type: none"> <li>- Low implementation rate of activities planned in the improvement plan (25/47 activities carried out in 2018, or 57%) mainly due to insufficient funding</li> </ul>	<ul style="list-style-type: none"> <li>- Continue to implement the improvement plan with a focus on priority activities</li> <li>- Evaluate the implementation of the plan at the regional and district level</li> </ul>

Despite the existence of a plan, the biomedical waste management system remains weak due to the lack of functional incinerators at the district level, and the weakness of the mechanism for waste collection, transport and disposal.

**Services provided**

Routine vaccination throughout the country is carried out according to 2 strategies depending on whether you are in a large city or in a landlocked area:

- The fixed strategy is carried out every working day (Monday to Saturday) in health centres for all antigens except BCG, VAA and VAR, which are administered twice a week during which messages on the importance of vaccination are broadcast.
- The advanced strategy is carried out according to schedule with an average of 2 outings per month and per health area.

However, these existing strategies do not reach all the target children of the EPI.

In urban areas, service delivery faces challenges such as the emergence of private structures, most of which do not offer vaccination services, the uncontrolled flow of populations between neighbourhoods and sectors, other socio-cultural and political factors that lead to rumours and misinterpretations. This situation is being rectified with the installation of solar refrigerators in about 100 private, associative, religious and armed forces structures to expand the supply of quality vaccination for the population.

As for isolated areas such as mountainous regions, islands, and mines, etc., the main problem lies in the poor accessibility (geographical, low standard of living and education...) to vaccination services in addition to the factors already known.

Actions targeting the improvement of immunization service delivery under the 2016-2020 cMYP aim to increase from 53% in 2015 to at least 80% in 2021 and to improve the coverage of fully immunized children throughout the country with a particular focus on the 21 low-performing health districts. On the other hand, the results of the DHS V conducted in 2018 show a vaccination coverage of fully vaccinated 12-23 months-old children of 24%, a decrease of 13% compared to 2012, when this coverage was 37%.

The implementation of HSS2 is an opportunity to significantly improve the challenges related to service delivery, taking into account the different specificities. However, during 2018, the effectiveness of this implementation was only possible from the second half of the year and mainly at the intermediate level linked to the non-compliance with conditionalities for the disbursement of funds.

At the central level, integrated formative supervision activities were carried out with the support of the World Bank through the Primary Health Care Support Project (PASSP) in the health districts of the Labé and Faranah regions.

The main achievements at the operational level were as follows:

- a) capacity building for health workers at the level of health facilities in the 21 priority districts on the implementation of the RED approach in a specific way and on EPI management in general; training of managers of health centres/health posts in effective vaccine management.

**The table below shows the number of officers trained by region.**

Régions	Besoins existants dans les 21 Districts prioritaires	Nombre des personnes formées sur l'ACD/gestion PEV	Nombre des personnes formées GEV	Effets escomptés
DRS N'Zérékoré	490	294	261	Amélioration des compétences techniques
DRS Kankan	864	929	130	

DRS Faranah	440	152	229	des agents de santé en vue d'offrir les services de qualité en matière de vaccination.
DRS Mamou	360	77	114	
DRS Labé	328	111	162	
DRS Kindia	392	69	70	
DRS Boké	392	82	64	
DSVCO	226	104 (40 à Matoto et 60 à Ratoma)	29 (Ratoma)	
<b>Total</b>	<b>3492</b>	<b>1818</b>	<b>1059</b>	

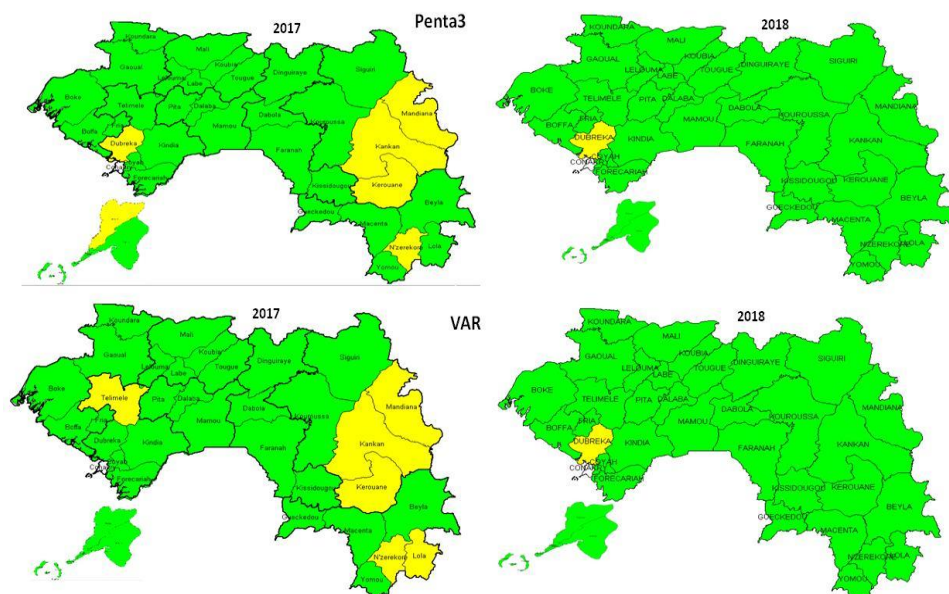
b) the implementation of advanced strategy activities (AS) at the level of health centres: out of a total need expressed at 4,875 sites for all health districts, 2,272 functional sites, 1,891 of which were supported in the third quarter of 2018 in the target DS with HSS2 funding. An uncovered Gap of 1,145 was found. Thus, 26,581 advanced strategy sessions, including 14,450 in the 21 priority SDs, were held in 2018;

c) integrated formative supervision carried out in 5 districts on HSS2 financing; in addition, some districts such as Labé have been supported by other technical and financial partners such as the World Bank, the European Union, the GIZ.....;

d) the assumption of duties by 5 NOB vaccination consultants in November 2018 was used to carry out a rapid analysis of the EPI in order to identify bottlenecks from the peripheral level to the regional level (PS, CS, DPS and DRS);

e) As part of the integration of activities, the pilot initiative "40 convergence municipalities" launched in April 2018 by the Ministry of Health and the Ministry of Territorial Administration and Decentralization (MATD) with an essential component on strengthening routine vaccination began in June 2018. This initiative was materialized by: training 190 CSAs and 1,855 community relays (RECOs) on essential family practices (EFPs), including immunization, to support not only social mobilization but also active research and catch-up of children not or insufficiently immunized; and the beginning of the process of systematically counting children under 5 years of age and pregnant women.

All these achievements have made it possible to improve the administrative CVs of ROs generally between 2017 and 2018, as shown in the figure below, which illustrates the CVs in Penta 3 and VAR. Only the Dubréka health district remained stationary during the period.



Comparison of vaccine coverage in Penta3 and VAR health districts in 2017 and 2018.

Despite all these achievements, there are still bottlenecks for which some solutions and strategies have been identified in the following table.

Bottlenecks	Solutions/strategies
Mobility of the target population by location (control of out-of-area areas), and not control of health area targets	-Carry out the count with unique coding up to the central level according to a standard model validated by the Ministry of Health
Difficult geographical accessibility for some localities (mountainous regions, islands, mines...)	-Update the mapping of difficult access areas to complement the equity analysis -Implementation of advanced and mobile strategies with adequate resources (human, material and financial)
Poor accessibility of the target to be vaccinated in urban areas (emergence of private structures)	-Continue the involvement of private/confessional structures, army health services in routine vaccination -Develop special strategies such as vaccination in public sites such as markets, platforms, stations....
The deficit in infrastructure, equipment and personnel	-Update health mapping -Build, renovate and equip health facilities -Ensure the recruitment and initial and ongoing training of health personnel
Insufficient implementation of advanced strategies despite the availability of motorcycles in the CSs;	-Closely monitor the MOE schedule of SA activities planned by the district
Insufficient supervision at all levels	-Adhere to the supervision schedule and accountability framework -Make available the necessary resources for the implementation of supervision
Non-compliance with free vaccination in some places and insufficient motivation of EPI agents	- Grant a bonus / incentive award to successful EPI agents

As part of Community health policy, it is necessary to capitalise on Community interventions in order to scale up.

**Results related to community engagement in strategies to generate demand for immunization services:**

In line with the logic of strengthening the budgeting system and coordinating interventions to promote the demand for health services, the priority actions focused on:

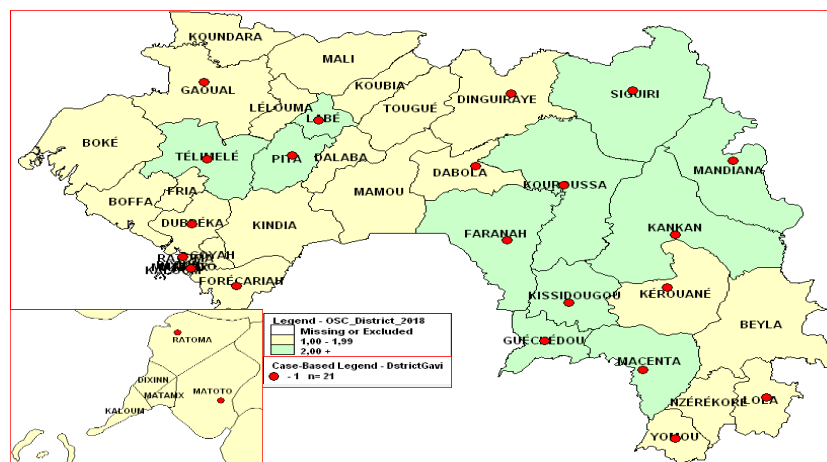
- **Strengthening coordination and monitoring of immunization promotion interventions:** A network of DRS communication/social mobilization officers, DPS/DCS has been established for the planning, monitoring and reporting of communication, social mobilization and community engagement interventions in support of immunization + IEPTs. 46 communication focal points are designated by memos in all health districts and regions and contribute to the development of a good immunization promotion strategy aimed at encouraging individuals and other stakeholders to adopt attitudes and behaviours that are favourable to the demand for the services offered.
- **Vaccination promotion materials and monitoring tools:** Vaccination schedules (for women and children) are developed and available to increase the level of knowledge of populations about the different vaccination appointments. Also, tools for data collection and monitoring of communication activities at different levels (DRS, DPS, CS) are developed, quantified and available in the EPI to document the different interventions.

As part of the development and diversification of partnerships for the promotion and generation of demand for health services, including immunization, actions have been carried out at different levels:

- **At the national level:** A collaborative framework agreement has been facilitated and signed between the Ministry of Health and the Ministry of Information and Communication to promote interventions to engage communities and other stakeholders in the promotion of health services, including immunization. This agreement is accompanied by an action plan



- **At the operational level:** 34 rural/community radio stations based in the various health districts provide support for health promotion, including immunization. A total of 64 microprogrammes/issues were produced in national languages (Poullar, Malinké, Sousou, Pkèlè,...) and broadcast monthly by radio on essential family practices, the need for vaccination, the vaccination calendar, the storage of vaccination records, etc.
- **Recruitment and deployment of CSA/RECO:** the pilot initiative of 40 convergence municipalities and the new community health policy were jointly launched in April 2018 by the Minister of Health and Territorial Administration and Decentralization (MATD). A total of 190 CSAs and 1,855 community relays (RECOs) were recruited, trained and deployed in the 40 convergence communes that are among the most isolated areas to promote community health with a focus on immunization services. The existence of these relays down to the village level is an opportunity to reach the most vulnerable communities.
- **Contractualization with Civil Society Organizations (CSO/CBOs):** 49 CSO/CBO/CONSORTIUMS were selected and partnership agreements signed through a decentralized and participatory process under the authority of the prefects. Drafts of action plans are drawn up on the basis of a diagnosis made with the health centres on the obstacles related to the demand for vaccination services. The implementation of immunization + IEPT promotion activities will be carried out after the training of CSO/CBO/CONSORTIUM representatives and the provision of funds.



**Other actions are underway to promote the generation of demand for health services, including immunization, namely:**

**Implementation of an accountability framework for the Prefectural Development Service (SPD):** It will be implemented at the prefectural (district) level under the leadership of the prefect.

**Approach:** Extend the SPD to other actors involved in health promotion as a multisectoral platform for accountability at the prefectural level with the participation of internal actors (DPS, DPE, DMR, DPJ, social action, planning, housing, agriculture, environment, fisheries,...) and external actors (CSO/CBO, media and social networks, private sector, trade unions, mayors, district presidents, neighbourhood/sector leaders, traditional and religious leaders, single-member parliaments).

**Immediate action:** Advocacy by the Minister of State, Minister of Health to the Minister of Territorial Administration and Decentralization to extend participation in SPD sessions to external actors (CSO/CBO, media and social networks, private sector, trade unions, mayors, district presidents, neighbourhood/sector leaders, traditional and religious leaders, single-member parliaments).

**Involvement of the media and social networks in health promotion, including vaccination.**

**Strategy:** Operationalize the collaborative framework agreement signed by the Minister of Health and the Minister of Communication through the development of action plans

**Public Media (DGRRG and DGRTG):** Based on district needs for health promotion and immunization strengthening through the media, develop and implement annual action plans

**Private media (community, commercial, TV, print media):** Based on the needs of districts in terms of health promotion through the media, develop and implement annual action plans at the level of each health district. The

partnership process must be fully inclusive. The action plans will be signed by the DPS, the heads of the district's private media and the mayor

**Social networks (information sites, facebook, bloggers, u-report,...):** Include social networks in communication plans for health promotion, including vaccination

**Involvement of RECO/ASC in the promotion of vaccination and other health interventions:**

CSO/CBOs will work in collaboration with RECO/ASC to catch up with those who have lost sight of them and to plan, implement and monitor the various health promotion interventions, including community immunization.

**Visibility of the EPI and vaccination:** Develop and distribute posters, leaflets, T-shirts, caps, vests, vaccination schedules, at all levels.

**Involvement of telephone calls for health promotion, including vaccination**

Organize a major advocacy meeting with the telephone companies (Orange, MTN and Celcom) with the presentation of the EPI's expectations for improving indicators. This meeting should lead to commitments made by the telephone companies following the implementation of the recommendations of the national forum on vaccination.

**GOULOTS ET PROPOSITIONS DE SOLUTIONS**

**BOTTLENECKS AND PROPOSED SOLUTIONS**

Bottlenecks	Proposals for solutions
On the structural level, <b>low accountability of</b> health managers at different levels for interventions to promote demand for immunization services	<ul style="list-style-type: none"> <li>➤ Include communication and community engagement activities in the <b>performance indicators of</b> DPSs and heads of health centres/posts</li> </ul>
<b>Low community ownership of</b> immunization services	<ul style="list-style-type: none"> <li>➤ Contract with CSO/CBOs to promote my vaccination+ IEPTs and build their capacity</li> </ul>
	<ul style="list-style-type: none"> <li>➤ Establish partnerships with the media, social networks and telephone companies to promote vaccination +PFE</li> </ul>
	<ul style="list-style-type: none"> <li>➤ Establish partnerships with Ministries of Youth and Education to engage youth structures and education officials at different levels as well as students in the promotion of immunization + IEPT</li> </ul>
<ul style="list-style-type: none"> <li>➤ Low level of <b>resource mobilization and allocation</b> for demand generation of immunization services</li> </ul>	<ul style="list-style-type: none"> <li>➤ Integrate vaccination into the <b>Annual Investment Plan of the municipalities</b> and revitalize the COSAHs</li> <li>➤ Allocate at least <b>15% of the immunization budget</b> at all levels to interventions to promote demand for immunization services</li> </ul>
<ul style="list-style-type: none"> <li>➤ Insufficient <b>qualitative data on</b> community perceptions of the importance and use of immunization services</li> </ul>	<ul style="list-style-type: none"> <li>➤ Conduct a <b>behaviour change survey/study</b> to improve interventions for generating demand for immunization services</li> </ul>

**Barriers related to gender inequality faced by carers:**

The barriers faced by caregivers that lead to inequity in immunization include: religion, cultures, prejudices, mores. The analysis of refusals to vaccinate highlights perceptions that the administration of the vaccine would later lead

to infertility in the girl. In addition, insufficient in-depth analysis of the dimensions of equity in immunization and consideration of operational strategies to reach hard-to-reach populations, including island areas, the poor in remote urban and rural areas, hill, valley and dispersed populations, migrants, religious groups, transhumant populations and those in mining areas, are also factors that hinder equity. This situation is being corrected with the conduct of the analysis of vaccination equity in 12 ROs during this year 2019. On this basis, micro plans exist for the relaunch of the EPI in order to reach the most marginalized populations.

In addition to these elements, there are also problems listed in the table below.

**Table:** Other problems and possible solutions

Domains	Problems	Possible solutions
<b>Barriers related to gender inequality faced by the</b>	Problems related to the control of operational targets;	Count the operational target of the EPI in the 38 health districts
	Low use of vaccination services (MAPI and Rumours);	Increase parental awareness and information about vaccination; Increase the number of points of advanced strategies.
	Absence of maps of children to be vaccinated and caught up;	Locate target children by area
	Low proportion of private and faith-based structures integrated into routine immunization;	Continue the process of integrating public, private and faith-based health facilities into immunization
	Parents have little knowledge of the importance of vaccination;	Raise parents' awareness of the importance of vaccination
	Insufficient data collection tools adapted to immunization;	Provide all vaccination structures with appropriate management tools

#### Data / information system

The timeliness of monthly immunization reports poses enormous challenges at the national level. It varies from 67% in the Faranah region to 100% in the Labé and Mamou regions.

As for the completeness, it is 100% with a delay of more than 3 months for all districts, all regions throughout the country.

Bottlenecks are among other things:

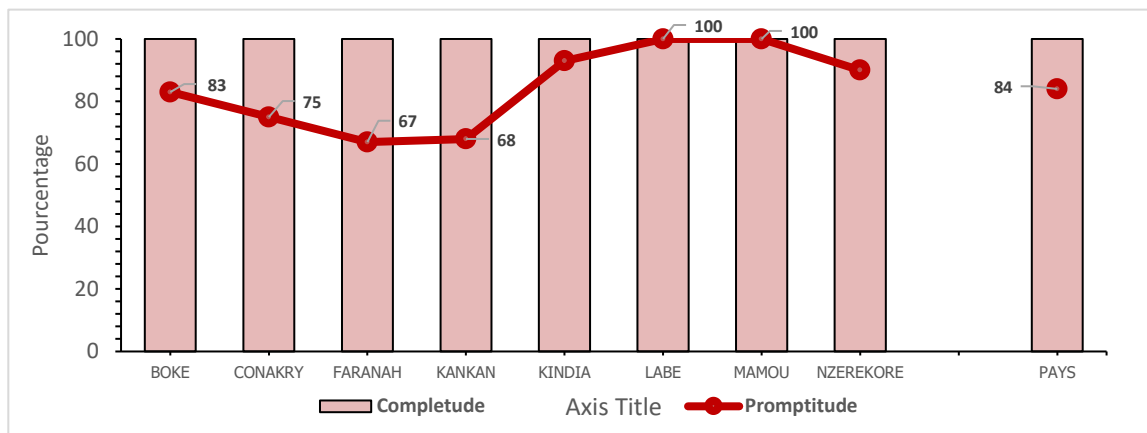
- Insufficient trained personnel dedicated to data management, especially in private structures;
- Insufficient application of the accountability framework;
- Weak follow-up of recommendations;
- Inadequate immunization data management tools;
- Low integration of the private sector into the SNIS;
- Insufficient supervision of training coupled with DQS;
- Interference of activities;

#### Priority actions

- Make the data quality committee operational at the national, regional and district levels (Creation and implementation of TOR);
- Make management tools available in all integrated structures;
- Ensure staff training / Conduct formative supervision missions coupled with the DQS;
- Develop and implement a monitoring and evaluation plan for the EPI
- Annual review of immunization data/preparation of DQAP 2021-2025 ;
- Establish a local civil service for the recruitment of health workers;

- Ensure the follow-up of the resolutions of the recommendations resulting from the quarterly reviews with a roadmap.

The graph below shows the promptness and completeness of the monthly immunization reports (MIRs) recorded in 2018 by region and at the national level.



**Graph:** Promptness and completeness of vaccination reports by Region. Guinea 2018

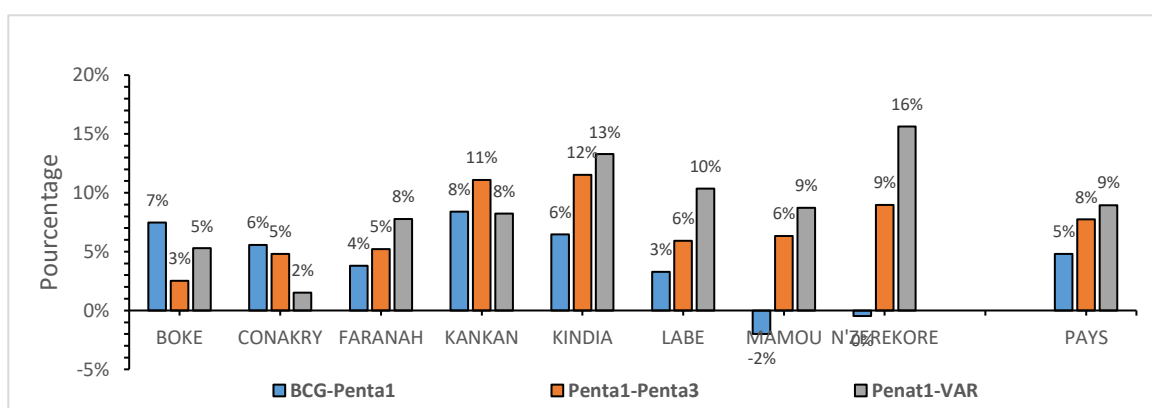
During 2018, all 38 health districts use DHIS2, in which vaccination data are entered monthly.

**Situation on the transition on DHIS2**

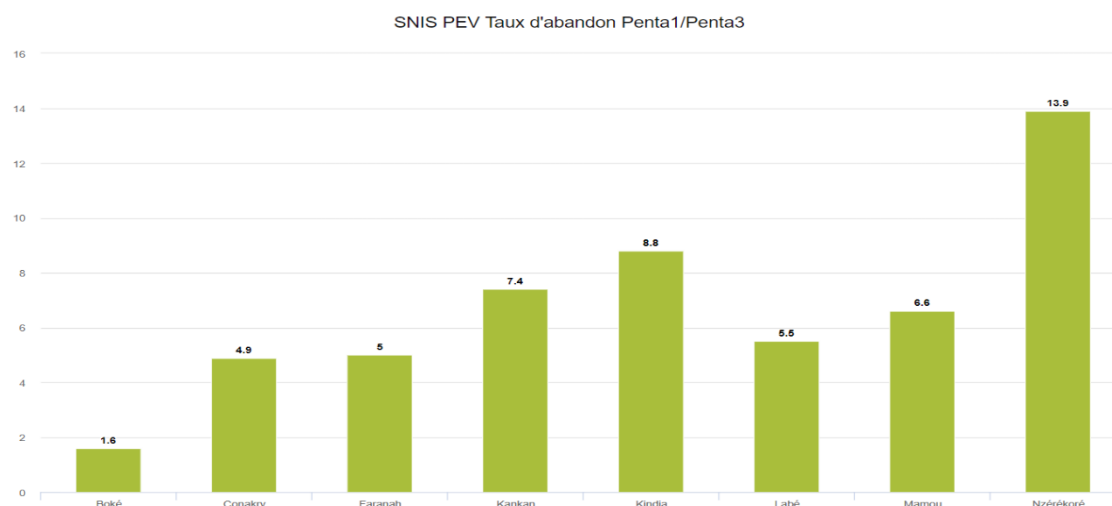
At the level of health centres, 178 out of 417, or 43%, enter vaccination data into the DHIS2. After the evaluation of the experience in the first centres, the extension will continue until 2020 to cover all health centres.

At the national level, for all antigens administered, the completion rate was generally satisfactory with a drop-out rate ranging from 5% for BCG/Penta1, 5% between Penta1/Penta3 and 9% between Penta1/MCV.

In the regions, the drop-out rate between Penta1/Penta3 varies from 3% in Boké to 11% and 12% respectively in Kankan and Kindia. As for the drop-out rate compared to the Penta1/VAR, it varies from 2% in Conakry, 13% in Kindia and 16% in Nzérékoré. However, negative dropout rates between BCG and Penta1 were recorded in the Mamou and Nzérékoré regions.



**Graph:** Vaccine dropout rates by region and in Guinea in 2018



**Graph:** Dropout rate Penta1-Penta3 according to DHIS2 in 2018

According to DHIS2, the specific drop-out rate (Penta1-Penta3) varies from 1.6% in the Boké region to 13.9% in the Nzérékoré region. However, analysis of the drop-out rate at district level shows that 9 out of 38 districts have a drop-out rate above 10%.

### Internal consistency of data

#### a) Outliers

The table below shows the proportion of extremely outliers, i.e. values greater than 3 standard deviations from the mean with the districts concerned.

**Table xx : Identification of outliers 2018**

#### Extremely outliers ( $\geq 3$ standard deviations of the mean) 2018

#### Valeurs extrêmement aberrantes ( $\geq 3$ écarts-types du moyenne) 2018

Le programme et l'indicateur	Score National %	Districts avec des valeurs aberrantes extrêmes par rapport à la moyenne		
		No.	%	Noms des districts
Immunisation - VPO 3	1,1%	5	13,2%	Dabola, Kérouané, Kouroussa, Dubréka, Forécariah
Immunisation - DTC-HepB-Hib3	0,9%	4	10,5%	Kouroussa, Dubréka, Forécariah, Mamou
Immunisation - VAA	0,7%	3	7,9%	Fria, Dubréka, Forécariah
Immunisation - VAR	0,9%	4	10,5%	Forécariah, Labé, Lélouma, Tougué
Immunisation - VAR 1	0,9%	4	10,5%	Forécariah, Labé, Lélouma, Tougué
Immunisation - VAT2	0,2%	1	2,6%	Forécariah
Total (tous les indicateurs ensemble)	0,8%			

With regard to this table, at the national level, scores vary from 0.2% compared to VAT(Td) in Forécariah to 1.1% compared to OPV3 in 5 districts (Dabola, Kérouané, Kouroussa, Dubréka, Forécariah).

Extreme outliers relative to the national average were recorded in some districts. These are 5 districts compared to OPV3 (13.2%), 4 districts compared to DTC-HepB-Hib3 (10.5%), 3 districts compared to VAA (7.9%), 4 districts compared to VAR (10.5%) and one (1) district compared to VAT2(Td) (2.6%).

a) **Consistency of data from year to year according to the DQR in 2018**

The graph and table opposite show the consistency of the data over the last three years by comparing the doses administered in 2018 with the average of the last three (3) years 2015 to 2017 for OPV3 respectively, DTP-hepB-Hib3, MCV et le VAA.

**Cohérence des données VPO3**

Année	2018
Tendance attendue	Constante
Comparer les districts au:	Résultat attendu
Seuil: % de différence maximum entre le ratio du district et le ratio national	20%
Ratio de la valeur national de 2018 par la valeur national moyenne pour les 3 années précédentes	116%
Nombre des districts avec les scores divergents	12
% des districts avec les scores divergents	32%

**Noms des districts avec les scores divergents**

Koundara, Matoto, Ratoma, Dabola, Faranah, Kouroussa, Siguiiri, Coyah, Dubréka, Forécariah, Beyla, Yomou

**Graphique** : Cohérence des données VPO3

Compared to OPV3 data, the above table shows a total of 12 districts out of 38 districts, or 32%, that recorded divergent scores with a ratio of the 2018 national value to the average value for the last 3 years (2015 to 2017) that is more than 116% higher. These are the districts of Koundara, Matoto, Ratoma, Dabola, Faranah, Kouroussa, Siguiiri, Coyah, Dubréka, Forécariah, Beyla, Yomou.

**Cohérence des données DTC-HepB-Hib 3**

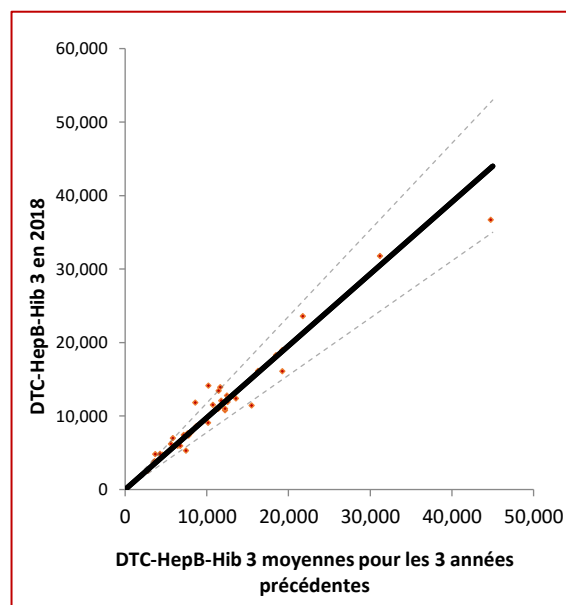
Année	2018
Tendance attendue	Constante
Comparer les districts au:	<b>Résultat national</b>
Seuil: % de différence maximum entre le ratio du district et le ratio national	20%
Ratio de la valeur national de 2018 par la valeur national moyenne pour les 3 années précédentes	114%
Nombre des districts avec les scores divergents	10
% des districts avec les scores divergents	26%

**Noms des districts avec les scores divergents**

Matam, Siguiiri, Coyah, Dubréka, Forécariah, Pita, Beyla, Guéckédou, Macenta, Yomou

**Graphique 1** : Cohérence des données DTC-HepB-Hib3

With regard to the DTC-HepB-Hib3 (Penta3) data, the above table shows a total of 10 districts out of 38 districts, i.e. 26%, which recorded divergent scores with a ratio of the 2018 national value to the average value for the last 3 years (2015 to 2017) that is more than 114% higher. These are the districts of Matam, Siguiiri, Coyah, Dubréka, Forécariah, Pita, Beyla, Guéckédou, Macenta, Yomou.

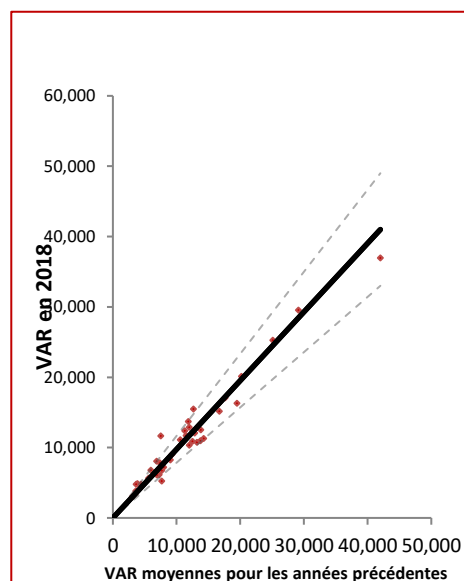


**Cohérence des données VAR**

Année	2018
Tendance attendue	Constante
Comparer les districts au:	<b>Résultat national</b>
Seuil: % de différence maximum entre le ratio du district et le ratio national	20%
Ratio de la valeur national de 2018 par la valeur national moyenne pour les 3 années précédentes	111%
Nombre des districts avec les scores divergents	10
% des districts avec les scores divergents	26%

**Noms des districts avec les scores divergents**

Matam, Matoto, Kouroussa, Coyah, Dubréka, Forécariah, Pita, Gueckédou, Macenta, Yomou



**Graphique 2 : Cohérence des données VAR**

According to data recorded in 2018 in DHIS2, there are also outliers in some districts (colored cells) by antigen. See table below.

**Table:** Example of Districts with outliers by antigen according to DHIS2. Guinea 2018

Unit	Data	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18
Mamou	SNIS BCG administree - Stock	1503.0	2076.0	2680.0	2226.0	2172.0	2439.0	2272.0	28345.0	2474.0	2499.0	2364.0	2458.0
Kankan	SNIS Unités reçues de vat	450.0	840.0	3760.0	8546.0	8350.0	7170.0	4890.0	9240.0	5910.0	6540.0	17720.0	5340.0
Mamou	SNIS VAR administree	1578.0	1857.0	2076.0	2158.0	2384.0	2103.0	2250.0	3447.0	2885.0	1764.0	2013.0	12406.0
Kankan	SNIS VAA administree	6175.0	5012.0	7374.0	6067.0	14904.0	6413.0	5876.0	9756.0	7103.0	4870.0	7422.0	6523.0
Boké	SNIS Unités reçues de vat	1250.0	780.0	2830.0	3760.0	2480.0	3323.0	10651.0	2910.0	3520.0	2918.0	3435.0	5270.0
Faranah	SNIS Unités reçues de vat	5930.0	8280.0	11870.0	2990.0	2093.0	3035.0	7010.0	6270.0	5945.0	3294.0	6867.0	5970.0
Mamou	SNIS Unités reçues de vat	490.0	450.0	1890.0	1120.0	1550.0	1580.0	2950.0	7950.0	1630.0	3250.0	1552.0	1650.0
Labé	SNIS Unités reçues de vat	2520.0	1860.0	1890.0	2410.0	3590.0	2390.0	2730.0	5340.0	2620.0	2690.0	5640.0	4040.0
Nzérékoré	SNIS Penta 1 administree	5739.0	7888.0	5776.0	5399.0	5733.0	5795.0	5779.0	9047.0	6005.0	5420.0	5690.0	5928.0
Kindia	SNIS Td2 FE administree	2269.0	1829.0	1861.0	2292.0	2953.0	2215.0	4750.0	5175.0	2403.0	2694.0	2416.0	2231.0
Kindia	SNIS Unités reçues de vat	250.0	100.0	5430.0	1070.0	2012.0	3140.0	1562.0	540.0	1750.0	3390.0	330.0	350.0
Mamou	SNIS VAA administree	1827.0	4776.0	2309.0	2351.0	2391.0	1962.0	2346.0	3471.0	2646.0	3334.0	2366.0	2263.0
Kindia	SNIS VAA administree	3342.0	3423.0	3729.0	4443.0	4515.0	3869.0	3672.0	7412.0	4119.0	4595.0	3909.0	4047.0

For districts with data quality problems, corrective actions have been considered, among others:

- Implementation of the data quality improvement plan;
- Use of the DHIS2 platform for reporting vaccination data;
- Monitoring of the implementation of the emergency plan for the recovery of vaccine coverage;
- Supervision of health facilities with audit of the quality of immunization data,

Domains	Strengths	Difficulties	Possible solutions
Collection system	-Existing harmonized tools;	-Low availability of harmonised tools at the	

	-Existence of electronic tools (DVD-MT, SMT, DHIS2,);	level of vaccination structures; -Poor mastery of DHIS2;	
Reporting	-Existence of the information circuit with definition of transmission delays for each level; -Existence of electronic tools (DVD-MT, SMT, DHIS2,) -Existence of EPI reporting forms -Existence of electronic and hard transmission channels, -Feedback at the operational level	-Poor compliance with reporting deadlines	
Integration into the information system	-Integration of EPI data into the national health information system		
Research (surveys)	Carrying out the external review of the EPI		
Data quality	Realization of DQS, Monthly, semi-annual monitoring		
use of data	Planning and decision-making		
Links with surveillance systems	EPI monitoring is integrated into the IRCS		

**Leadership, management and coordination**

At the Ministry of Health and at the central level, 5 accountability frameworks are identified:

1. Performance contracts of the 8 DRS signed on 8 February 2019 under the authority of the MS SG and managed by the BSD;
2. Siguiri Polio Model implemented in 2016 following the Polio outbreak. It is multi-sectoral and chaired by the political-administrative authority concerned;
3. Accountability framework of the National Directorate of Major Endemics and Disease Control (DNGELM), which evaluates programmes on a quarterly basis;
4. Accountability framework in the 40 convergence municipalities with quarterly meetings chaired by the relevant political and administrative authority;
5. Performance framework for the quarterly EPI, which determines the granting of bonuses based on the objectives achieved.

In order to strengthen accountability at all levels, it is essential today to develop an integrated approach with different levels of responsibility. The recommendations made during the workshops of the 2019 Joint Assessment are to harmonize and expand the Siguiri accountability model to a broader scope and to continue the process of evaluating performance contracts in the DRS/DPS. In addition, it is important to share and deploy at the DRS level (2 tests) the approach based on the performance objectives currently developed at the central EPI.

At the operational level, local authorities are now involved in their management and financing. The current mechanism is as follows:

- ✓ Local authorities manage the funds through a single bank account dedicated to the Town Hall and have access to accounting management tools;
- ✓ The investment budget is allocated to local authorities via ANAFIC (Local Development Plan) by partners and local funds;
- ✓ On the other hand, local authorities do not yet have an operating budget that should be allocated by the State; Note that the State has undertaken to make operating budgets available in 2020



- ✓ Today, UNICEF pays the salaries of RECOs and ASCs in the 40 convergence municipalities.

The recommendation is the need to strengthen accountability, governance, coaching and ownership mechanisms at the community level. In addition, it is important that health centres and health posts, which are areas of competence of local authorities, become more involved in the development of the LDP.

At the level of programme coordination, it should be noted that there is an organizational framework that has led to the preparation of job descriptions and the identification of performance objectives. At the decentralized level, an evaluation of the organizational framework is planned in two test districts at the end of 2019.

## 6. Immunisation financing<sup>12</sup>

Please provide a brief overview of the main issues affecting the planning, budgeting, allocation, disbursement and execution of funds for health and immunisation. Please take the following aspects into account:

- **Availability of timely and accurate information for planning/budgeting (e.g. quantification of vaccine needs and pricing data), availability of medium-term and annual immunisation operational plans and budgets, whether they are integrated into the wider national health plan/budget, their relationship and consistency with microplanning processes and how they are reflected into national health financing frameworks.**
- **Allocation of sufficient resources in national health budgets for the immunisation programme/services, including for Gavi and non-Gavi vaccines, as well as operational and service delivery costs. Discuss the extent to which the national health plan/budget incorporates these costs, which partners might be providing funding for traditional vaccines, and any steps being taken to increase domestic resources for immunisation. If any co-financing defaults occurred in the last three years, describe any mitigation measures that have been implemented to avoid future defaults.**
- **Timely disbursement and execution of resources: the extent to which funds for immunisation-related activities (including vaccines and non-vaccine costs) are made available and executed in a timely fashion at all levels (e.g., national, province, district).**
- **Adequate reporting on health and immunisation financing and timely availability of reliable financing information to improve decision making.**

- The budget of the Ministry of Health represents 6% of the National Development Budget (BND) in 2018, i.e. 1,305,150,379 GNF out of a total of 20,155,542,568 GNF. It decreased by 1.98% in 2012, 1.75% in 2013 and 2.16% in 2014, followed by an increase of 4.9%, 5.6% and 6% in 2016, 2017 and 8% 2018 respectively.
- Despite this growth in the Ministry's budget, the State provides funding for the purchase of vaccines and the payment of Gavi co-financing. On the other hand, the EPI in Guinea remains highly dependent on external funding for its functioning and the implementation of operational activities. In 2018, the EPI's financing needs were estimated at 32,858,305,627 GNF and the expenses executed amounted to 16,796,727,277 GNF. The State's share of these needs was 16%, including co-financing. It should be noted that the amount of co-financing for the purchase of traditional vaccines (yellow fever and DTP) was \$232,500 in 2017 and \$391,320 in 2018.
- In the medium term, the financing needs of the EPI in the cMYP show a progressive decrease in the financing secured by the various contributors, while the needs are growing. Thus, the financing gap increases from \$942,187 in 2017 to \$5.1 million in 2020, representing an 82% increase in the need for secure financing. However, estimates made in the cMYP show an increase in co-financing of the state budget for the purchase of vaccines from 2% in 2017 to 5% 2020 while there is a decrease in the Government's contribution to other costs (operating, HR, equipment, etc.).
- Out of 148 activities scheduled for 2018, only 32 were fully implemented, or 22%, and 101 were not implemented (68%). This low rate is due to financial difficulties that have hindered the implementation of the EPI operational plan as a whole. Pooling financial support for the coordination of the expanded programme on immunization as a structure responsible for coordinating, supervising and providing technical support to regional directorates and health districts in order to improve the quality of the supply of immunization services remains a challenge. This pooling should represent the framework for the payment of all financial support allocated by the technical and financial partners in the health sector and intended to support the implementation of the operational work plan of the national coordination of the EPI as a framework structure at the operational level. Despite these difficulties, the EPI National Coordination ensured the permanent availability of inputs (vaccines and consumables), the regular supply of vaccination inputs to health districts, support for the implementation of vaccine-preventable

<sup>12</sup> Additional information and guidance on immunisation financing is available on the Gavi website <https://www.gavi.org/support/process/apply/additional-guidance/#financing>

disease surveillance activities, the regular holding of consultation frameworks and the organization of intensive vaccination activities (NIDs and LIDs).

## 7. PERFORMANCE OF GAVI SUPPORT

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

Provide a succinct analysis of the performance of Gavi's HSS support for the reporting period.

- **Progress of the HSS grant implementation** against objectives, budget and workplan, and significant deviations from plans (e.g. implementation delays, low expenditure rates, etc.), **using the below table.**

Objective 1	
Objective of the HSS grant (as per the HSS proposal or PSR)	<b>Increase the functionality of health districts from 52% in 2015 to 80% in 2021, particularly the 21 target districts</b>
Priority geographies / population groups or constraints to C&E addressed by the objective	21 low-performing health districts
% activities conducted / budget utilisation	Although the level of expenditure is 4.7%, the rate of achievement of the various activities for this objective is 30% (12/40 activities). This is explained by the contribution of funding from other programmes to the conduct of health sector reviews, the holding of the technical coordination committee of the Ministry of Health, the holding of certain coordination meetings without cost;
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	<ul style="list-style-type: none"> <li>• Organizational and human resources analysis of the ongoing Expanded Programme on Immunization (EPI),</li> <li>• External review of the EPI financed on HSS2;</li> <li>• Holding of 2/4 meetings of the Inter-Agency Coordination Committee (ICC) and one extraordinary meeting during the joint evaluation (PV and recommendations in Annex 2).</li> <li>• Institutional support to the eight CTHSS in the health regions financed by HSS2 at the end of August 2018</li> <li>• Revision of the Ministry of Health's financial management procedures manual and training of stakeholders</li> <li>• Institutional support for the EPI</li> <li>• Participation in the National Health Assembly through the Health Commission in the activities of the EPI and in the mobilization of State resources in favour of the EPI through the financing of UNICEF's regular resources</li> </ul>
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated changes in technical assistance <sup>13</sup> )	<ul style="list-style-type: none"> <li>• Support the development of integrated annual operational action plans for the 21 districts and 8 health regions</li> <li>• Conduct a study on cost recovery and COSAH functionality</li> <li>• Organize 4 quarterly meetings per year of the Technical Group of the Council on Immunization (TGV) with the technical assistance of IST and WAHO</li> <li>• Organize advocacy meetings for resource mobilization at the national, regional and prefectural levels</li> <li>• As part of the implementation of technical assistance and the accountability framework at the central EPI level, the system is being gradually implemented.</li> </ul> <p>Carry out formative supervision in regions, districts and health areas</p>
Objective 2:	
Objective of the HSS grant (as per the HSS proposal or PSR)	<b>Increase from 53% in 2015 to at least 80% in 2021 the coverage of fully vaccinated children in the 21 target health districts</b>
Priority geographies / population groups or	21 so-called low-performance health districts

<b>constraints to C&amp;E addressed by the objective</b>	
<b>% activities conducted / budget utilisation</b>	Out of a total of 19 activities, 7 have been fully implemented on HSS2 funding, one is in progress and 11 are to be reprogrammed for 2019. The main major achievements are.
<b>Major activities implemented &amp; Review of implementation progress</b> including key successes & outcomes / activities not implemented or delayed / financial absorption	<ul style="list-style-type: none"> <li>• Out of a total of 3,492 providers will have to be trained, 1818 have been trained in ACD/practical vaccination and 1059 in GEV.</li> <li>• Provision of 818 vaccination points by motorcycles, including the new 125cc off-road motorcycles with difficult access for advanced strategies</li> <li>• Finalization of the Recruitment process of 21 EPI focal points at the district level supported by Gavi. The recruitment process did not entail any costs</li> <li>• Out of 3,036 points of planned advanced strategies, 1891 were achieved with HSS2 funding, representing 62% coverage</li> </ul>
<b>Major activities planned for upcoming period</b> (mention significant changes / budget reallocations and associated <b>changes in technical assistance</b> <sup>13</sup> )	<ul style="list-style-type: none"> <li>• Organize the equitable analysis and implementation of ACE micro plans in the 21 health districts</li> <li>• Train health workers on the implementation of the RED approach in the 21 target districts of Gavi</li> <li>• Organize vaccination sessions as advanced strategies in the 861 vaccination sites</li> <li>• Train ECDs and CCSs on the results-based funding approach (RBF) in the 21 HSS2 target districts</li> <li>• Expand the FBR approach in 8 target districts as part of the improvement of EPI indicators</li> <li>• Organize at the regional level the EPI middle-level management training (MLM course)</li> </ul> <p>Deployment of 21 EPI focal points at district level</p>
<b>Objective 3:</b>	
<b>Objective of the HSS grant</b> (as per the HSS proposal or PSR)	Increase the average Effective Vaccine Management (EVM) score from 37% in 2016 to at least 80% in 2019 and maintain this performance until 2021
<b>Priority geographies / population groups or constraints to C&amp;E addressed by the objective</b>	<ul style="list-style-type: none"> <li>• Pendulum population in the 18 health districts housing mining areas Peri-urban population/urban, island, and those living in hard-to-reach areas</li> </ul>
<b>% activities conducted / budget utilisation</b>	Out of a total of 49 activities, 15 have been fully implemented on HSS2 funding, one activity is ongoing (supply chain modelling) and 33 are to be rescheduled for 2019. The main major achievements are as follows.
<b>Major activities implemented &amp; Review of implementation progress</b> including key successes & outcomes / activities not implemented or delayed / financial absorption	<ul style="list-style-type: none"> <li>• Training of an EPI manager on the Solar Cold Chain organized by the LOGIVAC center</li> <li>• Holding of quarterly meetings of the National Technical Logistics Committee</li> <li>• Training of health centre/health post managers in Effective Vaccine Management</li> <li>• Equipping the central level of a 40m3 cold room</li> <li>• Curative and preventive maintenance of certain solar fridges</li> <li>• Provision of 43 cold chain curative maintenance kits for DPS and DRS</li> <li>• Allocation by the Ministry of Health of 05 4x4 supervision vehicles (coordination EPI 04, and BSD 01)</li> <li>• Acquisition of equipment under the CCE OP (848 solar refrigerators, 05 ARKTEKs and 2000 Fridge-Tags on CCEOP financing plus 20% co-financed on HSS2 funds) and 240 acquired on UNICEF funds</li> <li>• Acquisition of 1200 freezing indicators (Freeze -Tags) for the transport of vaccines</li> <li>• Fuel supplies to the central EPI for the operation of the cold rooms</li> <li>• Data logger installation (MULTILOG2)</li> <li>• Recruitment and implementation of a logistics P3</li> </ul> <p>Equip regions and districts with sufficient coolers for maximum supply</p>

<p><b>Major activities planned for upcoming period</b> (mention significant changes / budget reallocations and associated <b>changes in technical assistance</b><sup>13</sup>)</p>	<ul style="list-style-type: none"> <li>• Carry out a supply chain modelling study</li> <li>• Train 100 district and regional managers, including the national pool of trainers on Effective Vaccine Management (EVM)</li> <li>• Equipping the central level of a 40m3 cold room</li> <li>• Provide 268 sites with solar fridges</li> <li>• Provide formative supervision</li> <li>• Continue training on effective vaccine management (Centre/ Health Centre)</li> <li>• Build a warehouse and administration services for the national coordination of the EPI</li> <li>• Conduct a mid-term self-assessment</li> <li>• Provide health posts with vaccine carriers</li> </ul> <p>Continue to implement the maintenance plan</p>
<p><b>Objective 4:</b></p>	
<p><b>Objective of the HSS grant</b> (as per the HSS proposal or PSR)</p>	<p><b>By 2021, at least 95% of the parents of the target population in the 21 selected health districts accept and request vaccination services</b></p>
<p><b>Priority geographies / population groups or constraints to C&amp;E addressed by the objective</b></p>	<ul style="list-style-type: none"> <li>• Pendulum population in the 18 health districts housing mining areas</li> </ul> <p>Peri-urban population/urban, island, and those living in hard-to-reach areas</p>
<p><b>% activities conducted / budget utilisation</b></p>	<p>2 activities carried out/17. These achievements correspond to the expenses incurred (10%) since the beginning of January with the recruitment and implementation of C4D consultants</p>
<p><b>Major activities implemented &amp; Review of implementation progress</b> including key successes &amp; outcomes / activities not implemented or delayed / financial absorption</p>	<ul style="list-style-type: none"> <li>• Support for IEC meetings (information, education, community) around each advanced strategy point for a better consideration of immunization issues in the information package provided to women of childbearing age</li> <li>• Contractualization process with CSOs (38 districts have a network of 49 CSOs), a process initiated at no cost</li> </ul> <p>Recruitment and implementation since early January 2018 of 9 C4D consultants, including 1 at the district level</p>
<p><b>Major activities planned for upcoming period</b> (mention significant changes / budget reallocations and associated <b>changes in technical assistance</b><sup>14</sup>)</p>	<ul style="list-style-type: none"> <li>• Organize a national workshop on the development of a multimedia plan and revision of immunization communication modules</li> <li>• Develop specific messages in support of the introduction of each of the new vaccines (French and 5 national languages)</li> <li>• Organize awareness meetings (38 districts and 8 regions) with religious denominations, traditional healers for their adherence to vaccination twice a year</li> <li>• Advocate with MPs (health commission) for their involvement in vaccination activities in their constituencies</li> <li>• Organize annual advocacy meetings (by level) with the association of paediatricians, the media, mobile phone companies and the private sector for their involvement in vaccination</li> </ul>

<sup>13</sup> When specifying Technical Assistance (TA) 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 in the JA. TA needs should however describe - to the extent known to date - the type of TA required (staff, consultants, training, etc.), the provider of TA (core/expanded partner) the quantity/duration required, modality (embedded; sub-national; coaching; etc.), and 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 reference guide.

<sup>14</sup> When specifying Technical Assistance (TA) 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 in the JA. TA needs should however describe - to the extent known to date - the type of TA required (staff, consultants, training, etc.), the provider of TA (core/expanded partner) the quantity/duration required, modality (embedded; sub-national; coaching; etc.), and 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 reference guide.

	<ul style="list-style-type: none"> <li>• Train members of women's groups on immunization awareness and mobilization.</li> <li>• Periodic sharing of information on immunization with mayors of urban municipalities and sub-prefects to strengthen their commitment and obtain their support for routine immunization.</li> <li>• High level advocacy meetings with religious leaders in Conakry</li> <li>• Train 91 journalists and presenters (2 x 33 DS and 5 x 05 Municipalities of Conakry) in collaboration with radio directors</li> <li>• Produce radio spots in French and in 5 national languages (Soussou, Malinké, Poular, Kpele and Kissi)</li> <li>• Produce TV spots in French and in 5 national languages (Soussou, Malenke, Poular, Kpele and Kissi)</li> <li>• Establish a contract with 7 TV stations for the broadcasting of messages in favour of routine vaccination</li> <li>• Train 08 managers of the EPI and MS communication unit in strategic communication</li> <li>• Establish a communication focal point in each of the 8 regions, 38 health districts and 412 health centres</li> </ul>
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In the text box below, briefly describe:

- **Achievements against agreed targets** as specified in the grant performance framework (GPF), and key outcomes. E.g. how does the number of additional children vaccinated and under-immunised children in districts supported by the HSS grant compare to other non-supported districts/national targets. Which indicators in the GPF were achieved / impacted by the activities conducted?
- How Gavi support is **contributing to address the key drivers of low immunisation** outcomes?
- Whether the **selection of activities is still relevant**, realistic and well prioritised in light of the situation analysis conducted, as well as financial absorption and implementation rates.
- Planned **budget reallocations** (please attach the revised budget, using the Gavi budget template).
- If applicable, briefly describe the usage and results achieved with the **performance based funding (PBF)** the country received. What grant performance framework (GPF) metrics will be used to track progress?
- **Complementarity and synergies with other donor support** (e.g. the Global Fund, Global Financing Facility)
- **Private Sector and INFUSE<sup>15</sup> partnerships** and key outcomes (e.g. increasing capacity building and demand, improving service delivery and data management). Please outline the sources (e.g. Private sector contributions, Gavi matching Fund and Gavi core funding – HSS/PEF) and amount of funding.
- **Civil Society Organisation (CSO) participation** in service delivery and the funding modality (i.e. whether support provided through Gavi's HSS or other donor funding).

## 7.2. Performance of vaccine support

Provide a succinct analysis of the performance of Gavi vaccine grants, focusing on **recently (i.e. in the last two years) introduced vaccines**, or planned to be introduced vaccines, **and campaigns**, supplementary immunisation activities (SIAs), demonstration programmes, MACs etc., as well as switches in vaccine presentations. This section should capture the following:

- **Vaccine-related issues which may have been highlighted for the vaccine renewals**, such as challenges on stock management (overstock, stock-outs, significant consumption variations etc.), wastage rates, target assumptions, annual consumption trend, quantification data triangulation, etc., and **plans to address them**.
- **NVS introductions and switches**: If country has recently introduced or switched the product or presentation of an existing vaccine, then the country is requested to highlight the performance (coverage) and lessons learned from the introduction/switch, key implementation challenges and the next steps to address them.
- **Campaigns/SIA**: Provide information on recent campaigns (since last JA) and key results of the post-campaign survey, including the coverage achieved. If achieved coverage was low, provide reasons. Provide other key lessons learned and the next steps to address them. If post-campaign survey has not

<sup>15</sup> INFUSE was launched by the Gavi Alliance to help bridge the gap between the supply and demand side for new technologies and innovations and to create a market place for these innovations.

been conducted, highlight reasons for the delay and the expected timelines. Are there any key observations concerning how the operational cost support was spent? Explain how the campaign contributed to strengthening routine immunisation e.g. by identifying zero-dose children and lessons learned.

- Update of the **situation analysis for measles and rubella** (using the latest immunisation coverage and surveillance data for measles, rubella and congenital rubella syndrome from national and sub-national levels<sup>16</sup>) and update of the country's **measles and rubella 5 year plan** (e.g. future dates of MR intro, MCV2 intro, follow-up campaigns, etc.).
- **Describe key actions related to Gavi vaccine support in the coming year** (e.g. decision-making on vaccine introduction, future application, planning and implementation of introduction/ campaigns or decisions to switch vaccine product, presentation or schedule) **and associated changes in technical assistance**<sup>13</sup>.

Since the introduction of IPV in 2015, the expanded programme of immunization has not introduced any new vaccines, but it should be recalled that in May 2017, the process of replacing VAT with Td in routine immunization was finalized and since January 2018 its use has been effective throughout the country.

With regard to supplementary immunization activities, 2018 saw two polio vaccination campaigns: one national in the 38 health districts and the second local in the regions of Conakry, Kindia, Kankan and Faranah, which performed less well in the first round.

Administrative coverage was **102.2%** and **103.6%** respectively. For each of these campaigns, a LQAS survey was carried out with the support of WHO, the results of which are as follows:

Polio vaccination campaigns: out of 38 health districts, 24 were deemed to be successful with less than 5% of children not vaccinated and **14/38** less successful with insufficiently covered areas justifying the organization of a second round.

2- JLV: Out of the 15 health districts that were concerned by the 2nd round, the vaccination coverage of 07 of them were considered acceptable by the survey against those of 08 unacceptable DS with more than 5% of children not vaccinated.

It should be noted that the organization of local vaccination days was combined with vitamin A supplementation for children aged 6 to 59 months.

The main reasons for the low vaccine coverage during LQS were: (i) the absence of children from home, (ii) reluctance/refusal, (iii) non-visiting households by vaccination teams

In addition, there are some observations from supervision, including the lack of close monitoring of vaccination teams in some health centres.

**Corrective actions:** Strengthen communication and social mobilization at all levels with the involvement of all stakeholders; strengthen local supervision; review the situation and capitalize on achievements.

**The main lessons learned:** regular meetings of the national polio response unit, including teleconferences with the regions, WHO/IST and UNICEF; contribution of territorial administrators in mobilizing for immunization and managing refusals (governors, mayors, prefects, sub-prefects, district chiefs and districts; important contribution of the press, Ministry of Social Action for mobilization and acceptance of immunization.

As part of the **strengthening of routine immunization during SIAs**, the skills of about 10,053 vaccinators were strengthened; several zero-dose children were vaccinated with OPV with data distributed as follows: 47,114 in Round 1 and 29,929 in Round 2; analysis of the reasons for not vaccinating children by LQAS,

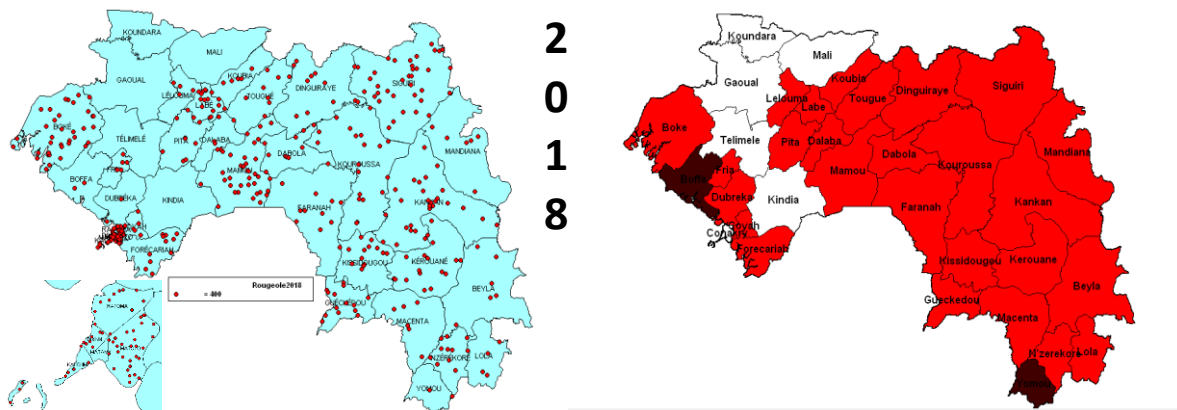
<sup>16</sup> Please refer to the JA analysis guidance document for additional information on the expected analyses for measles and rubella.

strengthening communication through the dissemination of key messages in favour of routine vaccination. In addition, the opportunity was taken to strengthen surveillance of vaccine-preventable diseases.

In the same context, an African vaccination week coupled with the Mother and Child Health Week was organized by the Ministry of Health through the EPI and the National Directorate of Family Health and Nutrition with the technical and financial support of partners in the country's 38 health districts from 1 to 6 August 2018. This immunization intensification activity made it possible to vaccinate 43,108 children from 0 to 11 months and 9,558 children from 12 to 23 months in Penta3; 46,629 children from 0 to 11 months and 8,912 children from 12 to 23 in MCV and 40,794 pregnant women in Td, among others.

**Situation analysis for measles and rubella**

Since 2016, Guinea has faced recurrent measles epidemics. During 2018 1884 suspected measles cases including 530 IgM confirmed cases and 15 positive rubella cases were reported in 33 health districts, with a high prevalence in Boffa, Yomou and Matam districts. The figures below show the geographical distribution of cases.



Distribution of reported and confirmed suspected cases of measles by Health District in Guinea in 2018.

In response to these outbreaks, local responses were organized by the districts concerned. Despite the conduct of these responses, herd immunity could not be increased as new cases were subsequently confirmed, thus demonstrating the circulation of the virus in the country.

This situation is believed to be due to many persistent risk factors in most of the country's health districts, including: (i) the high population density in urban areas, especially in Conakry, Siguiri, Boké and Kindia; (ii) the persistence of cases of refusal/reticence to vaccination in some localities; (iii) the poor accessibility and use of health services resulting in low vaccination coverage for target children; (iv) the poor performance of the measles case surveillance system with an overall reporting rate of less than 1 case/100,000 inhabitants/year; (v) the poor implementation of an immunization platform in the second year of life and the absence of a second dose of measles in routine. In the same vein, a survey on factors related to the persistence of measles in Guinea was carried out in order to contribute to its control and elimination. Thus, the main factors were the insufficient monitoring of children lost to follow-up; the lack of daily vaccination of children against measles in order to reduce the rate of loss; the lack of knowledge of the vaccination certificate as a means of preventing measles by some parents; the insufficient control of the vaccination calendar by parents of children....

In addition, in accordance with the objectives of the GVAP 2011-2020, the country has developed a strategic measles elimination plan covering a period of 5 years (2019 to 2023), while the process of submitting plans for the introduction of VAR 2 into the routine EPI and organizing a follow-up measles vaccination campaign began in 2018 and is ongoing in 2019.

In the same vein and with reference to the cMYP 2016-2020, in addition to the 2nd dose of VAR in routine vaccination, the submission process for Hepb and Men A was to be carried out with a view to their routine introduction in 2019, but unfortunately this was not effective for reasons of financial resource mobilization for Hep B. As for the planning of Men A, it was postponed for the following year.

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

If your country is receiving CCEOP support from Gavi, provide a brief update on the following:

- **Performance** on five mandatory CCEOP indicators and other related intermediate results – achievement against agreed targets as specified in the grant performance framework (GPF) with discussion on successes, challenges and solutions for reaching targets;
- **Implementation status** (number of equipment installed / waiting installation, user feedback on preventive maintenance training, refrigerator performance, etc.), including any challenges / lessons learned;
- **Contribution** of CCEOP to immunisation performance (i.e. how CCEOP is contributing to improving coverage and equity);
- **Changes in technical assistance** in implementing CCEOP support.<sup>13</sup>

Note: an updated CCE inventory must be submitted together with the CCEOP renewal request.

Guinea has committed to review its performance framework with 3 mandatory indicators and 02 intermediate indicators in accordance with the Performance Framework of the submission document.

**Performance against mandatory indicators:**

1. **Number of equipped institutions that replace (if applicable) the ECF with ILRs, SDSs or long-term passive devices, of any model, eligible for the platform, regardless of the funding source:** In the submission to the POECF in 2016, it was planned to replace obsolete, broken down cold chain equipment that did not comply with PQS standards, regardless of the model. This equipment was not included in the first instalment of the POECF implemented in 2018-2019. The performance of this indicator cannot therefore be measured.
2. **Number of facilities previously without equipment and now equipped with ECFs eligible for the platform (i.e. ILR, SDD or long-term passive devices):** a total of 853 health stations were equipped with cold chain equipment including 848 SDD solar refrigerators and 05 long-life coolers (ARKTEK) all installed and functional. Two refrigerator models were installed, namely 638 for the TCW2043 SDD model of the BMS brand and 210 for the HTCD-160 SDD model of the Haier brand.
 

The TCW2043 SDD refrigerator is equipped with a continuous remote temperature recorder. However, 200 of the 638 health stations in BMS do not have a mobile network to connect the sim-card of the refrigerator data logger. Fifty ministry officials including partners have access to the platform for remote monitoring of equipment temperature.

The HTCD-160 SDD refrigerator is equipped with a continuous temperature recorder that must be connected to a computer with software to be installed on a computer to generate the temperature. However, health posts do not have computers to generate the temperature of the period and the recorder does not allow a 30-day temperature reading.

The 200 BMS refrigerators and 210 Haier refrigerators have been equipped with Fridge-Tag to facilitate temperature monitoring.
3. **Number of maintenance supervision performed on the number of supervision planned:** Since the end of the installation of refrigerators under the POECF in July 2019, maintenance supervision is included in the monthly supervision of the districts. To ensure the functioning and training of users, the CCEOP monitoring committee carried out specific supervision in 20 health posts.

**Performance of intermediate indicators**

1. **Operating status of cold chain equipment:** To date, 100% of the refrigerators installed under the CCEOP are functional. 34 districts out of 38, or 89%, have at least 90% of functional equipment.
2. **Number of health managers trained and sent to monitor the supply chain and the rate of reported follow-up activities:**

**Implementation status** (number of equipment/standby installations, user comments on preventive maintenance training, refrigerator efficiency, etc.) including any problems/lessons learned; 848 solar refrigerators and 05 Arkteks were planned and installed. According to most users, there was insufficient training. During the supervisions conducted by the members of the CCEOP Monitoring Committee (PMT), it was found that some users do not know how to read the temperature of the HTCD-160 SDD refrigerator's continuous recorder. The manual on the use of the refrigerator provided by the local Haier representative is in English, which is a handicap for users. As for the TCW2043 SDD refrigerator, the user does not have access to the platform but the temperature displayed by the data logger is visible on the indicator light. The 2 models installed in the country have temperatures between +2oC and +8oC.

- **CCEOP's contribution** to the performance of the immunization system (e. g. how CCEOP contributes to improving coverage and equity); the installation of 853 cold chain equipment (848 refrigerators + 05 Arkteks) that ended in July 2019 brought vaccination closer to the target population. The use of this equipment will



undoubtedly make it possible to reach vulnerable populations and those living in the most remote areas and will contribute to increasing the country's vaccination coverage with the implementation of daily vaccination. It will also reduce vaccine stockouts and missed opportunities. Future immunization coverage evaluations will measure the impact of the POECF.

## 8. Financial management performance

Provide a succinct review of the performance in terms of financial management of Gavi's cash grants (for all cash grants, such as HSS, PBF funding, vaccine introduction grants, campaign operational cost grants, switch grants, transition grants, etc.). This should take the following aspects into account:

- Financial **absorption** and utilisation rates on all Gavi cash support listed separately<sup>17</sup>;
- **Compliance** with financial reporting and audit requirements noting each grant (listing the compliance with each cash support grant separately, as above);
- Status of high-priority "show stopper" actions from the Grant Management Requirements (GMRs) and other issues (such as misuse of funds and reimbursement status) arising from review engagements (e.g. Gavi cash programme audits, annual external audits, internal audits, etc.);
- Financial management **systems**<sup>18</sup>.

The tripartite agreement signed between UNICEF, the Ministry of Health and GAVI is for a total amount of USD 15,107,479. The amount received by UNICEF as at 18 December 2018 is USD 11,330,609.00 and USD 3,776,870.00 remains to be received. The cumulative expenditure on this amount amounts to 5,147,242.24, or 45% of the amount received. The amount not yet spent is for a total value of USD 6,183,366.76. The purchase of materials, equipment and supplies for services represents more than 60% of the total amount under the heading of programmed expenditure (see 6.3. Details of expenditure incurred).

Financial implementation under the tripartite agreement was effective in early January 2018 through the purchase of equipment and materials. With the exception of the 6 EPI trucks scheduled for purchase in 2019, all the other materials and equipment provided for in HSS2 are already purchased and being distributed. As previously noted, the transfer of HSS2 cash funds to the central EPI and the DSB could not be effective in 2018 due to the delay in the implementation of fiduciary risk management measures. However, in 2018, the direct payment modality was carried out on a small scale with specific activities that took place during the joint evaluation, the payment of WHO consultants in support of the external review of the EPI and the Datas Managers, the purchase of fuel for the operation of generators at the central level, the installation of MULTiLOG2 in the central cold rooms and the transport of motorcycles acquired as part of the project. However, following official requests from the Minister of Health in 2018, a careful analysis by UNICEF led to the preparation of a guidance note on the direct payment modality, taking into account the budget closure phase and the need for it to be validated by the Secretary General of the Ministry of Health. It will be operational in the first quarter of 2019. At the level of the DRS, the transfer was effective when the specific HACT measures were put in place. The tables below describe the expenditure situation up to 15 December 2018.

### 1.1. Amount received in relation to the tripartite agreement

Amount of the tripartite agreement (USD)	15,107,479.00
Amount received as of 18 Decembe, 2018 (USD)	11,330,609.00
Outstanding balance to be received (USD)	3,776,870.00

### 1.2. Summary of expenses

Description	Cumulative Expenditures
Programmable expenses	4,902,135.47
Indirect support cost (5%)	245,106.77
Total:	5,147,242.24
Amount received (USD):	11,330,609.00

<sup>17</sup> If in your country Gavi funds are managed by partners (i.e. UNICEF and WHO), fund utilisation by these agencies should also be reviewed.

<sup>18</sup> In case any modifications have been made or are planned to the financial management arrangements please indicate them in this section.

Amount not yet spent	6,183,366.76
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**1.3. Details of expenses incurred**

Description	Expenses incurred		Cash advances	Expenses Cumulative	Commitments
	2017	2018			
Personnel costs and other personnel costs	0.00	604,332.19	0.00	604,332.19	0.00
Supplies and commodities	0.00	3,137,598.26	0.00	3,137,598.26	10,893.31
Contractual services	0.00	115,506.16	0.00	115,506.16	53,838.68
Travel	0.00	24,039.34	0.00	24,039.34	0.00
Transfers and grants	0.00	144,560.13	773,241.77	917,801.90	0.00
General operation + other direct costs	0.00	102,857.62	0.00	102,857.62	59,776.09
<b>Total Programmable Cost</b>	<b>0.00</b>	<b>4,128,893.70</b>	<b>773,241.77</b>	<b>4,902,135.47</b>	<b>124,508.08</b>
Indirect support cost 5%.	0.00	206,444.69	38,662.09	245,106.77	
<b>Total Total</b>	<b>0.00</b>	<b>4,335,338.39</b>	<b>811,903.86</b>	<b>5,147,242.24</b>	

**1.4. Breakdown of expenses incurred by the 5 components of HSS2**

Domains/ Objective	Overall amount per year and level of expenditure by objective					
	Year 1 (June 2017-June 2018)	Year 2 (July 2018-July 2019)	TOTAL	TOTAL EXPENDITURE 1st year	ECART GLOBAL	% OF DECAISSEMENT
	In USD		In USD			In % of
<b>Objective 1 - Coordination</b>	1,996,591	1,860,036	3,856,628	181,268	3,675,359	4.70%
<b>Objective 2 - Services provided</b>	2,202,858	2,771,317	4,974,175	2,235,976	2,738,200	44.95%
<b>Objective 3 - Logistics</b>	4,616,625	2,352,670	6,969,295	1,961,618	5,007,677	28.15%
<b>Objective 4 - Communication</b>	602,960	789,130	1,392,090	157,572	1,234,518	11.32%
<b>Objective 5 - Management Data from the</b>	781,511	511,661	1,293,172	224,703	1,068,469	17.38%
<b>Management costs -</b>	433,955	409,432	843,387	386,105	457,282	45.78%
<b>Grand total</b>	<b>10,634,501</b>	<b>8,694,246</b>	<b>19,328,747</b>	<b>5,147,242</b>	<b>14,181,505</b>	<b>26.63%</b>

**8.1. Transition plan monitoring (applicable if country is in accelerated transition phase)**

*If your country is transitioning out of Gavi support, specify whether the country has a transition plan in place. If no transition plan exists, please describe plans to develop one and other actions to prepare for transition.*

- *If a transition plan is in place, please provide a brief overview on the following:*
  - *Implementation progress of planned activities;*
  - *Implementation bottlenecks and corrective actions;*
  - *Adherence to deadlines: are activities on time or delayed and, if delayed, the revised expected timeline for completion;*
  - *Transition grant: specify and explain any significant changes proposed to activities funded by Gavi through the transition grant (e.g., dropping an activity, adding a new activity or changing the content/budget of an activity);*
  - *If any changes are requested, please submit a consolidated revised version of the transition plan.*

**8.2. Technical Assistance (TA) (progress on ongoing TCA plan)**

- *Describe the strategic approach to Technical Assistance (TA) delivery to improving coverage and equity in reaching the under-immunised and unimmunised children. (i.e. embedded support, subnational support, support from expanded partners etc.)*
- *On the basis of the reporting against milestones, summarise the progress of partners in delivering technical assistance.*
- *Highlight progress and challenges in implementing the TCA plan.*
- *Specify any amendments/ changes to the TA currently planned for the remainder of the year.*

**9. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL**

*Provide the status of the prioritised strategic actions identified in the previous Joint Appraisal<sup>19</sup> and any additional significant Independent Review Committee (IRC) or High Level Review Panel (HLRP) recommendations (if applicable).*

Prioritised actions from previous Joint Appraisal	Current status
1.	
2.	
3.	
4.	
5.	
Additional significant IRC / HLRP recommendations (if applicable)	Current status

*If findings have not been addressed and/or related actions have not taken place, provide a brief explanation and clarify whether this is being prioritised in the new action plan (section 7 below).*

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

<sup>19</sup> Refer to the section “Prioritised Country Needs” in last year’s Joint Appraisal report

Briefly summarise the **key activities to be implemented next year** with Gavi grant support, including if relevant any **introductions** for vaccine applications already approved; preparation of **new applications**, preparation of **investment cases** for additional vaccines, and/ or plans related to HSS / CCEOP grants, etc.

In the context of these planned activities and based on the analyses provided in the above sections, describe the five **highest priority findings and actions to be undertaken to enhance the impact of Gavi support or to mitigate potential future risks to programme and grant performance**.

Please indicate if any **modifications** to Gavi support are being requested (indicating the rationale and main changes), such as:

- Changes to country targets as established earlier, either from the agreed Grant Performance Framework (GPF) or as part of the NVS renewal request submitted by 15 May;
- Plans to change any vaccine presentation or type;
- Plans to use available flexibilities to reallocate budgeted funds to focus on identified priority areas.

**Overview of key activities planned for the next year and requested modifications to Gavi support:**

Taking into account the socio-political context, epidemiology and health system financing, in 2019, actions will mainly focus on strengthening coordination, synergy and complementarity between operational partners, actions aimed at increasing DTP-hEPb-hIB3 immunization coverage from 45% to 75% and reducing inequalities by developing differentiated strategies at the level of priority districts. This objective can only be achieved through a Community approach that will improve the supply of services by using vaccination as a preferred platform for this purpose.

The country will continue the process of introducing new vaccines with the preparation of new applications, the preparation of investment applications for other vaccines and/or renewed plans for HSS and POECF grants, etc.

This table draws from the previous JA sections, summarizing key findings and agreed actions, as well as indicating required resources and support, such as associated needs for technical assistance<sup>20</sup>.

<b>Key finding / Action 1</b>	Increase the functionality of health districts from 52% in 2015 to 80% in 2021, in particular the 27-priority districts
Current reaction	<b>26% of the structures evaluated in 2019 have a "high performance" (BSD Report of 22 June 2019),</b>
Agreed country actions	<ul style="list-style-type: none"> <li><b>a)</b> Support the validation and dissemination of the organizational and human resources analysis report of the Expanded Programme on Immunization (EPI)</li> <li><b>b)</b> Advocacy for the consideration of problems related to the management of the EPI and vaccination in consultation platforms such as the Presidency, the Prime Minister's Office, Parliament, the Ministry of Health, MATD with a view to mobilising additional resources for</li> <li><b>c)</b> Pursue/maintain the functionality of coordination frameworks at the national and operational level (CTC, ICC, NITAG, CTRS, CTPS, CTPS, Organisation of monthly teleconferences with DRS/DPS) with a view to strengthening accountability, complementarity and synergy of actions between the various actors</li> <li><b>d)</b> Draft legal texts related to vaccination - law on vaccination</li> <li><b>e)</b> Update annually the mapping of health sector interventions and financing</li> <li><b>f)</b> Support the process of developing action plans (EPI, BSD, DRS, domestic resource mobilization plan for the health sector)</li> <li><b>g)</b> Mission Support will be provided to the teams of the 8 Governorates to visit the 12 Priority 1 Health Districts for a dialogue with communities and implementing actors with a view to improving the performance of the EPI</li> <li><b>h)</b> Organize regional and prefectural control/inspection missions of structures</li> </ul>

<sup>20</sup> The needs indicated in the JA will inform the TCA planning. However, when specifying Technical Assistance (TA) needs, do not include elements of resource requirements. These will be discussed in the context of the Targeted Country Assistance (TCA) planning. 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. The TA menu of support is available as reference guide.

	<ul style="list-style-type: none"> <li>i) Revise the institutional framework of the DRS and DPS according to their coordination and support missions</li> <li>j) Review the national human resources development policy and plan</li> <li>k) Support the organization of a health sector review Support the health sector review</li> </ul>
Expected outputs/ results	High-performance structures increased from 26% to 40% at the end of 2019
Associated calendar	January - December 2019
Resources/ support and technical assistance required	National level managers (DSR, EPI, DNGELM, HR, DAF), LMC support, WHO, UNICEF, World Bank
<b>Main result/ action 2</b>	Increase from 53% in 2015 to at least 80% in 2021 the coverage of fully vaccinated children in the 21 target health districts
Current reaction	<b>24% of children under one year of age are fully vaccinated (EDS 2018)</b>
Agreed country actions	<ul style="list-style-type: none"> <li>a) Support for the organization of intensified immunization activities (AVI) for 3 consecutive weeks in the 12 priority health districts concerned by the equity analysis</li> <li>b) Organize integrated formative supervision from the EPI to the DRS and from the DRS to the DPS/CS and DPS to the CS in the field in order to strengthen the capacities of providers for effective and good quality immunization services including the integrated package (SR, SRAJ, PCIMNE, NN Ess care; Nutrit, SONU, FP etc.)</li> <li>c) Support for Immunization Strategies: financing and implementation of progress in the 27 priority SDs (priority 2); this support will be provided during the last 6 months of 2019 and will be continued in 2020;</li> <li>d) Institutionalization of interoperability between health and civil status at the communal level (birth registration) in convergence municipalities and other municipalities in priority districts Support for the relaunch of deadlines in CS/PS (hard or electronic deadlines);</li> <li>e) Support for the reduction of dropout rates - active research;</li> <li>f) Develop a system for monitoring unvaccinated children in all CS/PS through a reminder system of the population's vaccination schedule by telephone or other NICT;</li> <li>g) Support the active search for and catch-up of people lost to follow-up during AS, AVI, active case finding at vaccination sites.</li> <li>h) Train the 26 CCSs on the results-based funding approach (RBF) in the 2 target health districts in 2019 of HSS2 ( Dinguiraye and Labe)</li> <li>i) Extend the FBR approach to all health centres in the Dinguiraye and Labe health districts (26) with 15 quarterly evaluation indicators</li> <li>j) Ensure the monitoring and evaluation missions of the implementation of the FBR approach</li> <li>k) Organize micro-plan workshops on equity in districts with a greater number of non-vaccinated and/or low-performing children</li> <li>l) Support the implementation of microplan workshops on equity in districts with more non-vaccinated and/or low-performing children</li> <li>m) Organize the local support day for mothers who have observed good immunization practices (GVHD) preferably in June of each health month</li> </ul>
Expected outputs/ results	NA- programme coverage survey in 2020 and the next MICS in 2022
Associated calendar	January-December 2019
Resources/ support and technical assistance required	National level managers (DSR, EPI, DNGELM, HR, DAF), LMC support, WHO, UNICEF, World Bank
<b>Main result/ action 3</b>	Increase the average Effective Vaccine Management (EVM) score from 37% in 2016 to at least 80% in 2019 and maintain this performance until 2021
Current reaction	<b>ND. Auto GEV scheduled for the last quarter of 2019</b>

Agreed country actions	<ul style="list-style-type: none"> <li>a) Supply of vaccines to DSs at health centres and health posts with cold chain equipment;</li> <li>b) Monthly monitoring of vaccine management at district level (inventories, supervision, etc.);</li> <li>c) Replacement/Implementation of the maintenance plan for CdF equipment.</li> <li>d) Carry out a supply chain modelling study in terms of structures (subnational or regional depots) and distribution systems (push or pull) to improve availability, efficiency and equity</li> <li>e) Rehabilitate the loading and unloading area for vaccines to bring it up to standard</li> <li>f) Train 10 maintenance technicians (2 at the national level and 1 per region) on the Solar Cold Chain organized by the LOGIVAC center</li> <li>g) Establish a contract and ensure the maintenance of central and regional cold rooms</li> <li>h) Train 69 couriers in the use of vaccine management tools and vaccination equipment</li> <li>i) Purchase and installation of fire extinguishers for regional and district levels (3 per region and 2 per district)</li> <li>j) Provide the EPI with 2 transport trucks</li> <li>k) Provide the regions with 4 vans for the regions' relay cold rooms</li> <li>l) Install 25 incinerators and repair 4 failed incinerators</li> <li>m) Build a warehouse and administration services for the national coordination of the EPI</li> <li>n) Monitor and evaluate the implementation of the GEV improvement plan</li> <li>o) Multiplication and breakdown of strategic documents</li> <li>p) Ensure monthly connection fees for EPI and BSD</li> <li>q) Inventory of IMOs</li> </ul>
Expected outputs/ results	The average score for Effective Vaccine Management (EVM) increased from 37% in 2016 to at least 50% in 2019
Associated calendar	January-December 2019
Resources/ support and technical assistance required	National level managers (DSR, EPI, DNGELM, HR, DAF), LMC support, WHO, UNICEF, World Bank
<b>Main result/ action 4</b>	By 2021, at least 95% of the parents of the target population in the 27 selected health districts accept and request vaccination services
Current reaction	<b>ND. A small-scale CAP survey will be conducted in 2019.</b>
Agreed country actions	<ul style="list-style-type: none"> <li>a) Train members of women's groups on immunization awareness and mobilization</li> <li>b) Regular sharing of information on immunization with mayors of urban municipalities and sub-prefects to strengthen their support and obtain their support for routine immunization</li> <li>c) Institutionalization of community dialogues on immunization "plus" and Support IEC meetings (information, education, community) around each advanced strategy point for a better consideration of immunization issues in the information package provided to women of childbearing age</li> <li>d) High level advocacy meetings with religious leaders in Conakry</li> <li>e) Train 91 journalists and presenters (2 x 33 DS and 5 x 05 Municipalities of Conakry) in collaboration with radio directors</li> <li>f) Produce radio spots in French and in 5 national languages (Soussou, Malenke, Poular, Kpele and Kissi)</li> <li>g) Produce TV spots in French and in 5 national languages (Soussou, Malenke, Poular, Kpele and Kissi)</li> <li>h) Establish a contract with 28 rural radio stations, 28 private radio stations and 1 national radio station to broadcast messages in favour of routine immunization</li> <li>i) Establish a contract with 7 TV stations for the broadcasting of messages in favour of routine vaccination</li> <li>j) Train 08 managers of the EPI and MS communication unit in strategic communication</li> <li>k) Establish a communication focal point in each of the 8 regions, 38 health districts and 412 health centres</li> <li>l) Produce a documentary film on vaccination and EPI target diseases (year1 and year2 for production and dissemination, year3-an5 for dissemination only)</li> </ul>

	<b>m)</b> Develop public-private partnerships for service delivery, resource mobilization and advocacy (telephony)
Expected outputs/ results	<b>80% of the parents of the target population in the 27 selected health districts accept and request vaccination services</b>
Associated calendar	January-December 2019
Resources/ support and technical assistance required	National level managers (DSR, EPI, DNGELM, HR, DAF), LMC support, WHO, UNICEF, World Bank
<b>Main result/ action 5</b>	Reduce the gap between administrative data and Penta3 immunization coverage survey data from 30 points in 2015 to 5 points in 2021
Current reaction	In 2018, the gap between administrative data and WENIC data in Penta3 is 55 points
Agreed country actions	<p><b>a)</b> Implementation of the data quality improvement plan</p> <p><b>b)</b> Reproduction and availability of management tools (vaccination registers, child health records, child health records, etc.) in all vaccination points (413 CS+ 846 SPs/private structures, associations/Army Health Services = 1259);</p> <p><b>c)</b> Bimonthly supervision of the central level in the field during the first 6 months: deploy the staff of the central level EPI and partners in the field in the priority districts; provide funds to support the supervision of the DRS, DPS in the 27 districts; it will also be necessary to plan targeted supervision to solve the problem of collecting and entering vaccination data. Indeed, there is a real need for training of vaccinators to fill in the quality of the reporting tools for vaccination activities. This supervision will make it possible to monitor the accountability framework in order to monitor the evolution of performance with the development and use of the dashboard that will be derived/linked to DHIS2.</p> <p><b>d)</b> Child enumeration coupled with a light survey (LQAS) to monitor children vaccinated with DTP 3 and fully vaccinated in the 2 priority DS (Ratoma and Siguiri). This enumeration will be followed by a community feedback of the results with the presence of all stakeholders (prefects, mayors, health workers, RECO, ASC etc.) which will be followed by planning/developing targeted micro plans to organize the catch-up/AVI of children;</p> <p><b>e)</b> Organisation of monthly meetings around the 413 CSs, in the 38 DPSs and quarterly meetings for the 8 DHSS to analyse data and monitor the performance of the EPI;</p> <p><b>f)</b> Development of a database to monitor the vaccination schedule of fully vaccinated children according to EPI targets according to age and dose requirements in the 12 priority 1 districts. This database will be managed by data managers in the DRS and in collaboration with regional and district health data managers;</p> <p><b>g)</b> Organization of an evaluation of the performance of the AVIs (first phase of the emergency plan) in January 2020 with the involvement of UNICEF, WHO, GAVI, CDC, MS, INS;</p> <p><b>h)</b> Produce and disseminate the quarterly EPI Feedback Bulletins to DRS, DPS, CS/PS.</p>
Expected outputs/ results	In 2019, the gap between administrative data and WENIC data in Penta3 will increase from 55 to at least 45 points.
Associated calendar	January-December 2019
Resources/ support and technical assistance required	National level managers (DSR, EPI, DNGELM, HR, DAF), LMC support, WHO, UNICEF, World Bank

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

- Does the national Coordination Forum (ICC, HSCC or equivalent) meet the Gavi requirements (please refer to <http://www.gavi.org/support/coordination/> for the requirements)?
- Briefly describe how the Joint Appraisal was reviewed, discussed and endorsed by the relevant national Coordination Forum (ICC, HSCC or equivalent), including key discussion points, attendees, key recommendations and decisions, and whether the quorum was met. Alternatively, share the meeting minutes outlining these points.

## Joint Appraisal (full JA)

- *If applicable, provide any additional comments from the Ministry of Health, Gavi Alliance partners, or other stakeholders.*

The country has a functional ICC with reference to a proposal for a restructuring decree of June 2018 by the Ministry of Health. This project was signed during the month of September 2019 by the Minister of Health.

The joint evaluation conducted from 26 to 30 August 2019 was completed under the authority of the ICC chaired by the Senior Advisor to the Minister of State, Minister of Health accompanied by the WHO and UNICEF Resident Representatives. Relevant recommendations were made to the various stakeholders. On this occasion, the adviser, chairman of the session, thanked, on behalf of the Minister of Health, all the partners and in particular those who are accompanying Guinea in achieving the objectives related to vaccination.



**12. ANNEX: Compliance with Gavi reporting requirements**

Please confirm the status of reporting to Gavi, indicating whether the following reports have been uploaded onto the Country Portal. **It is important to note that in the case that key reporting requirements (marked with \*) are not complied with, Gavi support will not be reviewed for renewal.**

	Yes	No	Not applicable
<b>End of year stock level report (due 31 March) *</b>			
<b>Grant Performance Framework (GPF) *</b> reporting against all due indicators			
<b>Financial Reports *</b>			
Periodic financial reports			
Annual financial statement			
Annual financial audit report			
<b>Campaign reports *</b>			
Supplementary Immunisation Activity technical report			
Campaign coverage survey report			
<b>Immunisation financing and expenditure information</b>			
<b>Data quality and survey reporting</b>			
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)			
<b>Annual progress update on the Effective Vaccine Management (EVM) improvement plan</b>			
<b>CCEOP: updated CCE inventory</b>			
<b>Post Introduction Evaluation (PIE) (specify vaccines):</b>			
<b>Measles &amp; rubella situation analysis and 5 year plan</b>			
<b>Operational plan for the immunisation programme</b>			
<b>HSS end of grant evaluation report</b>			
<b>HPV demonstration programme evaluations</b>			
Coverage Survey			
Costing analysis			
Adolescent Health Assessment report			
<b>Reporting by partners on TCA</b>			

*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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