Joint appraisal report

Country	Sierra Leone
Reporting period	*2014*
cMYP period	*2012 - 2016*
Fiscal period	*January – December*
Graduation date	*Not applicable*

1. EXECUTIVE SUMMARY

(MAXIMUM 2 PAGES)

1.1. Gavi grant portfolio overview

Based on the outcome of the JA report the Government of Sierra Leone (GoSL) is requesting the High Level Review Panel to approve grant renewal for NVS;

- DTP-HepB-Hib, 10 dose(s) per vial, LIQUID
- Measles second dose, 10 dose(s) per vial, LYOPHILISED
- Pneumococcal (PCV13), 1 dose per vial, LIQUID
- Rotavirus, 1dose per Vial LIQUID
- Yellow Fever, 10 dose(s) per vial, LYOPHILISED

HSS1 and HSS2 have been reprogrammed to support the Routine Immunisation Recovery Plan. The country is eligible to apply for a new HSS support for the period 2015-2019.

1.2. Summary of grant performance, challenges and key recommendations

Grant performance (programmatic and financial management of NVS and HSS grants)

- Coverage of all antigens in Sierra Leone is generally high. BCG, Penta, PCV and Pol3 all have for several years had an estimated coverage above 90%. MCV and YF show slightly lower coverage but still well above 80%. WHO and UNICEF best estimate of vaccine coverage (WUENIC) however show a decline of about 10 percentage points in all antigens in 2014. The reported decline is mainly due to the Ebola Virus Disease (EVD) outbreak.

- Infant and Under 5 Mortality (U5MR) is improving although the numbers are significantly higher than the regional average. This is an area of great concern especially since the most common causes of death among children are related to Vaccine Preventable Diseases (VPD).

- Equity analyses show that immunisation cover is higher in rural areas compared to urban and peri-urban district. They also show poor households in general has a higher coverage than richer households.

- Changes in the population during the last decade makes reported coverage unreliable. A new census is planned for the end of 2015.

New vaccine support

- In March 2014 Sierra Leone introduced Rota virus vaccine nationwide and reached a coverage of 71% (JRF)/53% (WUENIC). The introduction was according to plan and the target was achieved.
- HPV demonstration project, which was launched in 2013 in Bo District, was only completed in April 2014 when the last dose was administered. The implementation of the demonstration project was delayed due to the EVD outbreak. The demonstration project is now completed and a Post Introduction Evaluation (PIE) has been conducted. The demo attained a coverage of 98.5% (JRF/Admin data)

- The country also conducted infection prevention and control (IPC) training in the context of EVD nationwide. This training greatly contributed to restore coverage of basic vaccines during the heat of the EVD outbreak.

HSS support

- No HSS activities were implemented in 2014. As a result of the EVD outbreak remaining funds from HSS1 and HSS2 were reprogrammed to support the RI Recovery plan. Implementation started in May 2015. The country is preparing a new HSS application for the period 2015-2019.

Other relevant achievements in the EPI programme

- Data collection and management capacity was enhanced at all levels from district to national through trainings, logistics and reporting mechanisms;

- During the EVD outbreak, the capacity of the national surveillance system was improved. Community based surveillance was also strengthened to increase community case detection and reporting;

- A communication strategy to revitalise demand creation for immunization services has been developed. It is to be revised and validated to take into account lessons learned from EVD response.

Challenges

- The biggest challenge in grant implementation during the reporting period has been the EVD outbreak. The effect of the EVD outbreak on immunisations services was severe. Among the challenges was a general decline in health seeking behaviour by communities due to the fear of possible EVD infections, which made patients miss out on immunisation services. In addition health workers were forced to focus on efforts to control the EVD outbreak; and the disease was infecting health workers themselves. Human resource management was and still is a major challenge.

Key recommended actions to achieve sustained coverage and equity (list the most important 3-5 actions)

Key recommended actions listed below are linked to the health sector recovery plan and aligned to the 5 pillars.

- Improve immunization service delivery including Human Resource management, supportive supervision, demand creation and social mobilisation;
- Improve integrated disease surveillance in all districts;
- Improvements in logistics and cold chain including expansion, upgrading, and supply chain management;
- Improve data quality and management of data including data collection tools, data validation, and use of data for strategic planning and action;
- Improve coordination within EPI, between EPI and DHSPPI, and with other Disease Specific Programmes (GF);
- Prepare HSS proposal fully in line with health sector recovery plan.

1.3. Requests to Gavi's High Level Review Panel

Grant Renewals

New and underused vaccine support

Sierra Leone will not require a change in vaccine presentation(s). The current vaccine presentations and doses should be renewed

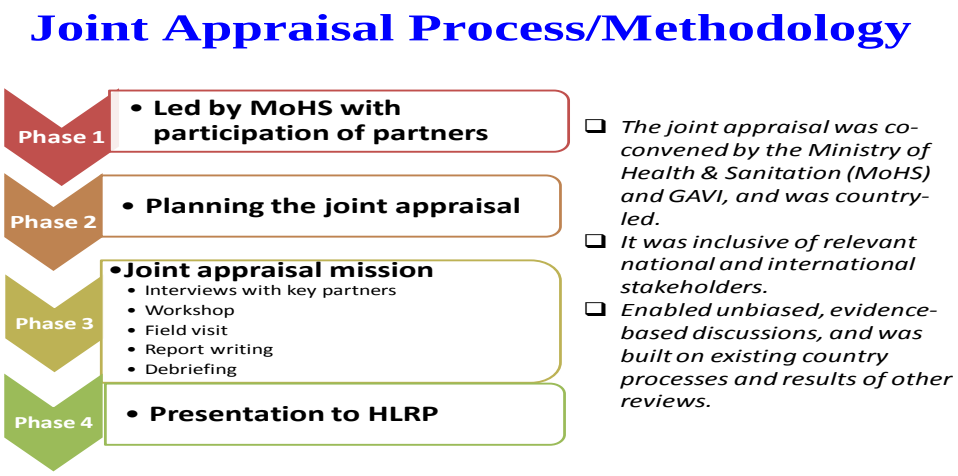
- DTP-HepB-Hib, 10 dose(s) per vial, LIQUID
- Measles second dose, 10 dose(s) per vial, LYOPHILISED
- Pneumococcal (PCV13), 1 dose per vial, LIQUID
- Rotavirus, 1dose per Vial LIQUID
- Yellow Fever, 10 dose(s) per vial, LYOPHILISED

Health Systems Strengthening support

- Not applicable

1.4. Brief description of joint appraisal process

The GAVI Joint review Appraisal process commenced one month prior to the review with the selection of dates. Several planning meetings were held with local and external partners including sharing of documents of the review. A more detailed description of the process is found in Annex C.



2. COUNTRY CONTEXT

(MAXIMUM 1-2 PAGES)

2.1. Comment on the key contextual factors that directly affect the performance of Gavi grants.

Sierra Leone is located on the West Coast of Africa, sharing international borders with the Republics of Guinea in the north and east and Liberia in the south. Basic fact about the country is found in Annex A.

Epidemiological profile
The Sierra Leone DHS (2013) estimates under-five and infant mortality rates at 156 and 92 per 1000 live births respectively. This is significantly higher than the regional average of 81 and 55 per 1000 live births respectively (GHO data). The immediate causes of childhood deaths are malaria, pneumonia, diarrhoea and conditions of the new born such as asphyxia, prematurity and sepsis. Underlying these deaths is the problem of malnutrition. Despite the gains in immunisation services, the country is still experiencing periodic Vaccine Preventable Disease (VPDs).

The EVD outbreak
In August 2014 a State of Emergency was declared in response to the rapid and uncontrolled outbreak of EVD. As at 4th September 2015, Sierra Leone has reported a total number of 8,698 cumulative confirmed cases of EVD and 3,587 cumulative confirmed deaths from all districts. 220 of these were health workers.

The EVD outbreak forced the country and especially the health sector to focus almost all its resources to try to control the epidemic. The reprioritisation meant that the majority of the normal health services were brought to a halt. Routine disease surveillance for example including surveillance of vaccine preventable diseases declined significantly. Outreach services were discontinued, NIDS and MCHW had to be postponed and cancelled. Fear of contracting the disease kept patients away from health centres and hospitals, and the fact that many health workers themselves were infected increased the workload for those remaining in service. It should however be noted that despite the challenges RI services were never discontinued.

In order to recover from the EVD outbreak and build a stronger and more resilient health system the Government of Sierra Leone in collaboration with key development partners developed a post Ebola National Recovery Plan. An RI Recovery Plan with a specific focus on reactivating and recovering the EPI programme as part of the National Recovery Plan was developed in conjunction. Some activities have already been implemented, including conducting measles campaign, and three multi-antigens catch up campaigns. In addition Immunisation In Practice trainings have been conducted to refresh health workers on immunisation service delivery. The new policy context calls for more coordination and integration between development partners and especially the disease specific programmes (Gavi and GF).

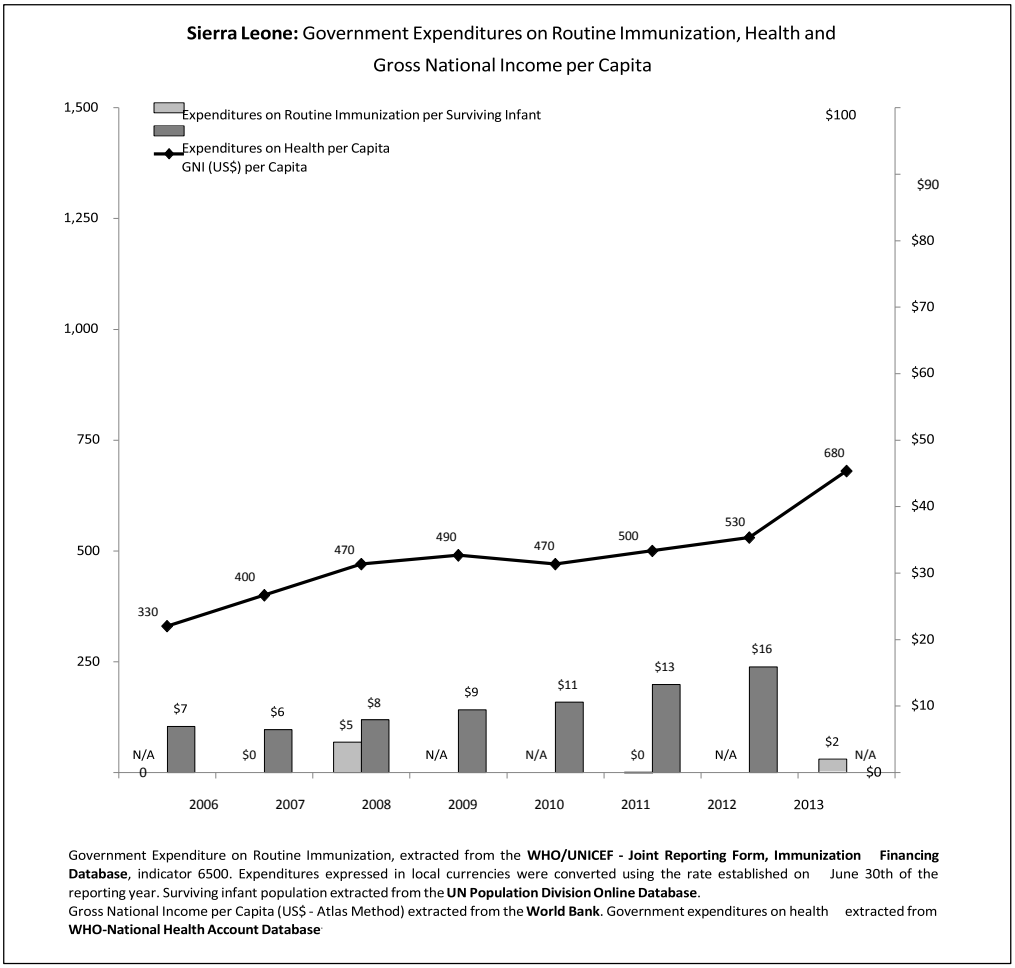
Leadership, governance and programme management
The Health Sector Steering Group/ (HSCC/ICC) is functional. However, due to the EVD outbreak, only one meeting was held in 2014 as all senior Ministry officials and key partners focused attention on the Emergency Operations Centre (EOC), which was established to oversee EVD response (co-chaired by MoHS and WHO). Notwithstanding the Technical Coordination Committee (TCC) held several meetings where Gavi grant activities were discussed. (See Annex J for ICC ToR).

There was a recent change in EPI programme management. The EPI management has now stabilized and MoHS established a Health Systems Strengthening Hub that is staffed with experts that provide technical assistance, including advisory support to Ministry leadership on all HSS matters. In addition, MoHS, in consultation with partners, embarked on a journey to re-establish the Integrated Health Projects Administration Unit (IHPAU) to manage all donor funds channelled through the MoHS.

Health expenditure data
Over the period 2006-2013, Sierra Leone's Gross National Income increased from US$330 to US$680 per capita, doubling in eight years. According to the WHO/UNICEF Joint Reporting Form (JRF), the

Sierra Leonean government spent less than $1 on routine immunization per surviving infant in 2007. By 2013, this figure had risen to $2. In addition, the government share of total routine immunization expenditures rose from 0% to 9% from 2011-2013. In 2013 GoSL expenditure on health was US$ 14 per capita and budget allocation reached about 5% of total budget (Annex E). The data suggests that Sierra Leone has progressed towards country ownership of its immunization program.

Figure 1: Government Expenditure on RI



Source: SABIN Vaccine Institute, Feedback on Financial Indicators 6470-6520, WHO/UNICEF - Joint Reporting Form (JRF) (2013)

For more information see Annex E: Funding of the immunisation programme in Sierra Leone.

3. GRANT PERFORMANCE, CHALLENGES AND RENEWAL REQUESTS

(MAXIMUM 3-5 PAGES)

3.1. New and underused vaccine support

3.1.1. Grant performance and challenges

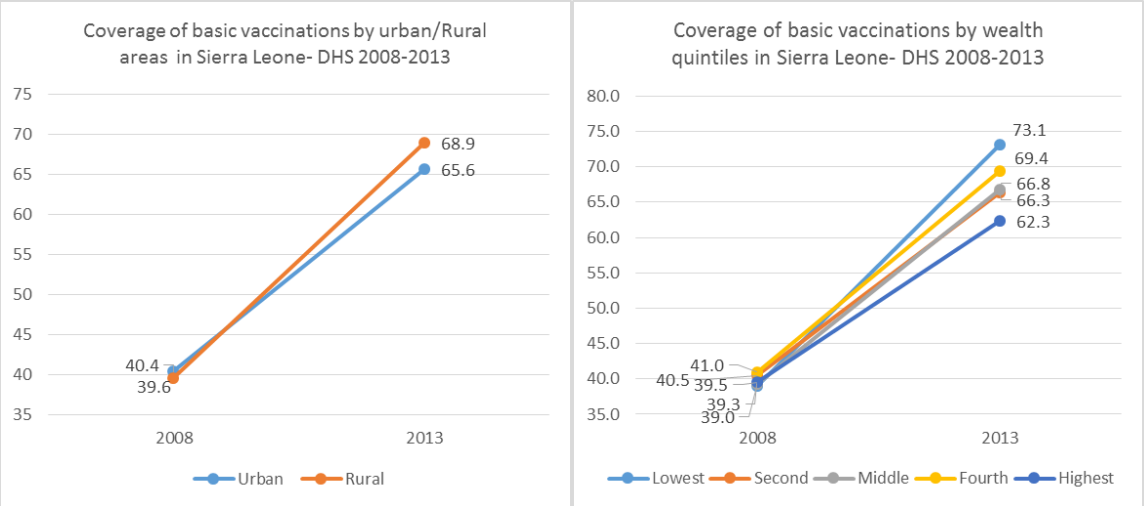
General achievements

During the reporting period there was a decline in coverage of about 10 percentage points across the board due to the EVD outbreak (Table 1 in Annex F). JRF reported data for 2014 shows a coverage of ≥ 90% for all antigens, except Rotavirus vaccine. 93% of districts achieved administrative coverage of ≥ 80% for Penta 3. District level data however shows a wide range (see Table 10 in Annex E) . A national Pentavalent dropout rate of 8.2% was achieved with the highest of 14.1% in Tonkolili district and the lowest of 4.7% in Moyamba district (Table 10 Annex E).

Sierra Leone has shown good progress in EPI coverage in an inclusive manner for the poorest rural areas. At the same time, analysis of data from DHSSL 2008 and 2013 shows that the poorest quintile on average has a higher immunisation coverage compared to the wealthiest quintile.

In addition coverage is generally higher in rural districts compared to urban and peri-urban districts such as Western Urban. Immunisation data is not disaggregated by sex, which makes is difficult to assess gender-related inequities in immunisation services.

Table 3: Equity analysis



In general the Gavi NVS grant performed well, vaccine targets for penta, PCV and rotavirus vaccine were met, YF was slightly below target. Vaccine shipments arrived on time and the country did not experience any stock outs (See Annex G for vaccine stock analysis). Vaccine Introduction Grants (VIG) for rotavirus arrived on time. The ISS funds were available for operational costs including vaccine clearance. The availability of vaccines was instrumental in ensuring continued RI services in facilities even during the EVD outbreak. The planned activities for HSS1 and 2 could not be implemented during the reporting period.

Specific achievements

- Introduction of Rotavirus vaccine into routine immunisation services in March 2014. A target of 53% was set for the first year, which was achieved. A communication strategy was developed prior to the introduction of rotavirus vaccine. Existence of planning and coordination structures that involved other partners contributed to the successful introduction. The country received a GAVI vaccine introduction grant of $193,500 for Rotavirus vaccine.

- The country completed the first year of HPV demonstration project in May 2014. The strategy used was that of campaign (community and schools based), as opposed to RI method proposed in the introduction plan. This led to the higher costs. Funds to support implementation were exhausted already in year 1, hence lack of fund for year 2 demo project. A Post Introduction Evaluation (PIE) was conducted simultaneously with the third dose of HPV. The HPV PIE Findings indicated that demonstration project was successful (See annex I for more details).

Other relevant achievements

- Data collection and management capacity was enhanced at all levels from district to national through trainings, logistics and reporting mechanisms.

- During the EVD outbreak, the capacity of the national surveillance system was improved. Community based surveillance was also strengthened to increase community case detection and reporting. Sentinel surveillance established in 2013 for Rotavirus, Influenza and PBM is on-going.

- The country developed a communication strategy to revitalise demand creation for immunization services before the EVD outbreak. The strategy will be revised before validation based on lessons learnt from the EVD response to included strategies for populations living in difficult to access areas, nomads, urban poor settings, population affected by disasters or conflicts. This will be done through mapping of NGOs/CBOs operating in underserved communities.

- The EVD response mechanisms coordinated by the DHMTs created active communication structures at community level. These structures can be effectively used for routine immunisation services.

Challenges related to EVD

- EVD outbreak resulted in community mistrust in the health system including immunisation services thereby reducing immunisation services in the first three months of the outbreak. In addition health staff were repurposed to EVD response while others were afraid of contracting the disease;

- Due to the EVD outbreak, planned NIDs and Maternal Child Health Week (MCHW) activities were not conducted;

- The EVD epidemic resulted in a reduction in the laboratory analysis of specimens for other diseases including VPDs. In addition the Disease Surveillance Officers had to focus on EVD response and could pay limited attention to VPDs, thus a reduction in surveillance indicators.

- AEFI monitoring and reporting during routine vaccination has not been prioritised by the health staff;

- Sierra Leone is heavily reliant on solar refrigerators for its cold chain. There are challenges related to conducting regular preventive maintenance of the equipment. There is also human resource capacity gap including low capacity of technicians and unavailability of trained and qualified technical staff/engineers to support and supervise. Cold chain data flow is usually incomplete and irregular (i.e. timeliness, completeness and quality). Functional cold chain equipment at peripheral level is inadequate. Better and more frequent supportive supervision is needed.

- There is high staff attrition and turnover across the board in the health sector (poor condition of service, frequent transfers and other problems). This affects the EPI programme as well. There is therefore a need to build staff capacity at service delivery point (quality, quantity and competence of staff). There is need for better feed-forward and feedback mechanisms to lead and coordinate strategically.

- The general problem of unreliable denominators at district and HF levels makes it difficult for health staff to correctly assess performance against targets and puts defaulter and drop-out tracing at risk. Data generated at HF level is thus unreliable and cannot be used as a basis for strategic planning at district level. Poor feedback from DHMT to HF staff is also a problem creating a lack of coordinated action to address immunisation bottlenecks in the district as a whole. Incomplete and irregular data management at all levels leads to unreliable reporting and data discrepancies;

Corrective actions/Recommendations

- Rebuild trust in the health system and immunisation services in the communities by resuming outreach services, NIDS, MCHW and other critical routine services to improve immunisation coverage.

- To enhance social mobilization and community engagement, it is recommended to revisit the current communication strategy that existed before the EVD outbreak and to conduct a KABP survey to inform or evaluate communication for development (C4D) strategic plans. There is also a need to identify the social barriers to uptake of services and conduct desk based reviews for other preliminary research to address knowledge gaps. A few of the sub activities to understand the community perceptions could include focus groups, key informant interviews, qualitative/ quantitative surveys, audience analysis and channel analysis.

- Support case based surveillance for vaccine preventable diseases (specimen collection and transportation, reverse cold chain tools, active case search). Strengthen AEFI monitoring system at all levels including the development of a database (Including training of health staff); Resume quarterly IDSR and AEFI review meetings. Strengthen community event-based surveillance activities nationwide (Reactivated during the EVD outbreak);

- Provide technical support for the installation, repairs and maintenance of cold chain equipment. Build capacity of cold chain technicians at district level to conduct repairs and maintenance of cold chain equipment. Provide adequate support to conduct regular preventive maintenance including access to spare parts. Replace all obsolete refrigerators and their accessories. Conduct EVM and CCL assessment and implement recommendations from these assessments.

- Improve conditions of service for health workers at all levels (remote area allowances, housing, transport, incentives, formative supervision). Improve feed forward and feedback mechanisms. Improve capacity at District level to manage and motivate staff

- Improve data flow (feed forward and feedback) including timeliness, completeness and accuracy of data at all levels. Provide internet facilities (servers) to all District Health Management Teams. Build the human resource capacity of health staff on data management. Improve regular monitoring and supportive supervision at all levels. Conduct equity access analyses and mapping of underserved communities. Develop and implement strategies for defaulter and dropout tracing. Conduct census in 2015.

3.1.2. NVS renewal request / Future plans and priorities

The current GAVI supported vaccines should all be renewed in their current presentations. The country plans to introduce measles second dose in November 2015 and IPV in January 2016. The future plans and priorities for the program are summarised below. (A more exhaustive list is attached in Annex H)

The EPI Team in collaboration with Directorate of Health System Policy Planning and Information (DHSPPI), WHO, UNCEF and other key development partners will prioritise the following areas going forward:

Improvement of immunisation service delivery, including:
Resume outreach services and other key routine services to increase coverage. Intensified and improved supportive supervision at all levels, including training of staff and incentives. Develop and implement relevant strategies to reach underserved populations, (urban and peri-urban areas, other hard to reach areas), identify defaulters and reduce dropout rate.

Improve disease surveillance in all districts
Support case based surveillance for vaccine preventable diseases, Strengthen AEFI monitoring system at all levels including the development of a database. Strengthen community event-based surveillance activities nationwide. Support quarterly IDSR and AEFI review meetings.

Improve data quality and data management
Collaborative and inclusive effort to improve HMIS in close collaboration with DHSPPI and other partners, including GF. Conduct Data Quality Self-assessment (DQS) and Service Availability and Readiness Assessment (SARA) to improve data quality. Training of staff in data management.

Improve Logistics and Cold chain
Improve cold chain functioning and capacity at all levels, including improvement sin hardware as well as recruitment and training of staff.

Improve coordination between programmes.
The national health sector recovery strategic plan provides the overall framework for planning of all health sector program activities including EPI. The DHSPPI is the coordinating body and the EPI program will work closely with this directorate. Special effort will be made to coordinate with GF programmes to ensure efficient use of HSS support to the country.

Sierra Leone submitted proposals to Gavi for the introduction of Measles/Rubella and Inactivated Polio Vaccine (MR & IPV) for which approval was received for IPV.

3.2. Health systems strengthening (HSS) support

3.2.1. Grant performance and challenges

In 2014 no HSS activities were conducted mainly because Gavi Cash Program Audit (CPA) resulted in the suspension of the HSS I funding in 2013, and a request GoSL to refund an amount of US$ 523,303. Repayment of the funds was made in October 2014.

In order to improve the overall management capacity of HSS Grants the Ministry of Health in collaboration with partners has developed and established an Integrated Health programme Administrative Unit (IHPAU). Just recently the Government recruited a team of five professionals to manage IHPAU starting October 2015. One of the most immediate deliverables for the incoming IHPAU staff is to complete the Joint Financial Management Manual, in close consultation with all donors to ensure endorsement by all. A joint assessment of IHPAU will subsequently be conducted between 3 and 6 months of senior management team commencing duty to establish capacity requirements to manage donor funds, Gavi will be invited to be part of the joint assessment which is expected to take place between January and March 2016. This will improve the oversight and coordination of support provided by development partners including Gavi.

In addition to the above, the EVD outbreak further changed all priorities and led to delay in the restructuring process. The MoHS requested and received Gavi approval to reprogram the remaining HSS Grants (HSS1 and HSS2) to support the post Ebola RI Recovery Plan. Implementation started in May 2015 with the Measles Campaign.

3.2.2. Strategic focus of HSS grant

Initially, HSS support was programme focused. The health sector under the leadership from the Ministry of Health and Sanitation and full support of partners, is moving toward a more harmonized and more streamlined health systems strengthening support, which will include all partners including disease specific programmes such as Gavi and GF. A recent submission to the Global Fund of a health system strengthening proposal focuses on strengthening the entire system including laboratory/diagnostics capacity, supply chain management, health management information system, community systems strengthening and building national structures to manage programmes. The health system of Sierra Leone will benefit significantly from harmonized programming to strengthen the health system and the country's decision to harmonize across focus areas is a step in the right direction to build a stronger and more resilient health system. The focus of future request to Gavi will take this new thinking into consideration.

3.2.3. Request for a new tranche, no-cost extension, re-allocation or reprogramming of HSS funding / Future HSS application plans

Gavi has invited the Government of Sierra Leone to submit a new HSS proposal with a ceiling of USD 12 million. The MoHS is now embarking on the preparation of this proposal in line with the five key health system priorities areas outlined in the Health Sector Recovery Plan and in line with the priorities outlined in this assessment.

3.3. Graduation plan implementation *(if relevant)*

Not applicable

3.4. Financial management of all cash grants

Cash utilisation performance and financial capacity constraints
The financial management of HSS funds is explained in section 3.2.1 above. The Immunization System Strengthening (ISS) funds have been utilized mainly for the clearing of vaccines and cold chain maintenance, supportive supervision, EPI consultative meeting, Programme management and the construction of a negative cold room. The total expenditure in 2014 amounted to USD 276,307. The ISS funds are managed by Ministry of Health and Sanitation. The Directorate of Financial Resources provides oversight of Gavi support funds. The report of the last audit by Audit service Sierra Leone did not show any issues arising from cash programme. The 2014 MoHS audit is on-going.

Financial performance and challenges
IHPAU has been restructured and will be functional effective 1st October 2015 to ensure adequate mechanism is put in place to manage gavi and other cooperating partners cash grants.

3.5. Recommended actions

Actions	**Responsibility** (government, WHO, UNICEF, civil society organisations, other partners, Gavi Secretariat)	Timeline	Potential financial resources needed and source(s) of funding
Improve immunization service delivery	MoHS and partners	May 2015 Onwards	
Support integrated disease surveillance in all districts	MOHS and partners	Continuous	
Support logistics and cold chain	MoHS and partners	Continuous	
Improve data quality and management	MoHS and partners	July 2015 Onwards	Improve data management
Improve coordination	MoHS and partners	Continuous	
Prepare HSS proposal fully in line with health sector recovery plan	MoHS (EPI, DHSPPI, IHPAU) and partners	2015	

4. TECHNICAL ASSISTANCE

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4.1 Current areas of activities and agency responsibilities

The country received technical assistance as follows:

Cold chain assessment (UNICEF/WHO)
EPI coverage (UNICEF/WHO)
HPV Demonstration, implementation, PIE and costing tool (UNICEF/WHO)
STOP team consultants (UNICEF/WHO)
Development of EPI communication strategy (UNICEF)
SARA (WHO)
Sustainable Immunization Financing (SABIN)
Establishment of HSS Hub (World Bank)
C4D - National and International (UNICEF)
Immunization Specialist and Officer - National and International (UNICEF)
Surveillance and Laboratory support (WHO,CDC)

4.2 Future needs

In line with the identified needs going forward as outlined in the JA report the country needs Technical Assistance in the following areas:

- New vaccine post introduction evaluation (WHO)
- tOPV/bOPV switch (WHO/UNICEF)
- Comprehensive EPI review (WHO/UNICEF)
- EVM (UNICEF/WHO)
- EPI coverage survey (WHO)
- HSS capacity building (WB/WHO)
- HMIS capacity building (WHO/other partners)
- SIAs (UNICEF/WHO and other partners)
- Sustainable Immunization financing (WHO/SABIN)
- cMYP development (WHO/UNICEF/SABIN)
- CCL assessment (WHO/UNICEF)
- Cold chain and logistics specialist (UNICEF/WHO**)**
- C4D - National and International (UNICEF)
- Immunization Specialist and Officer - National and International (UNICEF)
- Surveillance and Laboratory support (WHO,CDC)
- Ebola vaccine roll out (WHO/CDC/LSHTM/UNICEF)

5. ENDORSEMENT BY ICC, HSCC OR EQUIVALENT & ADDITIONAL COMMENTS

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HSSG meeting was held on Friday, 11 September 2015 and the Joint Appraisal was discussed.
Issues raised during debrief of joint appraisal findings to national coordination mechanism:

- **High Dropout rate**
  Based on 2014 data, there was high dropout rate in Koinadugu and Tonkolili districts. The EPI Programme was advised to monitor the trend of dropout rate in all districts and take corrective action.

- **Geographic Equity**
  The issue of immunization services and geographic equity was expressed indicating that urban and Peri-Urban areas are under served. The programme was advised to develop strategies to address the inequity.

- **Data Quality Issue**
  Concern was raised on high immunization coverage in some districts and the issue of population denominator in some districts. This will hopefully be addressed by the forth coming national census.

- **Routine Immunization Outreach Services**
  Due to the EVD outbreak, RI outreach services were not conducted. There is need to restart outreach services and resources will be required.

- **Coordination between GAVI and Global Funds Support**
  HSSG noted the need for synergy between the global funds and GAVI support. The programmes encouraged to work closely to avoid duplication and leverage of resources.

Additional comments from MoHS
The Ministry of Health and Sanitation under the new leadership of the Honourable Minister, Dr Abu Bakar Fofanah has made significant progress in advancing the national health agenda. In just one year, the Ministry has been rated as the best performing Ministry when scorecards of the various key Ministries were compared. This progress is important as MoHS work tirelessly to regain donor confidence and ensure better child health outcomes in Sierra Leone. (See Annex K for full presentation)

6. ANNEXES

Annex A. Key data (this will be provided by the Gavi Secretariat)

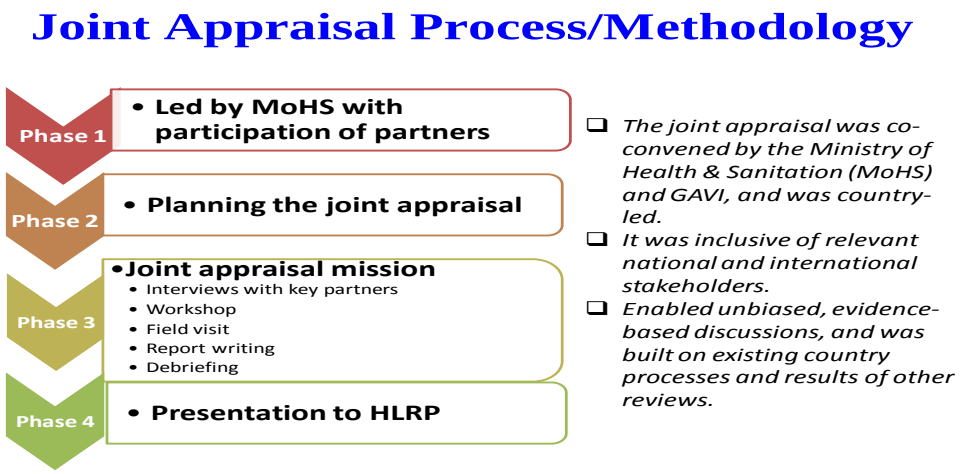
Annex B. Status of implementation of the key actions from the last joint appraisal and any additional High Level Review Panel (HLRP) recommendations

Key actions from the last appraisal or additional HLRP recommendations	Current status of implementation
Produce an M&E Framework with specific and measurable indicators. Consider adding one HS and one equity related indicator	Pending
In view of the available quantity of vaccines for the demonstration of HPV demo project, the country was advised to reduce the number of districts for the demonstration from two to one.	Done
The country was advised to select one age group instead of age range of 9 - 13 yrs	Done
Correct coverage reported as above 100% and correct BCG coverage inaccurately reported as 100%	Pending
Continue to address data quality issues based on recommendations from the ongoing IDQA	Plans are being prepared
Assess the implications of the EVD outbreak on immunisation financing	Pending
Financial clarifications recommended by PFO	

Annex C. Description of joint appraisal process

The GAVI Joint review Appraisal process commenced one month prior to the review with the selection of dates. Several planning meetings were held with local and external partners including sharing of documents of the review. A summary of the process is highlighted below;

- Led by MoHS
- Participation of external GAVI partners
- Involved national level key stakeholders including selected DHMTs
- Planning and coordination led by MoHS with support from SABIN, UNICEF and WHO
- Weekly joint review planning teleconference conducted
- Comprised courtesy calls to key stakeholders including the Minister of Health & sanitation, WHO and UNICEF Country reps, the financial secretary of the Ministry of Finance and Economic Development, conducted interviews with JICA and the National Malaria Control Programme
- Gathering of key documents for the joint appraisal and report writing
- Organising logistics and budget proposal
- Draft report was prepared prior to the review mission
- A one day work shop was conducted to review the draft report. Four working groups were constituted to review the different thematic areas followed by plenary discussions and consensus. This was very inclusive and participatory
- A one day field trip was conducted to Western Area Urban and Rural to familiarise the, mission team on RI service delivery in Sierra Leone.
- The mission team visited the national level cold room
- HSSG meeting conducted at the end of the process to brief all stakeholders and the report was endorsed
- Exit debriefing meeting with the minister
- Finalization of the report including incorporating comment from the HSSG debriefing meeting



Annex D. HSS grant overview

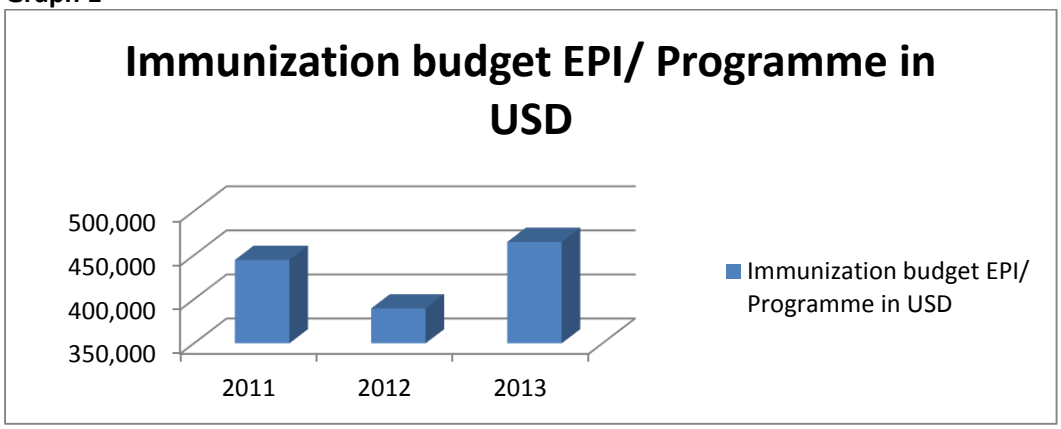
General information on the HSS grant							
1.1 HSS grant approval date							
1.2 Date of reprogramming approved by IRC, if any							
1.3 Total grant amount (US$)							
1.4 Grant duration							
1.5 Implementation year			month/year – month/year				
(US$ in million)	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
1.6 Grant approved as per Decision Letter							4,094,774
1.7 Disbursement of tranches							1,075,526
1.8 Annual expenditure							0
1.9 Delays in implementation (yes/no), with reasons			Yes, o Grant suspension o Ebola outbreak				
1.10 Previous HSS grants (duration and amount approved)							
1.11 List HSS grant objectives The general objective is to strengthen the functions of the health system of Sierra Leone so as to improve the following performance criteria: 1. Access to health services (availability, utilization and timeliness) 2. Quality of health services (safety, efficacy and integration) 3. Equity in health services (disadvantaged groups) 4. Efficiency of service delivery (value for resources) 5. Inclusiveness (partnerships)							
1.12 Amount and scope of reprogramming (if relevant) HSSI(2008) &HSS II(2012) The Government submitted an EPI post Ebola recovery plan wishing to reprogram HSS funds to EPI program. This amounted to a total of USD 4,094,774 out of which, 1,075,526 was released for the implementation of the measles campaign in June 2015. The Ministry of Health and Sanitation has requested that the balance amounting to USD 3,065,027 be transferred through WHO and UNICEF to support the remaining activities on the EPI recovery plan.							

Annex E. Funding of the immunisation programme in Sierra Leone

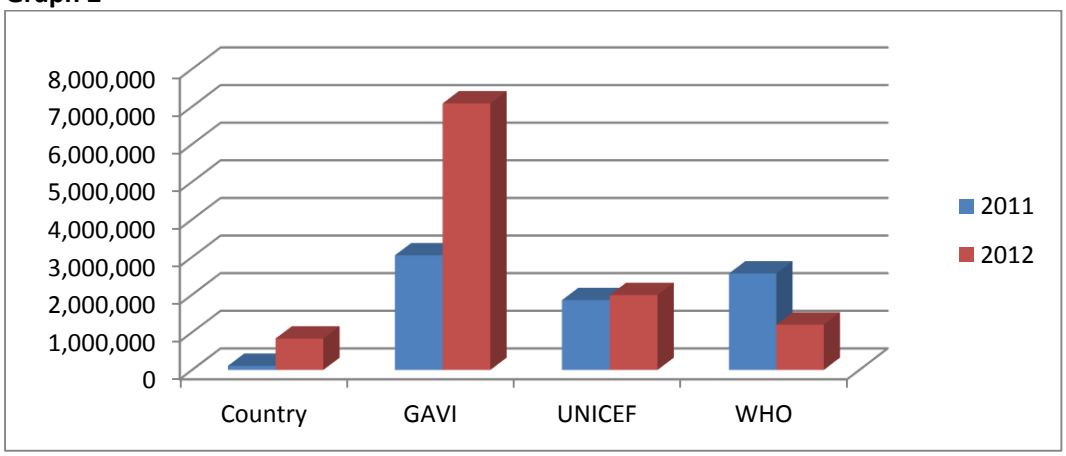
Table1[i] : Trend of budgets (total revenue and grant, MoHS, EPI –Immunization budget) and GDP

	2010	2011	2012	2013
GDP in Le	7 597 200 000 000	9 578 600 000 000	11 629 500 000 000	13 217 900 000 000
GDP in USD	1 766 790 698	2 227 581 395	2 704 534 884	3 073 930 233
Total revenue and grants in Le	1 551 581 000 000	2 183 177 000 000	2 303 845 000 000	2 487 639 000 000
Total revenue and grants in USD	360 832 791	507 715 581	535 777 907	578 520 698
Ministry of Health and Sanitation budget in Le	-	32 396 600 000	26 093 900 000	38 968 000 000
Ministry of Health and Sanitation budget in USD		7 534 093	6 068 349	9 062 326
Immunization budget Programme/EPI in Le	-	1 912 000 000	1 675 200 000	2 000 000 000
Immunization budget Programme/EPI in USD	-	444 651	389 581	465 116
% Immunization bud./ GDP	-	0,020	0,014	0,015

Graph 1



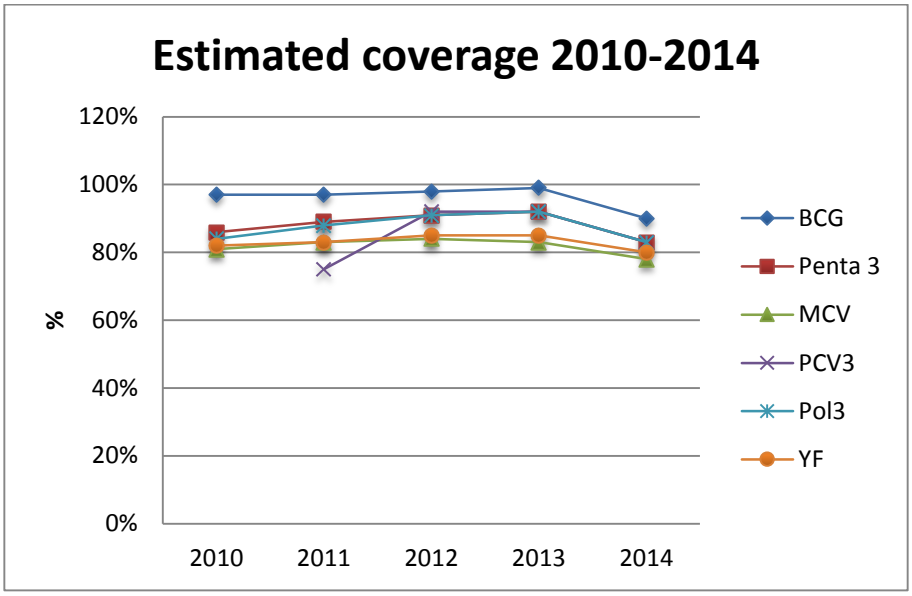
Graph 2



GAVI is the main contributor to the immunization financing in Sierra Leone followed by WHO and UNICEF. Funding from the government has increased from 2011 to 2012 but remains low considering the overall need.

Annex F. Coverage data

Table 1: Estimated coverage of selected antigens 2010-2014 (WUENIC data)



During the EVD outbreak in 2014 vaccine coverage declined significantly across the board. Penta 3 dropped to just above 80% in September 2014. Since then Penta 3 coverage has resumed and is now back at the same level as before the EVD outbreak (See Table 2 below). The trend is similar for the other antigens.

Table 2: Penta 3 coverage 2012-2014 by month (JRF data)

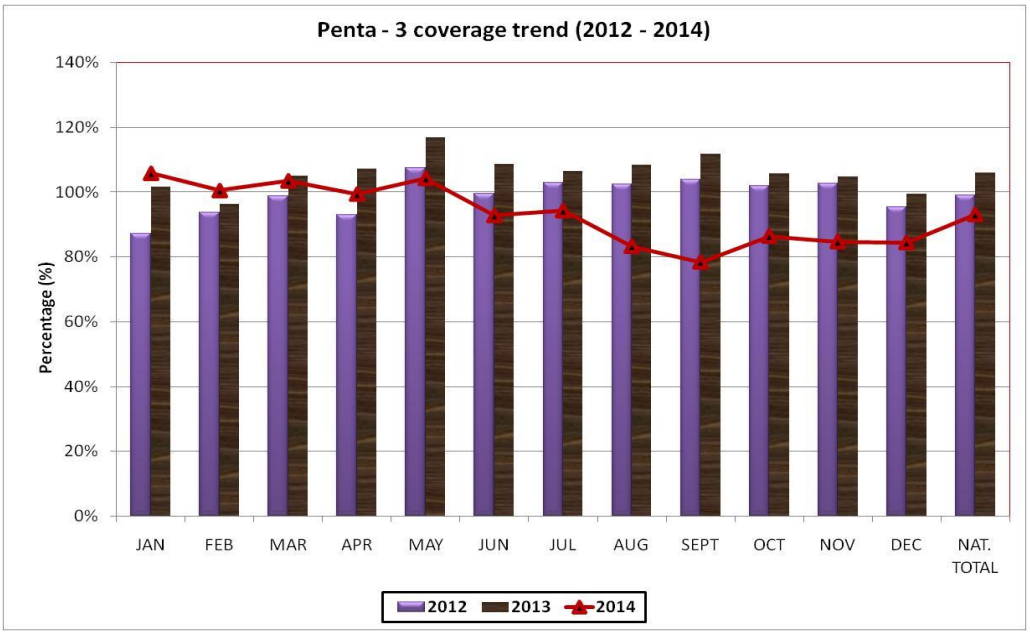
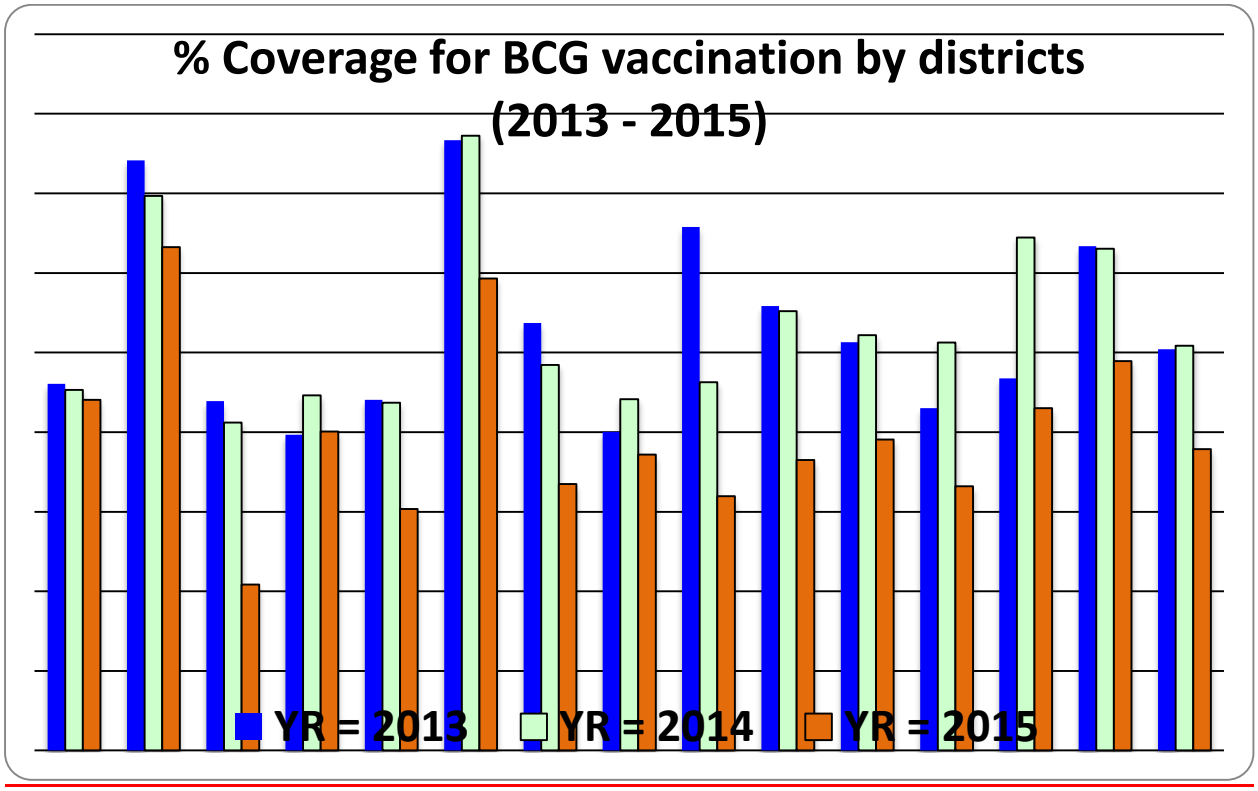
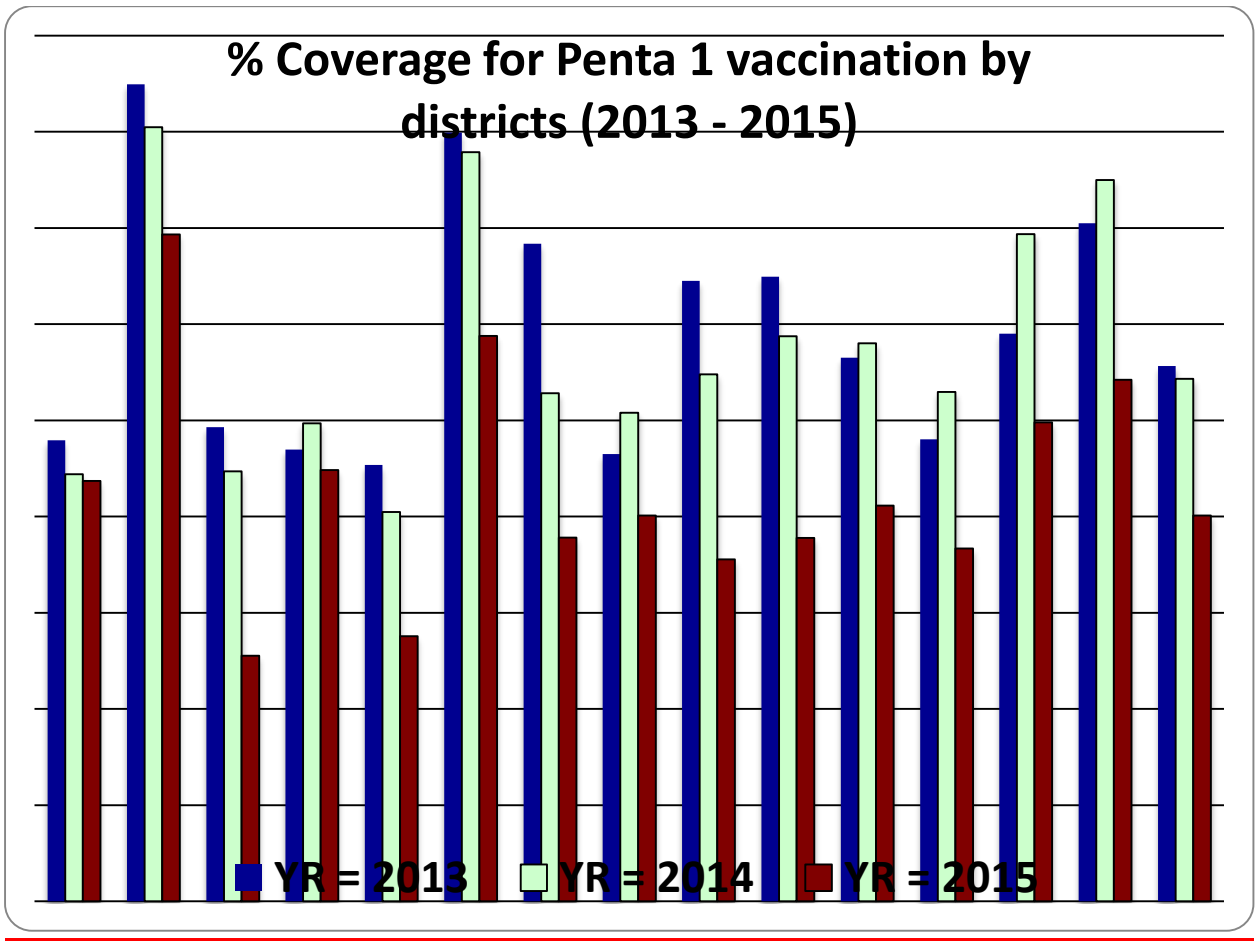
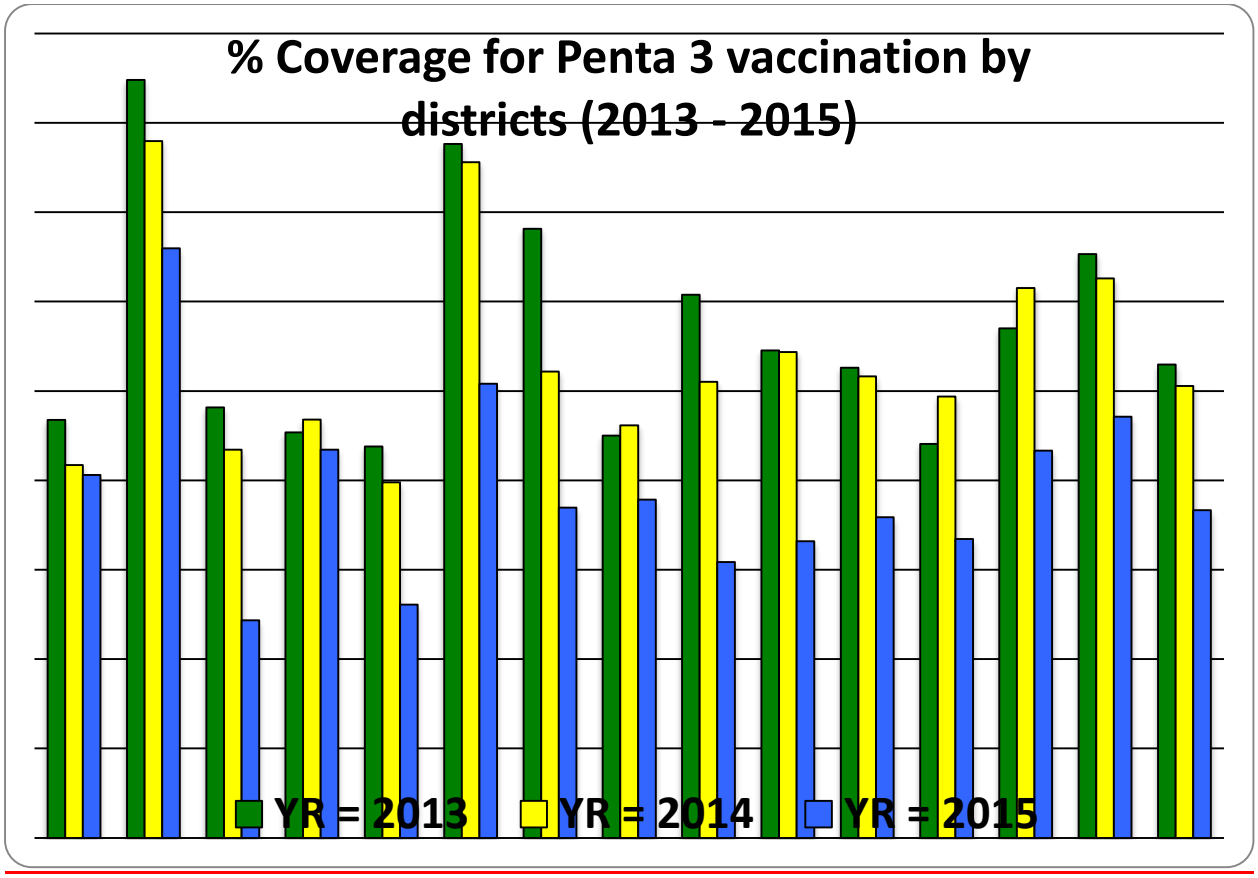
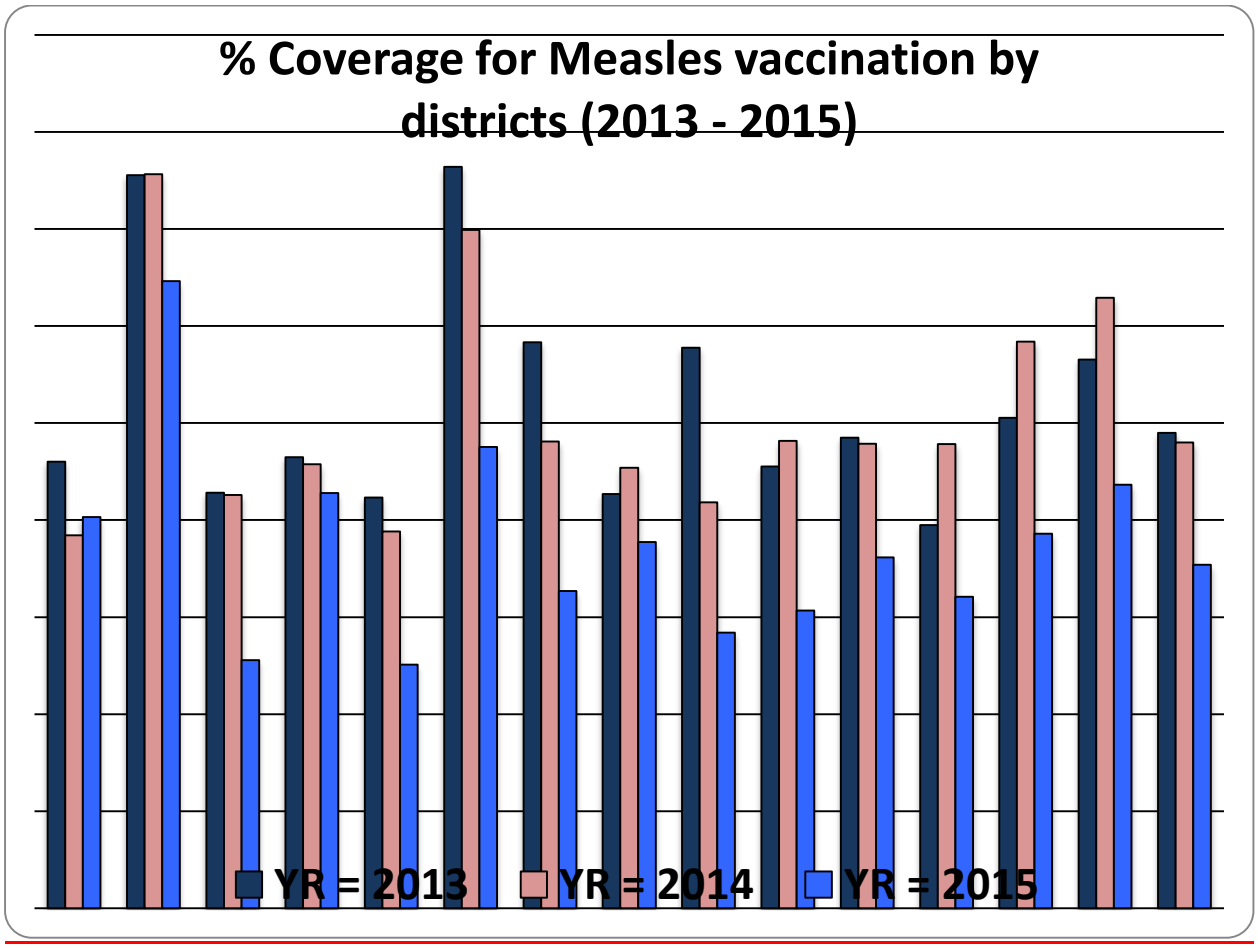


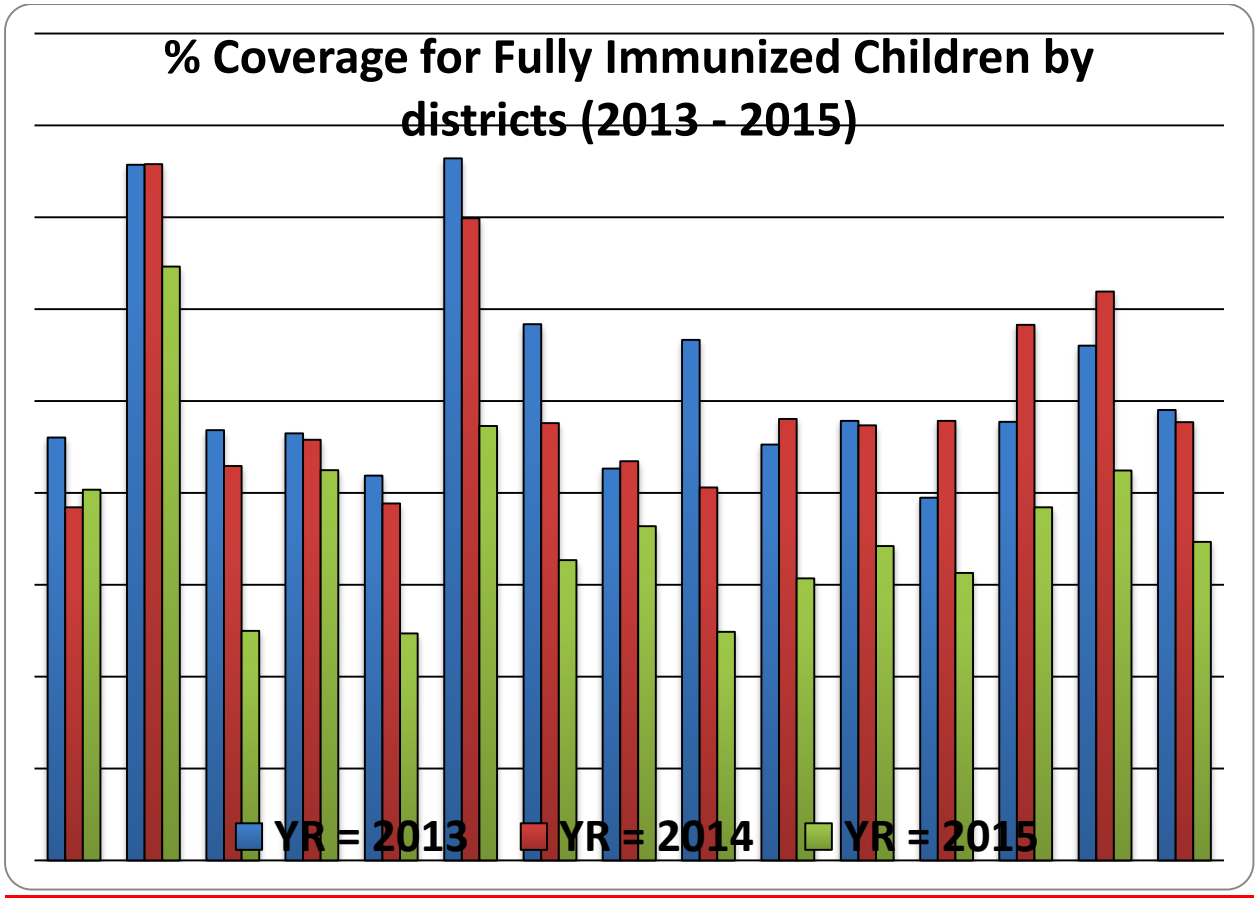
Table 3 – 9 EPI Coverage: January to June 2013 - 2015

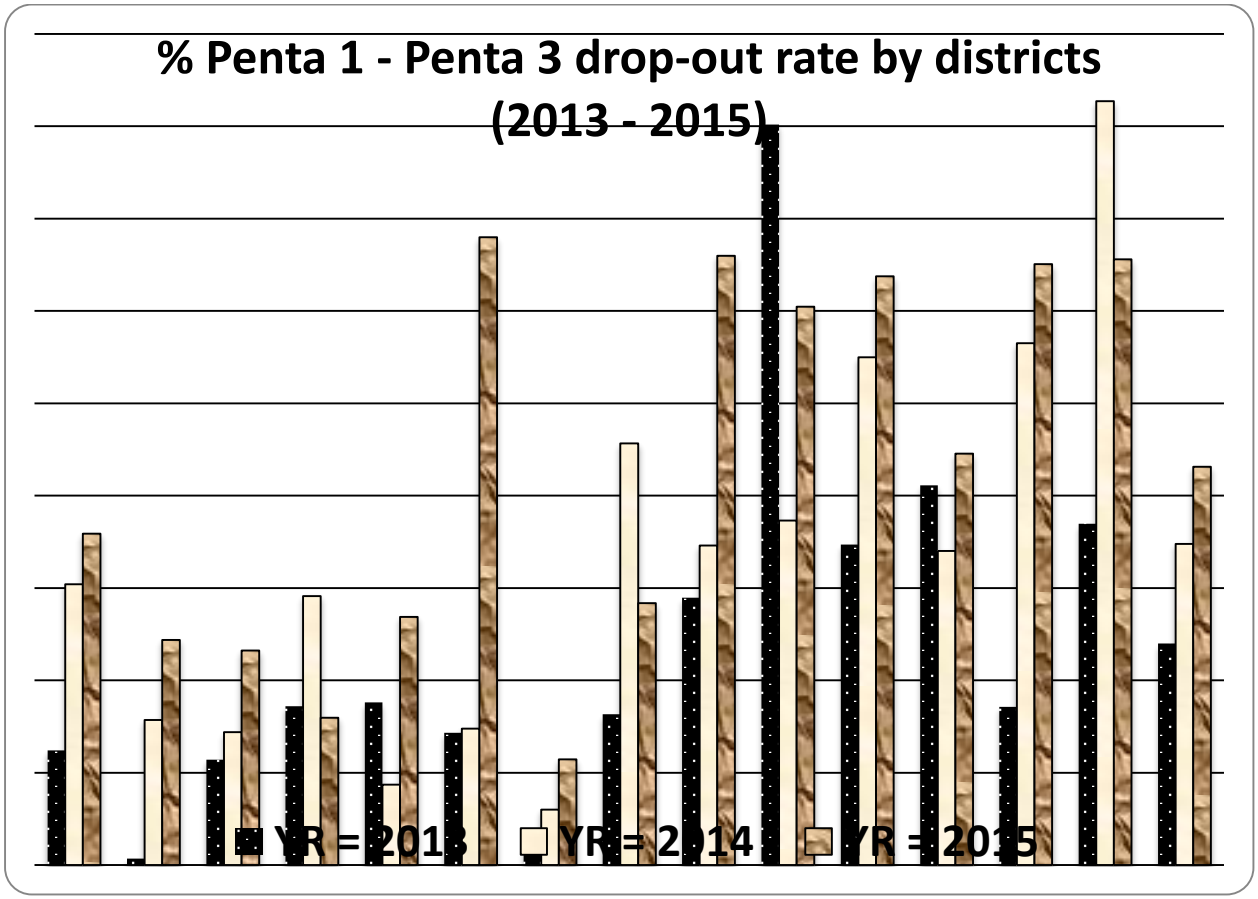





% Coverage for Penta 3 vaccination by districts (2013 - 2015)
YR = 2013
YR = 2014
YR = 2015


% Coverage for Measles vaccination by districts (2013 - 2015)
YR = 2013
YR = 2014
YR = 2015


% Coverage for Fully Immunized Children by districts (2013 - 2015)
YR = 2013
YR = 2014
YR = 2015


% Penta 1 - Penta 3 drop-out rate by districts (2013 - 2015)
YR = 2013
YR = 2014
YR = 2015

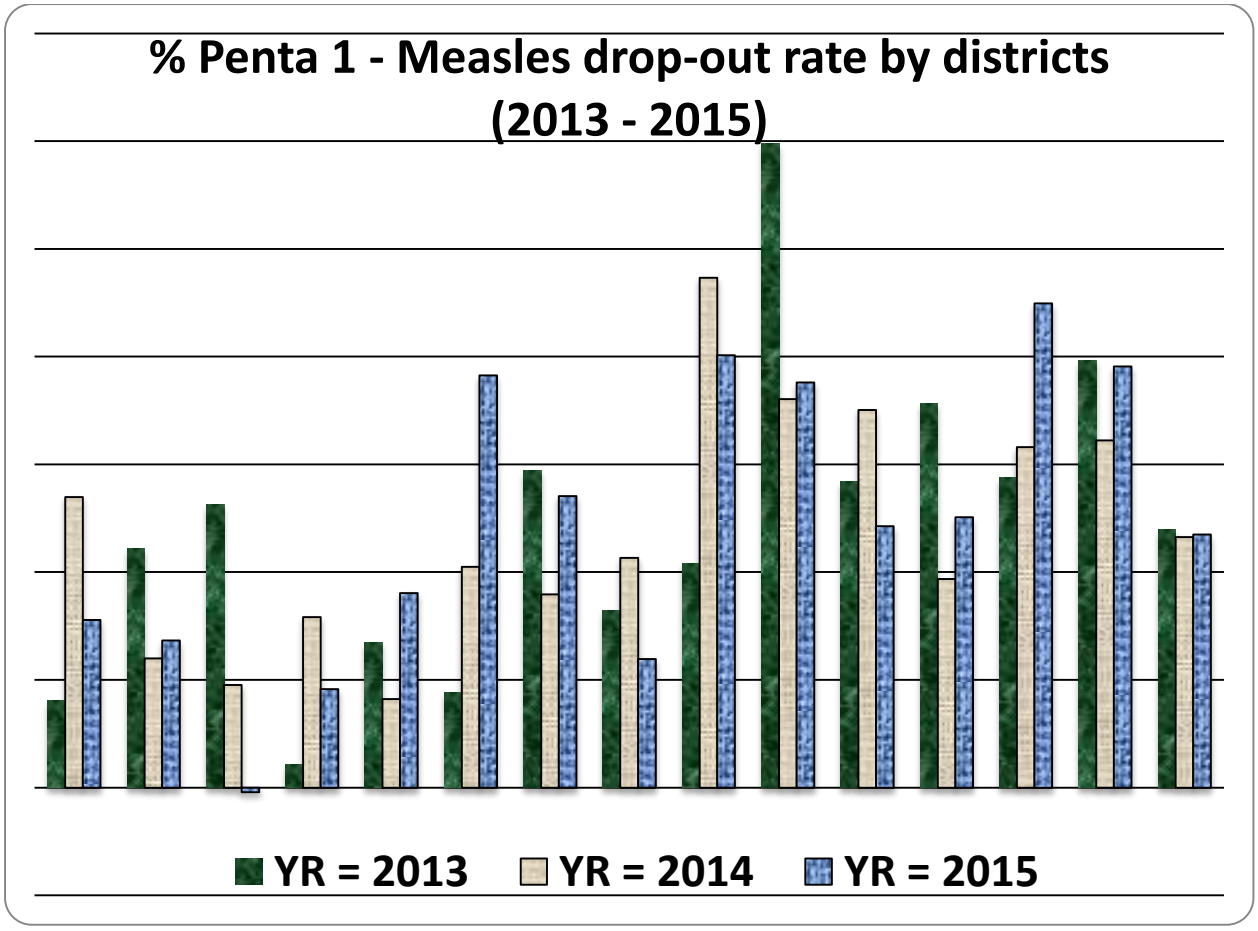


Table 10: National administrative % Penta 3 coverage and Pentavalent dropout rate (Source: JRF 2014)

DISTRICT	Penta 3 Cov (%)	Penta 1 - Pent 3 DOR (%)
BO	80%	8.7%
MOYAMBA	145%	4.7%
KENEMA	88%	5.1%
PUJEHUN	91%	5.8%
WESTERN URB	71%	7.2%
WESTERN RUR	133%	9.2%
BONTHE	80%	6.7%
KAILAHUN	88%	5.8%
KONO	94%	8.6%
KAMBIA	101%	6.1%
PORT LOKO	87%	8.9%
BOMBALI	91%	9.6%
KOINADUGU	114%	12.2%
TONKOLILI	119%	14.1%
NATIONAL	**93%**	**8.2%**

Annex G: GAVI Supported Vaccine Stock in 2014

Vaccine type	Total doses for 2014 in Decision Letter	Shipment according to VAR in 2014	Total doses received by 31 December 2014	Doses brought forward from 2013	Actual No. of children vaccinated in 2014?	Total doses brought forward in 2013 and Total doses received in 2014
Pneumococcal (PCV13)	636,000	477,900	477,900	236,900	665,858	714,800
DTP-HepB-Hib	648,700	320,000	320,000	400,260	665,563	720,260
Rotavirus	607,500	561,000	561,000	0	289,825	561,000
Yellow Fever	108,800	175,700	175,700	85,640	205,477	261,340

Vaccine procured in 2014 took into account the 2013 stock balance as highlighted in APR. Based on the data above, the doses administered were less than the doses available for the period under review.

Annex H: NVS future plans and priorities

Improvement of immunisation service delivery,

- Support the conduct of regular quarterly and monthly supportive supervision by national and district level respectively;
- Analyze data for action, on monthly bases and share analysis with districts and partners;
- Conduct Refresher Training for Staff on Immunisation in Practice, Mid-Level Management (MLM) and Vaccine management to accelerate EPI service delivery;
- Support the implementation of the Reach Every District (RED) strategy;
- Conduct Supplementary Immunisation Activities/Maternal and Child Health Week activities;
- Conduct comprehensive review of the district RI micro plan, for better planning and implementation of outreach services;
- Improve uptake of Immunisation Service through nationwide catch up for all antigens in children less than 2 years, and conduct quarterly Periodic Intensified Routine Immunization (PIRI) in priority districts;
- Support the strengthening of outreach services (transportation, tools, incentives, cold chain equipment);
- Strengthen advocacy and Communication for EPI service delivery;
- Scale up social mobilization at National, district, chiefdom and village level through civil society, ward committees and other stakeholders for community engagement and ownership;
- Support the implementation of year two HPV demonstration project activities;
- Conduct comprehensive EPI review;
- Review and update major policies and documents (cMYP, training manuals, data collection tools, EPI Policy);
- Introduce measles second dose (MSD);
- Introduce IPV by January 2016;
- Implement tOPV and bOPV switch.

To support disease surveillance in all districts

- Support case based surveillance for vaccine preventable diseases (specimen collection and transportation, reverse cold chain tools, active case search);
- Strengthen AEFI monitoring system at all levels including the development of a database (Including training of health staff);
- Support quarterly IDSR and AEFI review meetings;
- Strengthen community event-based surveillance activities nationwide (Reactivated during the EVD outbreak).

To improve Data quality and data management

- Strengthen Health Management Information System (HMIS) through collaboration with Directorate of Health System Policy Planning and Information (DHSPPI) and other partners especially Global fund;
- Conduct monthly review meetings at district level with health facility in-charges, councils, civil society and community stakeholders;
- Improve Data Management through data harmonization meetings, provision of computers and accessories;
- Conduct Data Quality Self-assessment (DQS) and Service Availability and Readiness Assessment (SARA) to improve data quality;
- Monitoring of immunization budget process;
- Revise EPI data collection, reporting, and monitoring tools
- Support the conduct of EPI related trainings both locally and internationally
- Conduct integrated supportive supervision at all levels

To support Logistics and Cold chain

- Improve Vaccines, cold chain and Logistic maintenance at all levels;
- Replace or repair obsolete and faulty cold chain equipment at all levels;
- Procure additional cold chain equipment and spare parts;
- Conduct regular preventive maintenance and repair of cold chain equipment;
- Conduct temperature monitoring study as per WHO standards;
- Conduct repair and maintenance of EPI transports;
- Procure vehicles and motorbikes and improve management of existing fleet in line with MoHS transportation policy

To improve Coordination

Within the program the EPI will:

- Continue to conduct weekly technical coordination committee (TCC) meetings;
- Convene HSSG/ICC meetings regularly (quarterly), and as and when required;
- Conduct monthly review meetings at district, chiefdom level with health facility in-charges, councils, civil society and other community stakeholders;
- Conduct bi - annual EPI review meeting with DHMT's, Council and District Officers (DO's), key civil society representatives and Community stakeholders;

Work closely with DHSPPI to identify opportunities for coordination and integration with other disease specific programmes (e g GF).

Annex I: HPV PIE FINDINGS/RECOMMENDATIONS

The HPV PIE Findings indicated that demonstration project was successful. The key enabling factors included the following:

- Strong Coordination and timely involvement of all the partners and other stakeholders including the media
- Excellent collaboration from the Ministry of Education at all levels
- HPV vaccine has been highly accepted by the communties and targeted school girls
- Training was well organized and conducted using adequate training materials
- Pre-registration of all the targets before implementation including their phone contacts for easy tracking of defaulters
- Timely communication and information sharing with key stakeholders at all levels

Despite the success some weaknesses were identified including the following;

- Inadequate tools for effective communication of information on HPV vaccine/cervical cancer to teachers and girls
- Inadequate financial resources for the approved strategy particularly local resource mobilization

Annex J: ToR ICC

MCH/EPI DIVISION
MINISTRY OF HEALTH AND SANITATION

REVISED TERMS OF REFERENCE FOR THE INTERAGENCY CO-ORDINATING COMMITTEE SIERRA LEONE

JANUARY 2005

RATIONAL:

Sierra Leone is one of the governments represented in the World Heath Assembly (WHA) and one of the countries that participated in the World Summit for Children (WSC) where goals were formulated to improve immunization coverage, decrease morbidity and mortality in al member states. National governments, including Sierra Leone have since been striving to achieve these noble goals. The development of National infrastructure to improve access to health services, including immunization services. Immunization is known as the single most cost effective strategy to decrease childhood morbidity and mortality. There has been significant improvement in moving towards the goals at National and global levels. For Sierra Leone achieve these goals, it is crucial that the government and partners combine their effort in the mobilization and monitoring the use of the resources for EPI. Hence the need to have and maintain a strong Inter-Agency Committee in the country cannot be over emphasized.

There has always been a felt need by government and partners to coordinate technical and material inputs to the programme. In light of current and future support, increased technical coordination would ensure efficient use and greater impact of technical, material and financial resources.

To this effect the Inter-Agency Coordinating Committee (ICC) was established in 1998 to serve as an advisory body to the Ministry of Health and Sanitation (MoHS) with the following specific objectives:

- To provide the government the opportunity to work closely with partners and identify the resources and assistance necessary to strengthen immunization services in a sustainable manner.
- To participate in the planning, follow-up, management, monitoring and evaluation mechanisms of EPI Plus and advise on improvement.

ICC has two sub-committees (Technical and Social mobilization)

CRITERIA FOR MEMBERSHIP:

1. The membership of the Inter-Agency Co-ordination committee must be bodies or organizations with the ability to contribute technically, materially and financially to the overall improvement of the immunization services in the country.

2. The head of each immunization partner is automatically a member and each organization should delegate 1 to 2 persons who have a wide range of experience in the field of public Health with emphasis on immunization and disease control.

3. The organization must be able to provide concrete and unbiased advice to government on ways to strengthen the immunization systems in the country.

4. Members should be able to participate in the planning, follow-up, implementation, monitoring and evaluation of the program activities.

5. Member organization/agency must have a high National and International reputation in the technical, financial and coordination abilities of health Programmes.

Main Partners/members of ICC

- MoHS:
  - Primary Health Care Department
  - **Directorate of Planning and Information**
  - Disease Prevention and Control Department
  - Directorate of Management services
- WHO
- UNICEF
- Rotary International
- MSFs (Belgium, France, and Holland)
- Sierra Leone Red Cross Society
- Christian Children Fund (CCF)
- Sierra Leone Public Health Association (SLPHA)
- Potential new members: as it becomes necessary and as they become available

Specific Tasks of the committee includes but not limited to:

1. Overseeing the process of development of multi-year Strategic Plan for the EPI programme.
2. Participating in the development of technical policies and guidelines.
3. Coordinating support from partners to avoid duplication, gaps and inefficiencies
4. Ensuring the availability of sufficient resources – (financial, human and material) for the smooth management of the programme.
5. Providing technical expertise to the program
6. Ensuring that planned activities are implemented within the planned time frame.
7. Participating in review meetings and other Program monitoring activities.
8. Supporting Social Mobilization to ensure political commitment and community participation in immunization programme.
9. Ensuring collaboration and coordination among current and potential EPI partners in the country.
10. Coordinating national EPI program review every five years
11. Ensuring inter-departmental collaboration and cooperation within the MoHS to enhance program management.
12. Providing updates on innovations and research to guide the MoHS on way forward.
13. Strengthening technical and social mobilization sub-committee

Frequency of meeting:

- ICC: **monthly and more frequently as it becomes necessary**

- Technical sub-committee: weekly **(more frequently before and during SIAs)**
- Social mobilization sub-committee: **monthly (more frequently around SIAs)**

Monitoring of ICC activities:

- Regular meetings with minutes that will be circulated to members prior to the subsequent meeting
- Regular attendance of key partners and relevant MoHS department heads
- Annual action plans incorporating all aspects of immunization services discussed and endorsed, by the ICC

Secretariat:

- Chairperson: Chief Medical Officer-MOHS
- Secretary: EPI Manager
- Secretarial Support: WHO and UNICEF

Annex K: Presentation to the ICC on the JA