Joint Appraisal (JA) Report 2019

Country	Central African Republic
Full JA or JA update[1]	☑ **full JA** ☐ JA update
Date and location of Joint Appraisal meeting	10-12 July 2019, in Bangui
Participants / affiliation[2]	List of attendees
Reporting period	July 2017 - June 2018
Fiscal period[3]	July 2018 - June 2019
Comprehensive Multi Year Plan (cMYP) duration	2018-2022
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 ☒	No ☐	
Does the vaccine renewal request include a switch request?	Yes ☐	No ☒	N/A ☐
HSS renewal request	Yes ☐	No ☒	N/A ☐
CCEOP renewal request	Yes ☐	No ☒	N/A ☐

2. GAVI GRANT PORTFOLIO

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

Introduced / Campaign	Date	2019 Target		Approx. Value $
		%	Children	
Penta	2008	80%	130,461	US$ 307,000
PCV	2008	80%	131,200	US$ 1,169,000
IPV	2015	80%	130,376	US$ 746,000
MenA	2017	80%	131,000	US$ 45,500
Yellow fever	2003	80%	131,000	US$ 246,000
Measles campaign	October 2019 (upcoming)	100%	878,170	US$ 2.5 million (vaccines + operating costs)

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

Grant	Channel	Period	First disb-ursement	Cumulative financing status @ June 2018				Compliance	
				Comm.	Appr.	Disb.	Util.	Fin.	Audit
HSS2	UNICEF	2017-2019	July 2017	US$ 7.5 million	US$ 9 million	US$ 6.1 million	82% (Util./ disb.)	N/A	N/A
Comments									

[1] 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/
[2] If taking too much space, the list of participants may also be provided as an annex.
[3] If the country reporting period deviates from the fiscal period, please provide a short explanation.

Disbursement of remaining funds will be made before September 2019**. The Central African Republic (CAR) will officially request a no-cost extension for 2020.** The reason is that HSS activities began in September 2017 instead of January 2017.

Indicative interest to introduce new vaccines or request Health System Strengthening support from Gavi in the future[4]

	Programme	Expected application year	Expected introduction year
Indicative interest to introduce new vaccines or request HSS support from Gavi	Rotavirus vaccine	2011	2020
	MR	2020	2021
	HPV	2020	2022
	Hepatitis B vaccine at birth	2021	2022

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

Following the new guidelines on the Gavi performance framework, the CAR is in the process of finalising its performance framework (Deadline: 11 October 2019). This is also a mandatory condition for the disbursement of additional funds.

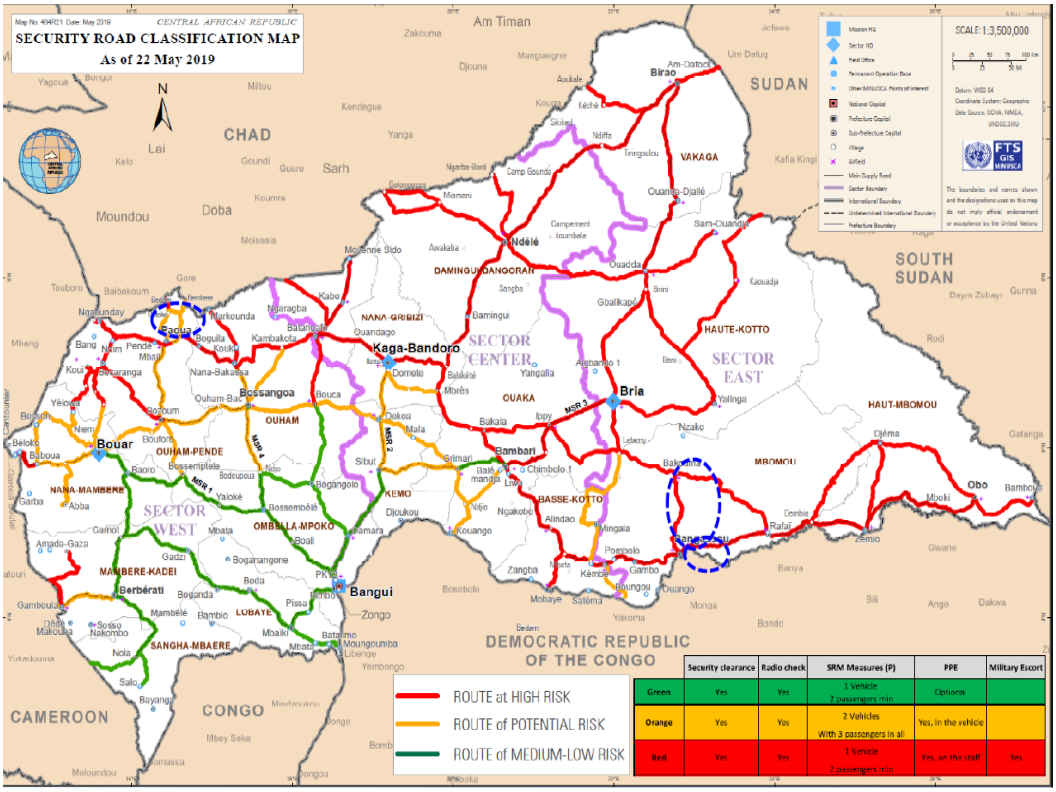
PEF Targeted Country Assistance: Core and Expanded Partners at May 2019 *(to be pre-filled by Gavi Secretariat)*

	Year	Funding (US$ million)			Staff in-post
		Appr.	Disb.	Util.	
TOTAL CORE	2018	2.3	1.7	0.9	8
	2019	2.8	2.1	-	
UNICEF	2018	1.4	1.4	1.1	6 of 7
	2019	1.6	1.2	-	
WHO	2018	0.9	0.8	0.5	2 of 3
	2019	1.2	0.9	-	
CDC	2019	0.012	0.012	-	
TOTAL EXPAND	2018	0.4			
	2019	0.4			
AEDES	2018	0.3			2
	2019	0.4			2
REPAOC	2018	0.1			
	2019	-			
OSLO	2018	0.09			
	2019	0.01			

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

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

The country context, since the last joint assessment, is still characterised by the unstable security situation, as indicated on the map below.



An important development is the Khartoum peace agreement signed on 6 February 2019 in Bangui between the Government and the armed groups.

The major changes that have taken place in the health sector are indicated below.

- In accordance with the provisions of Decree 18-214 of 17 August 2018 on the organisation and functioning of the Ministry of Public Health, Population and AIDS Control (MoH) and the allocation of the Minister, a new organisation chart has been established. It is marked by significant changes, such as the creation of four general directorates.
- The MoH has adopted a stronger vision of health development, the main elements of which are: adoption of the quality approach, universal health coverage, elaboration of a national health policy and of the future NHDPIII, and the strengthening of the health districts (HDs). As a result, many technical and financial partners (TFPs) have aligned themselves with this vision, with health system strengthening projects/programmes such as the EU/Bêkou 3 and the WB/SENI.
- The national health information system (NHIS) is now considered an essential element of the health system pillar. Consequently, a budgeted roadmap to fully revitalise the NHIS has been developed. To be implemented, it will have to be endorsed by all stakeholders and proposed at a multi-donor forum.
- Additional funding for CAR will be granted, in line with Gavi's policy of flexibility in favour of fragile countries. This additional fund is about 50% of the initial grant, thereby bringing the initial amount from US$ 9 million to US$ 13.5 million. The priority actions under these additional funds are immunisation coverage in conflict areas and special populations that are difficult to reach with current immunisation strategies.
- The CAR faces a new situation with the cVDPV cases in May 2019 in Bambari and Bimbo, a response to which was organised. Rounds 0 and 1 were carried out without incident, thanks to the commitment of the groups that signed the Khartoum peace agreement; round 2 is in preparation, for implementation in September 2019.
- In addition, measles outbreaks were recorded in the Paoua, Batangafo-Kabo and Vakaga HDs; response immunisation campaigns were organised in these affected districts. The measles

campaign is scheduled for October 2019. Gavi funds 100% of the additional costs as part of its fragility policy.

Potential future issues (risks)

1. Security situation still fragile despite the Khartoum agreement, and risk of political tensions due to the grouped elections in December 2020. Also, if the Special Criminal Court prosecutes leaders of armed groups once it becomes operational, there is the risk of renewed tensions and hostilities.
2. Polio and measles epidemics could occur in areas with low coverage. Efforts are thus still needed, particularly in conflict areas such as Health Region (HR) 6 and some urban areas affected by insecurity (Bangui II HR 7, where the largest number of non-vaccinated children are located). Surveillance will be strengthened thanks to the REDISSE project of the World Bank and other partners.
3. Stockouts and/or vaccine expiry due to weak supply chain and poor input management at the district and health-facility levels. It also seems that population movements and poor knowledge of the denominator (last census in 2003) are impacting the vaccine quantification process.
4. In the fourth quarter of 2019, three campaigns are planned in the country: polio, measles and tetanus. These campaigns may take away resources (people and time) from routine immunisation. Support from the topmost authorities to keep the focus on routine immunisation is important.
5. Challenge of catching up children age 12-23 months (flexibility approved by Gavi).

Previously, the CAR officially immunised only children under 11 months of age. Immunisation of those age 12-23 months was approved by the Ministry and Gavi in 2018. The guidelines were developed by the Ministry and sent to the health facilities between June and July 2019. Certain NGOs (MSF) started immunising children age 12-23 months after agreement with the MoH, but official introduction into routine immunisation is expected in August 2019.

This introduction of immunisation in children's second year of life presents:

- a challenge for consolidating increases in immunisation coverage;
- a need to heighten public awareness and the information/training of health centre staff.

6. Strong need for capacity building.

Support is needed at the central and district levels to position technical assistance. Support will first be provided by Expertise France (Gavi's LMC initiative), which will carry out an organisational audit and capacity assessment at the central and then decentralised levels.

Some examples of training needs: Project management / MLM at the central level, budget planning and management at the central and decentralised level, leadership (EPI Lamp), online or classroom LOGIVAC, practical training in immunisation, DVDMT and DHIS2 data management, additional training for technicians and maintenance technicians.

This capacity building will then help in implementing high-quality supportive supervision and coaching at all levels of the systems (by the Directorate of Research, Studies and Planning [DREP] and Directorate of Prevention through Immunisation [DPI] + supervision of health facilities by DMT at the Health Region (HR) 1,2,3 and 7 levels).

7. Data quality

Data quality is a major bottleneck in the CAR, a country that has not had a census since 2003. The NHIS/DHIS2 roadmap has been completed and a first University of Oslo HISP mission is expected before the end of 2019. A technical group for data quality was set up by official decree in July 2019.

4. PERFORMANCE OF THE IMMUNISATION PROGRAMME

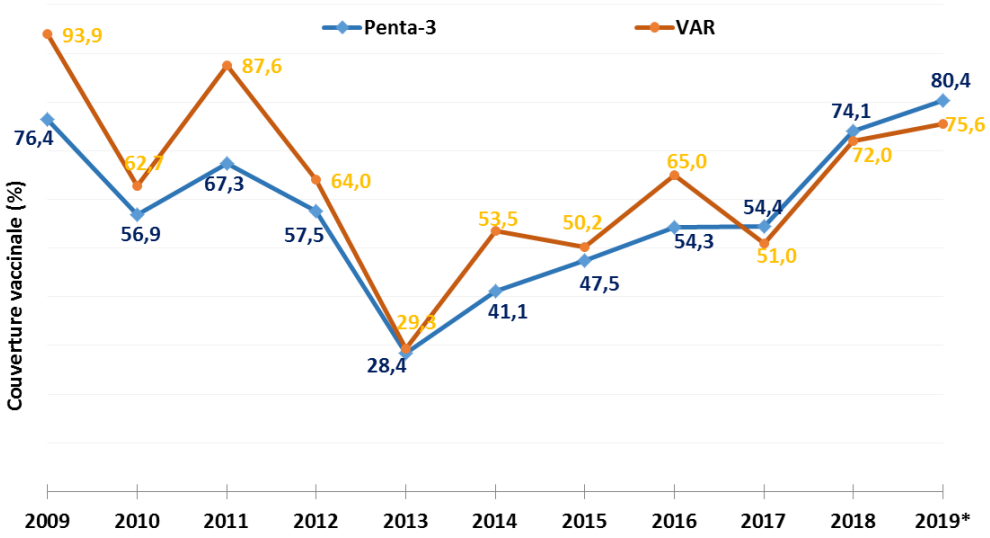
4.1. Coverage and equity of immunisation

Coverage:

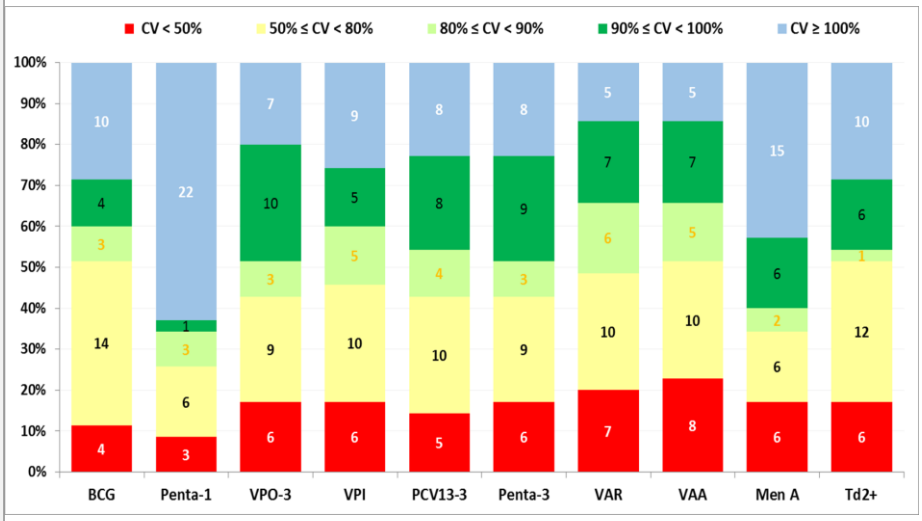
DTP3, MCV2, etc.

The CAR has undergone a decade of recurring conflicts that have had harmful consequences on basic social infrastructure, in particular in the area of health and in the delivery of preventive services such as immunisation. This makes it one of the countries with a large number of vulnerable children.

In this context of insecurity and reconstruction of a health system nearly completely destroyed, routine EPI performance has remained poor despite fluctuating trends between 2013 and 2017 (Fig. 1). However, there has been a significant improvement in EPI indicators since 2018, partly due to a strengthening of the MoH's leadership and the implementation of innovative strategies such as the urban strategy in Bangui and intensified immunisation (activities (IIAs) in some insecure zones. In 2017, a total of 17 HDs out of 35, or 49%, had Penta3 immunisation coverage higher than 80%, including 14 in the Gavi HSS intervention zone. In comparison, only 6 HDs out of 30 (20%) enjoyed such immunisation coverage in 2017. The number of children not immunised with Penta3 fell from 71,515 in 2017 to 41,425 in 2018, representing a decrease of 42%.



Since the beginning of 2019, it appears that the performance observed in 2018 has been maintained (Fig. 2).



However, it must be noted that the denominator both on a national and subnational level remains difficult to pinpoint given that the last census was in 2003 and due to the effects of population movements. Consequently, any analysis of immunisation coverage from one district to another and from one year to another will contain ambiguities.

Map 1: Immunisation performance mapping by HD for Penta3 and MCV antigens between January and May 2019 in the CAR

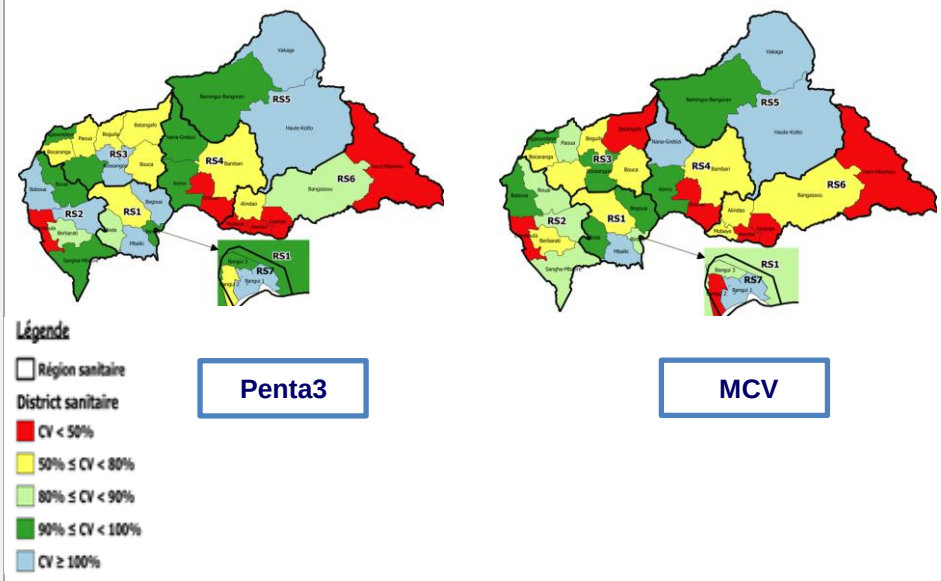
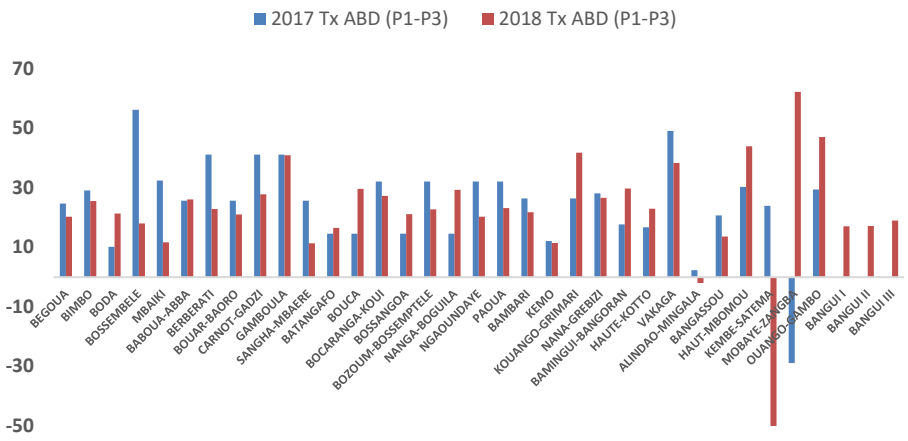


Table I: Trends in main indicators for routine EPI from 2014 to 2018

Indicators	2014	2015	2016	2017	2018	2019*
	Admin	Admin	Admin	Admin	Admin	Admin
IC DTP-HepB-Hib1	66%	69%	79%	70%	95%	102%
IC DTP-HepB-Hib3	41%	47%	54%	54%	74%	80%
IC MCV	54%	50%	65%	50%	72%	76%
Number (%) of districts with DTP-HepB-Hib3 ≥ 80%	3 (10%)	2 (7%)	5 (17%)	6 (20%)	17 (49%)	20 (57%)
Dropout rate for DTP-HepB-Hib1/ DTP-HepB-Hib3	37%	28%	31%	24%	22%	21%
BCG/MCV dropout rate	3%	27%	18%	26%	19%	20%
% districts with dropout rate >10%	97%	93%	99%	25 (83%)	33 (94%)	20 (57%)

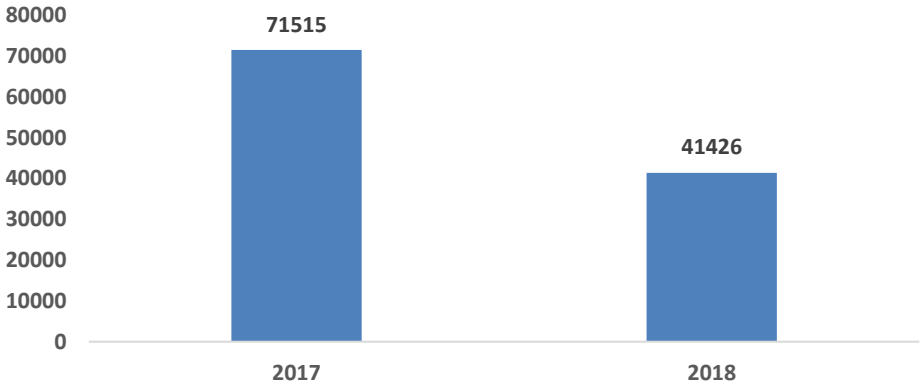
**Period from January to May 2019*

In 2018, schedules were distributed to HDs to develop and strengthen the system for catching up with those lost to follow-up in routine immunisation, but some districts are still not using these materials.



Specific dropout rate for Penta by HD:

In general, the specific dropout rate decreased between 2017 and 2018 but remains very high in the insecure districts where routine vaccination is irregular (districts in HRs 4, 5 and 6). The case of some districts in the HSS intervention area could be explained by a low geographical coverage of EPI delivery sites (Bimbo, Begoua, Baboua-Aba, Carnot-Gadzi) and/or of insecure areas (Gamboula, Bouca, Nana Bogula). Negative dropout rates reflect the poor quality of data, due to population movements, not knowing the denominator and the non-specificity of the numerator, particularly in areas of insecurity.

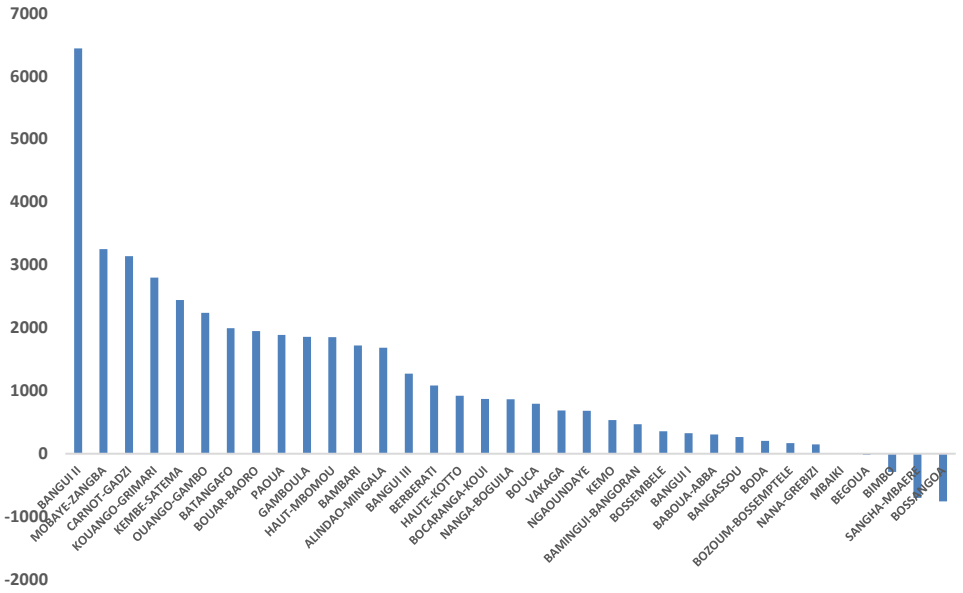


Comparison of the total number children not vaccinated with Penta in 2017 and 2018

This graph confirms an improvement in the overall performance of the routine EPI in 2018.

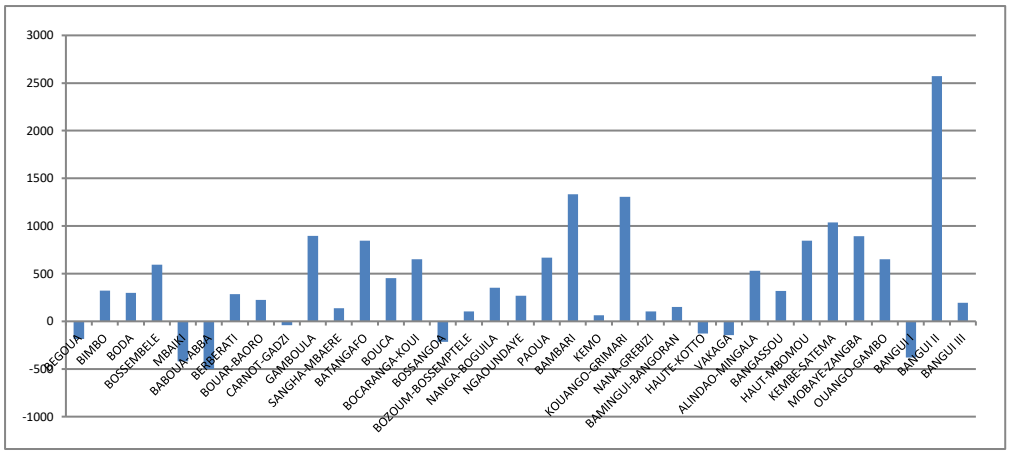
Coverage:

Absolute numbers of un- or under-immunised children



Number of children not vaccinated with Penta3 in 2018 by HD

While we can see a clear overall decrease in the number of children not vaccinated with Penta3 between 2017 and 2018, percentages nonetheless remain very high in the majority of HDs. The specific cases of the districts of the city of Bangui (Bangui II and Bangui III) bear witness to the poor accessibility of immunisation services (low geographical coverage, inappropriate delivery days and times).



Graph: Breakdown of number of children not vaccinated with Penta3 in 2018, by HD

Out of the 35 districts, 37% missed more than 500 children for Penta3; the total number of children in the first five months of 2019 is 14,095.

Equity:

- Wealth (e.g. high/low quintiles)
- Education (e.g. un/educated)
- Gender
- Urban-rural
- Cultural, other systematically marginalised groups or communities e.g. from ethnic religious minorities,

The last immunisation coverage survey (2016) did not indicate a gender-related equity problem. There are no factual data on specific immunisation coverage in the population groups recognised as marginalised in terms of immunisation (nomads, IDPs/refugees, fishermen, pygmies, mining site populations, etc.). The latest cases of VDPV 2 were nevertheless among these types of populations, confirming that herd immunity within these populations is fragile.

children of female caretakers with low socioeconomic status, etc.	

The Penta3 IC objective was achieved in 2018. The factors for success in 2018 included:

- strong involvement by the MoH ministerial office (holding weekly meetings every Friday chaired by the Minister; active collection of missing reports by the MoH, etc.);
- division of the Health Prefectures into districts and their ongoing operationalisation;
- capacity building of DMT/RMT through series of training on district management and priority programmes of the Ministry;
- implementation of the RED strategy in HRs 1, 2 and 3;
- organising IIAs in the insecure HDs [Bocaranga-Koui (HR 3), Bambari, Kémo and Nana-Grébizi (HR 4), Haute-Kotto (HR5), Bangassou, Mobaye and Alindao (HR 6)] with IFRC support;
- improvement in the internal and external completeness of the EPI data of the HDs;
- implementation of the Urban Immunisation Strategy in the city of Bangui;
- implementation of the immunisation strategy for special populations (nomads, pygmies, IDPs/refugees, fishermen, mining sites, markets, etc.) in the Gavi intervention areas;
- improvement of the supply chain (installation of solar cold chain equipment, purchase of five 4WD vehicles and two lorries for transporting EPI inputs, supervision of stakeholders on input management).

In 2019, we can add the implementation of important activities in the context of immunisation system strengthening, namely:

- organising the first DQR for immunisation, in February 2019;
- DVDMT training for the remaining HRs (HRs 4, 5 and 6);
- training of MLM trainers with the support of AFRO/IST-CA;
- the submission to Gavi of the proposal for additional funds for the HSS2, amounting to US$ 4.5 million.

The highly anticipated results of the ongoing surveys (SARA, MICS 6) will be able to provide us with more information on the performance achieved.

The Penta3 immunisation coverage was 79% for the period from January to May 2019, which indicates a good performance trend compared to the 63% for the same period in 2018.

4.2. Key drivers of sustainable coverage and equity

- **Staff**

The number of qualified MoH staff remains low. In addition, the distribution of personnel is uneven, with a greater concentration in Bangui. According to HeRAMS 2016, personnel at the intermediate (region) and operational (district and health-facility) level are distributed as follows:

- At the regional level: 23 health personnel facilitate activities.
- At the district level: 82 health personnel facilitate activities.
- At health facilities, distribution is as follows:
  - 1 doctor per 24,769 inhabitants;
  - 1 midwife per 18,509 inhabitants;
  - 1 registered nurse per 20,457 inhabitants;
  - 1 community health worker in health facilities per 1,643 inhabitants.

Community Health Workers (CHWs) in health facilities represented about 51% of the workforce for the CAR health system in 2016. EPI at the operational level is almost entirely under the responsibility of these very poorly qualified workers, who also manage other health programmes. This impacts the quality of service delivery.

Since then, the MoH has made a great effort to strengthen its health human resources. In March 2017, 143 physicians, 5 pharmacists, 1 dental surgeon and 244 paramedical staff were incorporated to meet the urgent need for staff. In June 2018, more than 250 other staff were incorporated into the civil service, to serve the MoH. These steps slightly improved the provision of services. However, the objective of achieving a ratio of 1 doctor per 10,000 inhabitants remains to be fulfilled.

- **Supply chain**

The supply chain is organised according to the country's health pyramid. It is structured on three levels: central, intermediate and operational (district and health facility).

The central level has five cold rooms.

No HR has a vaccine management warehouse. As part of the CAR supply-chain modelling, the creation of four regional warehouses is planned. These are the Berberati (HR 2), Bambari (HR 4 and 5), Bossangoa (HR 3) and Bangassou (HR 6) warehouses.

The operational level of the MoH includes 35 HDs, created by Order No. 043 of 16 October 2017. Each district has at least one refrigerator for storing EPI vaccines. The central level resupplies the districts on a monthly basis. The health centre level includes 534 service delivery points for routine immunisation, which also organise the implementation of supplementary immunisation activities (SIAs). The EPI centres obtain their supplies from the HDs.

The vaccine supply chain is marked by difficulties in mobilising internal resources for vaccine co-financing, inadequate logistics for resupplying HDs (some HDs must be supplied by air), lack of financial resources to produce management tools, and the absence of a standard operating procedure defining a response plan in the event of equipment failure or other emergencies at central level. However, preventive cold room maintenance is carried out at least twice a year by a subregional maintenance company thanks to UNICEF support. To ensure that this maintenance is regular, subcontracting to a local company is being considered.

There is a supply plan, but implementation suffers from a lack of financial resources. For some inaccessible regions such as HRs 5 and 6, supplies are flown in by air to the districts' base with the support of partners. Supply via air, however, is dependent on humanitarian flight programmes, which experience frequent cancellations and delays.

Factors that negatively affect the availability and functionality of the cold chain and Effective Vaccine Management at the HD level include: non-use or absence of standard operating procedures (SOPs), absence of a formal supply system for health centres, low storage capacity, frequent shortages of cold chain consumables (fuel, wicks, etc.), looting of equipment due to insecurity, and fire accidents related to fuel-powered refrigerators.

At the health facilities level: the number of health facilities that should offer immunisation services to meet the country' needs is unknown because no standards exist. The inventory showed that only 534 health facilities offer immunisation services, 391 of which have cold chain equipment and 143 of which have none. Vaccine stockouts sometimes occur at immunisation units due to delayed supplies and poor input management.

The Effective Vaccine Management (EVM) assessment was conducted in June 2016 in a context of political/military conflict. The conflict caused the collapse of the health system, with the destruction/pillaging of health infrastructure and inputs; a near total shutdown in the delivery of health care services, including immunisation services; displacement of healthcare personnel; and the loss of capacity to prepare for and respond to epidemics.

This assessment led to the development of an improvement plan aiming to maintain gains and provide corrective measures for the weaknesses identified. The main activities completed are listed below.

In leadership:

- Strengthening of the EPI logistics committee via technical assistance (UNICEF/WHO).
- Establishment of the CCEOP Management Committee.
- Training of stock managers at the HD level on EVM.
- Training of two supply-chain managers in health logistics (LOGIVAC).
- Training 25 health workers on installing and maintaining solar refrigerators.

In data management:

- Revising and reproducing tools/materials for vaccine and supplies management.
- Capacity building for central-level managers in the use of tools (SMT, inventory analysis, forecasting).
- Developing supply forecasts.
- DVDMT training for DMT.

In supply chain strengthening:

- Purchase of nine solar refrigerators for the HDs in Berberati and Gamboula, thanks to support from the French Red Cross.
- Within the framework of the CCEOP, the process of purchasing of 309 cold chain equipment sets is in progress.

Continued improvement of the supply chain:

- Availability of a not-yet-funded plan for cold chain equipment maintenance.
- Preventive maintenance contract for cold rooms.
- Daily stock management and regular sharing of the SMT report.
- Monitoring temperature records.
- Enlisting the involvement of NGOs and United Nations agencies in supplying vaccines and supplies for districts and health facilities.

➢ **Generating demand for immunisation**

Analysis of dropout rates (31% in 2016, 24% in 2017 and 22% in 2018) shows that there is a problem with the use of services and therefore with the generation of demand for immunisation within communities. This is partly due to the non-implementation of the integrated communication plans developed during the second quarter of 2018. A situational analysis conducted in March 2017 by the DSC highlighted the following weaknesses:

- At the institutional level:
  - Creation of a partnership service in charge of communication within the DPI and working in collaboration with the DSSP (Directorate of Primary Health Care).
  - No national policy documents on immunisation.
  - No permanent community communication bodies at the decentralised level.
- At the managerial level:
  - The 2018-2022 strategic communication plan for immunisation has not been implemented.
  - Lack of staff with knowledge and skills in EPI communication, in particular at the intermediate and operational level.
  - There is no mechanism for monitoring/evaluation, documenting or sharing communication actions for immunisation.
- At the social and educational communication level:

- There is a continuing tendency to favour disseminating text messages to the detriment of a C4D approach targeting communication for individual and social change and community participation.

- Communication/mobilisation strategies are not suited to the routine EPI by context (equity, supply of services, geography, security, socio-cultural aspects, etc).

- There is insufficient advocacy directed at parliament and the Government regarding immunisation and the corresponding expenditures committed.

- Opinion leaders, political leaders and community leaders are not sufficiently involved.

- Interpersonal communication at all levels (health workers, community liaisons, etc) is inadequate.

- There are insufficient strategies to support disadvantaged populations with regards to immunisation.

- Communities do not take sufficient ownership of immunisation because they are not made accountable (survey on inequities in immunisation).

➢ **Obstacles related to gender inequality**

According to the survey on inequity in immunisation carried out in 2015, analysis of immunisation coverage by sex and by antigen does not show significant differences between boys and girls.

➢ **Leadership, management and coordination**

The EPI Interagency Coordination Committee (EPI-ICC) held three extraordinary meetings between July 2018 and June 2019. Postponed and irregular ordinary sessions hinder in-depth analysis of factors behind the poor performance of routine EPI.

The EPI Technical Advisory Committee (EPI-TAC) meets monthly and as needed to discuss aspects of programming and monitoring. It plays an important role in the technical analysis of documents to be submitted to the ICC for endorsement. In all, six meetings were held from July 2018 to June 2019.

In addition to the ICC and EPI-TAC, which are dedicated to coordinating the EPI, there are two other consultation bodies, namely the Sectoral Health Sector Committee (CSS) and a Single Steering Committee for all MoH projects and programmes. While the CSS has not been operational since its creation, the Single Steering Committee for Programmes and Projects has met three times since the last appraisal.

At the regional and district level, quarterly coordination meetings are held regularly in the districts and regions where the area offices of UNICEF and WHO are located. Meetings in the other districts and regions are irregular because of a lack of support. From January to June 2019, there were no coordination meetings at the regional level due to lack of funding.

Several NGOs are continuing to play a vital role in implementing health activities, in particular for immunisation and health system strengthening, especially in remote and insecure areas. The long-term objective of the EPI is to formalise this NGO support through a framework of accountability for the interventions of all partners.

Because of the weakness of the consultation and coordination frameworks, it is not possible to capitalise on the efforts of all the partners working to strengthen the EPI.

➢ **Public financial management**

The fragility of government institutions and chronic political instability has increased financial risks in the CAR. This is exacerbated by the lack of a banking system within the country. For this particular feature of the CAR, the management of HSS resources has been delegated to UNICEF for an initial transitional period of 18 months. The assessment of the MoH's financial management capacities, which would end this transitional period if conclusive, has not yet been carried out. However, there has been no significant change in principle in the Ministry's management capacities.

Grant funds will be administered in accordance with financial regulations and financial management rules and any other applicable UNICEF regulation, procedure and practice. UNICEF is obliged to keep accurate accounts describing the use and disbursement of grant funds. To date, UNICEF remains the sole body responsible for disbursing grant funds for activities listed in the budget. UNICEF is responsible for taking all the necessary measures to ensure that all grant funds are used with the sole objective of carrying out planned activities. Any significant change in the scope or schedule of activities will be reviewed beforehand by the Government and UNICEF. UNICEF will then be responsible for obtaining confirmation from Gavi.

UNICEF disburses the funds it receives based on MOH requests that are in compliance with the established action plan for the period.

Following creation of technical documents for implementation prepared by the Ministry's technical directorates, funds are transferred from UNICEF's account to the bank account of the implementing partner. Two signatures are required for disbursement and implementation of activities in the field.

Once the resources have been made available to the Ministry, UNICEF's quality assurance process (HACT) is applied. This includes:

- Programming visits to verify effective implementation of activities in accordance with the established plan.
- Spot checks to assess the quality and validity of accounting documents and other documentation. This is accompanied by capacity building for implementing partners.
- An audit is triggered when a report of poor management and financial misappropriation is issued.

➢ **Other critical aspects influencing immunisation performance:**

1. Accessibility problems:
   - Geographical accessibility related to poor implementation of the RED approach.
   - Insecurity and armed conflicts.
2. Insufficient supervision at all levels.
3. Insufficient or complete lack of data analysis at all levels for corrective actions.

4.3. Immunisation financing[5]

- The public health services environment in the CAR is improving thanks to the political will and leadership of the Government and the support from its development partners.
- Analysis of fiscal room for manoeuvre and the mapping of health resources shows that the financing of services depends heavily on external assistance.
- Health financing is provided through strategic planning that is both sectoral (Interim Plan for the Health Sector 2018-2019; cMYP 2018-2022, POA, others) and multisectoral (National Peace Recovery and Consolidation Plan-RCPCA 2017-2021).
- The Interim Plan for the Health Sector has a total budget of XAF 105,944,450,087, 21% of which is allocated to maternal and child health, including immunisation. This Interim Plan remains in force until the NHDPIII is developed.

[5]Additional information and guidance on immunisation financing is available on the Gavi website: https://www.gavi.org/support/process/apply/additional-guidance/#financing

- The cMYP, available as an operational plan, was developed on the basis of the microplanning of the previous year (2017).
- Domestically, funding sources are primarily the State, households, communities, municipalities, and the private and denominational sectors.
- Vaccine needs are quantified and budgeted in the 2019 Forecast, and UNICEF supports the purchase of traditional vaccines.
- As part of the response to epidemic emergencies, MSF supports the funding of vaccines. However, the World Bank could also be a potential partner for the funding of vaccines.
- To ensure regular co-financing of new vaccines, the CAR has included a budget line in the Finance Act for the purchase of vaccines.

5. PERFORMANCE OF GAVI SUPPORT

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

Objective 1	
Objective of the HSS grant (as per the HSS proposal or PSR)	Strengthen governance and coordination of immunisation activities at the central, regional and peripheral levels.
Priority geographies / population groups or constraints to C&E addressed by the objective	Districts of HRs 1, 2, 3 and 7
% activities conducted / budget utilisation	69% (20/29) of activities fully completed, 7% (2/29) partially completed and 24% (7/29) not completed Financial absorption is 89%.
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	Governance and coordination at the central, regional and peripheral levels have been strengthened through (i) the establishment of and operating support for the Technical Committee for monitoring HSS2 activities, which brings together both the stakeholders at the central, regional and district levels and the implementing partners; (ii) support for holding meetings between the MoH's steering committee and its technical and financial partners; (iii) support for holding meetings of the National Coordinating Committee for Primary Health Care; (iv) operating support for the management teams (from Nana Mambéré, Sangha Mbaéré and RMT 2); and (v) the purchase of six vehicles (three for use by the three MoH directorates in charge of implementing the project and the other three for the operational level). The development of strategic documents such as the cMYP and the urban immunisation strategy with technical support from UNICEF and WHO has helped to facilitate political decision-making. The MoH's technical capacity has been strengthened thanks to the recruiting of 12 contract staff to support the following: (i) management by the HSS2 project management team of the DREP; (ii) the vaccine supply chain and management of the DPI; (iii) revitalisation of primary health care (PHC) entities; and (iv) strengthening of community participation at the DSSP level. As part of the revitalisation of PHC entities, three texts were revised during a multisectoral workshop and are awaiting validation. The texts deal with the creation, organisation and functioning of (i) PHC entities, (ii) regional and district hospital management boards, and (iii) management committees for health centres and posts. In the districts of HRs 1, 2 and 3, 693 members of the CONGES (Management Boards) and COGES (Management Committees) were trained in the management of health facilities.

	Ten HDs were supported in the development of annual integrated plans and monthly workplans to facilitate the assessment of district performance and the implementation of activities for each level of the health system. The following was done as part of monitoring implementation of the HSS2 planned activities: - Integrated supervision of the central level and HRs was carried out in 19 districts of the target areas. This action helped build the capacities of actors at the operational level, identify weaknesses and plan corrective actions. - A financial control mission was conducted in 10 districts that benefit from the Gavi grant. A delay was noted in the implementation of some activities, in particular: organisation of regional coordination meetings for EPI activities, support for the preparation of integrated district and regional plans, and supervision at all levels. This delay was mainly due to the slowdown in activities during the period of reorganisation of the Ministry's organisational structure, the redrawing of the health sector and the change and establishment of new management teams at the district and regional levels. The reallocation of the funds saved on the budget line for vehicles enabled the order (now in progress) of 5 4WD vehicles and 50 additional motorcycles for the HDs.
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **changes in technical assistance**[6]	- Strengthen the management and planning capacity of management teams in the 19 newly established HDs. - Continue renovation and equip the administrative bodies of three districts (Bouar, Ouham-Pendé and Bimbo) as well as the DREP, the DPI and DSSP at the central level. - Support the development of the Annual Work Plans of the four targeted regions. - Support the development of the 2020 Annual Work Plans for the 35 HDs. - Organise control missions in the districts receiving support (team of three inspectors) including supervision for the HRs and HDs. - Support contract staff recruited to support the MoH management team. - Provide operating support for the management team at the central level and for districts not supported by other donors. - Develop the guidelines for an immunisation procedure manual and proceed with drafting and endorsement (requires the establishment of a committee to draft the manual). - Provide specific support for regional coordination of EPI activities. - Ensure the maintenance of the lorries for medicine transport. - Implement the RED approach in all 19 HDs. - Develop tools and strategies likely to strengthen research. - Establish tools to ensure communication, documentation and visibility of supported activities.

	- Support holding meetings of the National PHC Coordination Committee for the validation of data or documents developed at the decentralised level. - Revitalise the consultation bodies of the actors (PHC entities) at the intermediate (3) and peripheral (10) levels. - Continue to reactivate COGES and CONGES operations in the remaining 14 targeted districts.
Objective 2:	
Objective of the HSS grant (as per the HSS proposal or PSR)	Ensure the conditions and quality of service offerings in curative, preventive and promotional health, in accordance with the MPAs in Regions 1, 2 and 3.
Priority geographies / population groups or constraints to C&E addressed by the objective	Districts of HRs 1, 2, 3 and 7.
% activities conducted / budget utilisation	42% (12/29) of activities fully completed, 35% (10/29) partially completed and 33% (7/29) not completed. Financial absorption is 69%.
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	Administrative data (JRF 2018) show a significant improvement in immunisation performance in 2018, mainly in the target areas of the grant. Between 2017 and 2018, national immunisation coverage in Penta3 increased from 54% to 74%. The completed activities led to a number of results: - Activities planned as part of the urban strategy were implemented. - Support was given to the implementation of outreach and mobile strategies, the organisation of monthly meetings to validate immunisation data and the supervision of health facilities by DMTs in the 19 HDs covered by the grant. - Tools (schedules) were developed and 134 community liaisons at 67 health facilities in the HR were trained to search for persons lost to follow-up. - Capacity building was provided for DMTs, through the organisation of central-level supportive supervision (coaching). - Five supply-chain managers were recruited for the base levels of the HRs to improve vaccine management at the operational level. - Thirty-eight health workers were recruited for the health facilities, to strengthen the provision of immunisation services. - To improve the quality and availability of vaccines at the delivery points, two lorries were purchased to aid (i) vaccine supply to the districts; (ii) the regularity of resupply of vaccines and fuel to the districts and health facilities; and (iii) cold chain maintenance at the central and peripheral levels in the project area. - In May 2019, HR 7 and the DPI were provided with five vehicles. These are helping to improve EPI performance in the city, particularly in terms of supportive supervision and the supply of vaccines and other inputs. The following activities currently underway will help reinforce what has already been achieved: - The ongoing renovation work of six health facilities and the completed evaluation of the remaining four; - Validation of the deployment plan for equipment from Gavi's CCEOP; - The ongoing purchase of 50 new motorbikes for health centres that offer immunisation services but that did not benefit from the first allocation of rolling stock.
Major activities planned for upcoming period	- Continue recruiting, on a contractual basis, 12 other qualified health workers for the health facilities of the supported HDs and health posts.

(mention significant changes / budget reallocations and associated **changes in technical assistance**[6]	- Pay the salaries of qualified health workers recruited on a contractual basis for the health facilities of the target districts. - Coordinate the ICC at the central level to represent the ICC in the consultation bodies of the Transition Plan for the Health Sector (PTSS). These bodies include the (Health Sector Strategic Consultation Framework-CCSSS, the Permanent Technical Secretariat and others). - Renovate the dry warehouse at the central level. - Build/renovate the two intermediate warehouses in HRs 2 and 3. - Provide maintenance for the cold chain equipment at the central level and in the three targeted regions. - Proceed with purchasing the equipment defined in the renovation plan, based on the EVM improvement plan. - Ensure fuel supply for the lorries that transport drugs, vaccines and inputs. - Set up incentive and retention measures for immunisation workers and DMTs not covered by other partners. - Mobilise the communities concerned. - Train the identified community liaisons.
Objective 3:	
Objective of the HSS grant (as per the HSS proposal or PSR)	Strengthen the quality and use of health information for epidemiological surveillance and the EPI.
Priority geographies / population groups or constraints to C&E addressed by the objective	Districts of HRs 1, 2, 3 and 7
% activities conducted / budget utilisation	70% (7/10) of activities fully completed, 10% (1/10) partially completed and 20% (2/10) not completed. The rate of financial execution was 59%.
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	Skills in computer processing of data from the data management units at the central and decentralised levels were strengthened through the purchase of computer equipment: 10 computer kits were purchased and made available to the 10 beneficiary HDs. Thanks to the savings made on this budget line through the UNICEF group purchasing supply system, a new order for 10 additional computer kits is being placed for the new districts in the project area that did not benefit from the initial grant. Quality data were collected, processed and analysed during NHIS monitoring meetings organised in the HDs. These meetings and the monitoring of immunisation data carried out at the health-facility level have made it possible to improve the completeness and promptness of EPI reports, which reached 70% for the 2018 period and 100% for the first quarter of 2019. A roadmap for a unified NHIS was proposed by the NHIS consultants, with the future DHIS2 in mind. This roadmap has allowed the service to review these activities for the last two quarters of 2019. The production of the 2018 NHIS statistical yearbook and support for the implementation of the NHIS operational plan have not been completed.
Major activities planned for upcoming period	- Support DMTs in monitoring immunisation data (DQS) in health facilities and districts/prefectures.

(mention significant changes / budget reallocations and associated **changes in technical assistance**)[6]	- Provide district-level entities with computer-protection and maintenance software. - Ensure twice-yearly monitoring of health facility/HD interventions. - Organise monthly meetings for monitoring immunisation data. - Produce and distribute NHIS data collection and processing tools. - Organise monthly meetings to validate NHIS data by DMTs with all health facilities in the districts of HRs1 to 3. - Produce quarterly and annual NHIS bulletins each year and the health statistics yearbook in 2019. - Continue to purchase computer kits (computer, printer, energy source, etc.) for the NHIS, in addition to actions by EU/WHO, Bêkou and PASS. - Hire IT specialists via a competitive process for the central level (two to work for the NHIS in configuring the DHIS2); two per HR for data entry, initially on a contractual basis from partners. - Configure a DHIS2 platform on the basis of this modular template (after harmonisation of the health pyramid with the current health map): support for TC. - Configure data import from MAGPI to DHIS2. - Train a pool of managers from the central level (directorates, programmes and partners) and regional level (department head, IT specialist hired) to work on the DHIS2: level 1 academy (data entry; data analysis) to be held in Bangui. - Set up this DHIS2 in the seven HRs, for data encoding by health facility + MAGPI data import. - Revitalise the existing NHIS committee in the form of a technical group working on a Routine Health Information System (RHIS), composed of M&E managers from programmes and partners. - Train committee members (directorates, programmes and partners) and regional managers (department head, IT specialist hired) in RHIS. - Recruit long-term technical assistance specialised in RHIS, to be embedded in the MoH for skills transfer. - Set up the NHIS service in suitable premises (furniture), with a permanent energy source (solar) and independent Internet access. - Revise data collection tools, in relation to variables; format tools (registers and templates) for optimal quality; test tools.

[6]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, subnational, coaching; etc.), and any timeframes/deadlines. JA teams are reminded to adopt both a retrospective approach (TA not completed or not successful in the past) and a forward-looking approach (planned vaccine introductions, campaigns, major upcoming HSS activities, etc.) when specifying TA priorities for the coming year. The TA menu of support is available as a reference guide.

	- Revise procedures for data collection, transmission and qualification (SOP). - Provide technical validation of tools and procedures via a national consensus workshop. - Provide for centralised reproduction and multiplication of tools (purchase a copy machine for the templates; framework contract with printer for registers based on precise specifications). - The NHIS service IT team will configure the DHIS2 on these new tools, after training in DHIS2 administration (level 2 academy) and with intermittent short-term support. - Purchase and set up two servers at the NHIS service. - Purchase and set up additional equipment (for supervision logistics, computers, connectivity and energy) for the HDs. - Gradually recruit contract workers according to the coverage plan for data entry in the HDs (giving priority to health technicians trained in RHIS, to strengthen staff stability, negotiate their incorporation into the civil service and institutionalise training). - Provide cascade training for teams from RDHs (4 persons) and HDs (4 people) on the NHIS by the national pool of trainers, followed by health training (concepts, use of tools, etc.) by the RDHs/HDs. - Train DMTs in basic IT, before their training in DHIS2, and train them in the handling of data extracted from DHIS2 of the RDH. - Train RDH and HD teams in the new configuration of the DHIS2.

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[7] 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.*
- *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).*

Priorities for 2019/2020 on HSS2: o Document and evaluate strategies and activities:

[7] 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.

- Faced with a significant increase in immunisation coverage and the implementation of multiple strategies, it is essential to examine what monitoring and evaluation processes are being implemented in the districts.
- Document experiences. Operational research with a research entity (the CAR has not yet identified an entity).

- Coordination and support at the district level:
  - Develop integrated action plans at the district level and finance them (State + partners).
  - Implement a common fund for partners.
  - Open a bank account for these districts.
- Prioritise health facilities:
  - Prioritise the health facilities with a large population base and a large number of children to immunise.
  - Health facility renovation: provide solar energy and water sources.
  - Update the mapping of operational EPI centres.

- Continue the programmatic and financial monitoring of the HSS within an EPI action plan: what was planned in 2018, what has or has not been done.

- Improve the quantification of vaccine needs. For example, conduct a triangulation exercise at the national and subnational level of data in the country: compare the number of vaccinated children vs. the number of vaccines to be used to understand stockouts and wastage rates.

- UNICEF fiduciary management: one of the bottlenecks for disbursement is the sending of supporting documents. A team will be set up at the MoH to remove the bottlenecks regarding verification of supporting documents, but this team will check document quality, so the bottleneck in providing documentation may persist . Gavi's support via the LMC (Expertise France) will provide support to the districts for programmatic and financial management at the decentralised level.

- Community liaisons: monitor and conduct advocacy to validate, popularise and implement the community health policy being developed and avoid the vertical use of these community liaisons.

- Conflict zones: develop innovative strategies for populations in hard-to-reach areas and support for decentralisation (AWP 2019 of the reviews prepared and reviewed in July 2019). If approved by Gavi's IRC, this strategy will be supported by additional funds in 2020 (US$ 4.5 million).

- Continue to work with the civil society platform that supports access to difficult areas for routine immunisation and during the polio campaign.

Other priority activities for 2019/2020:

- National Immunisation Forum.
- RED strategies.
- EVM implementation: EVM planned for Q4 2019. Operational Deployment Plan (ODP) developed and awaiting deployment of equipment.
- Use of SIAs to reinforce routine EPI.

5.2. Performance of vaccine support

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

The Gavi CCEOP process is being implemented, and the following steps have been taken:

- Approval of Gavi's decision letter.
- Establishment of a national committee for project management (PMT).
- Site evaluation, development and sending of a validated operational deployment plan (ODP).
- Development of the protocol for managing deviations and mapping risk.
- Launch of the call for tenders, evaluation of bidders.
- The order has been placed for 309 items of cold chain equipment. Now that the purchasing process has been started, the CAR is expecting the equipment to be received within approximately three [*Translator's note: omission here*], according to forecasts.

The CAR chose solar cold chain equipment, given that nearly all (93%) the immunisation service delivery points are not connected to electricity networks.

Important decisions to be made in the coming weeks:

- Make an implementation plan for cold chain remodelling (steps, schedule and human resource needs for each step).
- In particular, the Ministry must communicate the option chosen for the cold chain in the country (Push or Pull or hybrid). The CAR presented the Pull approach (district to regional hub), but without defining what implications this choice would have on human resources and supply (financial and logistics) resources.
- Present the needs for other cold chain equipment (vaccine carriers, long-life coolers, pads, temperature control, ice packs).
- Vaccine carriers made available by the Bill & Melinda Gates Foundation (BMGF): the country is encouraged to be proactive in its response to the BMGF.
- Have a pool of technicians in the country, and in particular qualified maintenance personnel for the four cold rooms, who will be able to carry out curative maintenance in the districts.
- The Ministry has mentioned the possibility of mobilising financing from the World Bank (CENI) and the European Union (Bêkou) to fill the gaps in the cold chain. The World Bank has confirmed the eligibility of cold rooms in the CENI project.

5.4. Financial management performance

The country received a total of US$ 6,040,817, of which US$ 4,989,090, or 82%, has been used since the project began in 2017.

After the joint appraisal in August 2018, the MoH set up a Single Steering Committee for projects and programmes to monitor the financing of activities, including HSS activities. In addition, the HSS Technical Monitoring Committee holds its meetings on a monthly basis under the leadership of the Ministerial office. These are an opportunity to review the progress of funding and the eligibility of expenditures during the month, the implementation status of field activities, any adjustments needed or bottlenecks encountered, and proposed solutions.

The reopening of some banking facilities in HR 2 has improved fund transfer at the peripheral level. Nevertheless, difficulties persist in HR 3. The transfer of cash funds from the central level to the districts entails risks of loss and traceability difficulties.

The funds were made available to the MoH in accordance with the terms of the tripartite agreement between the MoH, UNICEF and Gavi:

- After the Gavi ICC endorses the HSS action plan and programme budget, the funds are disbursed via UNICEF.
- Financial management is based on internal procedures of UNICEF, which is responsible for the funds.
- Requests are prepared by each of the three directorates and forwarded to UNICEF.
- After a request is analysed and approved, UNICEF proceeds with payment.
- UNICEF applies its quality assurance procedures to ensure that the financial and programme activities are carried out effectively.

- These quality assurance factors focus on the following three points:
  1. Five programmatic visits conducted jointly by the UNICEF programme managers and the implementation partner, to ensure the quality and effectiveness of interventions. This activity is conducted during implementation of the intervention.
  2. A spot check was carried out by UNICEF's quality assurance team to evaluate the quality and validity of financial and accounting documents related to the intervention.
  3. In May 2019, an internal audit was conducted by UNICEF of the EPI programme. The use of HSS funds by UNICEF was one of the issues addressed by the auditors mandated by UNICEF headquarters. The final report is expected by the end of July 2019.

As the financial absorption is not complete, 17% of the grant has not been used to date. Furthermore, the amendment to the grant agreement provides for payment in one instalment of US$ 2,959,183; this amount cannot be absorbed by the end of the initial project period on 31 December 2019. The MoH plans to send a request to the Gavi Executive Secretariat to extend the implementation period of HSS2 to 31 December 2020.

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

N/A

5.6. Technical Assistance (TA) (progress on ongoing TCA plan)

Within the framework of Technical Assistance, the CAR has received significant support in various forms. This support includes:

- Two residential Technical Assistants at the DREP and DPI levels;
- International TA for remodelling the vaccine supply chain;
- Recruitment of DII staff in charge of data improvement;
- Recruiting of two national DII consultants;
- International TA to coordinate the training of MLM trainers;
- Vaccine and cold chain supply management;
- Health system strengthening;
- Implementation of programme and immunisation coverage equity;
- Demand promotion and community participation;
- Organisation of the follow-up campaign against measles;
- Implementation of the urban immunisation strategy in the city of Bangui;
- Renovation/construction of health facilities.

This assistance has made it possible to achieve the following results:

- The CCEOP process is underway, essential steps have been completed and 309 pieces of solar cold chain equipment have been ordered. The SMT report is regularly shared with partners.
- As part of improving vaccine equity, the RED strategy has been implemented in the 10 target districts of the HSS2 project.
- The urban immunisation strategy document for the city of Bangui has been developed and is being implemented.
- Six health facilities, a district office and the three directorates at the central level are being renovated. The work is being monitored.

The postponement of the initial date of the measles monitoring campaign has resulted in delays in recruiting TA to support the organisation of the campaign.

6. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

Prioritised actions from previous Joint Appraisal	Current status
1. Catching up children aged 12-23 months, the target of the EPI.	Management tools revised and being replicated.
2. Implementation of the urban EPI strategy	Additional staff recruited and trained, creation of new EPI centres in private care facilities, purchase of four supervision vehicles for the region's three HDs, purchase of schedules for catching up with those lost to follow-up.
3. Development of innovative strategies for populations in hard-to-reach areas.	The strategies are included in the request for additional funding for 2020.
4. Guidance for decentralisation (financial management, managerial capacities and leadership, technical retraining).	Gavi's LMC support (Expertise France).
5. Strengthening of the NHIS, with the introduction of the DHIS2 (roadmap) and surveillance (sentinel site).	The actions describing the strengthening of the NHIS/DHIS2 are defined in the roadmap.
6. Implementing the EVM improvement plan, taking into account the CCEOP.	Validation of recommendations on supply-chain modelling: making four regional depots operational (HRs 2, 3, 4 and 6), strengthening the cold chain of district warehouses.
7. Support for the operationalisation/strengthening of the HDs/HRs.	Appointment of chief district physicians. DMT/RMT orientation sessions conducted. Health district AWPs available; supportive supervision of the 19 HDs carried out by the central level.
8. Reassessment of the Gavi intervention zones.	Initially, Gavi funding support concerned the 10 HDs in HRs 1, 2 and 3. After the new division, these 3 HRs now have 19 HDs. The 3 HDs in HR 7 were included in the urban strategy. With the additional funds, 12 other HDs will be included in HRs 4 and 6.
9. Updating the mapping of operational EPI centres.	Ongoing.
10. Determining a mechanism for giving incentives to EPI actors at the national level.	Ongoing.
11. Conducting supervision at all levels of the system.	Supervision by the central level of the 19 HDs in HR 1, HR 2 and HR 3.
12. Extension of immunisation services coverage.	Integration of immunisation services into certain private entities; implementation of outreach strategies; immunisation of special populations (nomads, fishermen, pygmies, mining population, IDPs/refugees, etc.).
Additional significant IRC / HLRP recommendations (if applicable)	**Current status**
Granting of additional funds of 50% of the initial grant for the CAR.	Proposal written, endorsed by the ICC, and sent to Gavi in June 2019.

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).

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

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

Changes related to Gavi's support:

- The CAR is in the process of finalising its GPF.
- In 2020, the country will submit a request for a new HSS and vaccines (PSR) (IRC round of June 2020). This is because the HSS and additional funds will end in 2020.
- The rotavirus vaccine must be introduced in 2020.

This table draws from the previous JA sections, summarising key findings and agreed actions, as well as indicating required resources and support, such as associated needs for technical assistance[8].

Key finding / Action 1	**Strengthening of the NHIS via the introduction of DHIS2 at regional/district level and implementation of the Data Improvement Plan (DIP) at all levels**
Current response	Given the great number of data collection platforms and the fragmentation of the NHIS, the MoH has opted for unity in the NHIS, within an efficient and digitised framework. As such, a roadmap for revitalising the NHIS with the gradual introduction of DHIS2 is available. Given the lack of evidence on data quality, the MoH is moving towards a DIP implementation by which the DVDMT is implemented at the district level and the DQR and DQS are performed on a regular basis.
Agreed country actions	• Provision of an international Technical Assistant to support the implementation of the DIP and data quality monitoring. • Provision of an international Technical Assistant: one on a long-term basis specialised in RHIS and one on a short-term intermittent basis in the introduction and use of the DHIS2.
Expected outputs / results	• The NHIS revitalisation roadmap is implemented and the DHIS2 is introduced and mastered for data digitisation. • Data quality is improved.
Associated timeline	• August 2019 to July 2020
Required resources	• 1 international Technical Assistant for 12 months on data quality. • 2 NHIS/DHIS2 international Technical Assistants for 12 months. • Computer equipment (computer, connectivity, Internet kit).
Key finding / Action 2	**Health System Strengthening (HSS)**
Current response	New health map based on the district health system, appointment and briefing of DMTs and RMTs on priority MoH programmes; however, DMT and RMT capacity in the management of HDs is low. Health policy is currently being prepared.
Agreed country actions	• Training of DMT/RMT + central level in district health system management. • Training of DMT/RMT + central level in EPI management (MLM and EVM courses). • Budget management at central and decentralised level, Leadership (EPI Lamp). • Training of health workers on vaccination practices including EVM.

[8] 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.

	• Strengthening supportive supervision and coaching.
Expected outputs / results	• Capacities of DMTs/RMTs and health workers strengthened.
Associated timeline	• September 2019 to December 2020.
Required resources	• International Technical Assistant for six months. • Financial resources.
Key finding / Action 3	**Strengthening the implementation of the Bangui urban strategy from a research-action perspective.**
Current response	Bangui urban strategy project currently being implemented, recruitment of additional human resources, purchase of rolling stock and of IT and office equipment for the region and HDs.
Agreed country actions	• Catching up targets aged 12 to 23 months who are un- or incompletely immunised. • Strengthening implementation monitoring. • Documentation of lessons learned.
Expected outputs / results	• Immunisation coverage and vaccine equity improved in the city of Bangui.
Associated timeline	• September 2019 to December 2020.
Required resources	• 2 national Technical Assistant and 1 international intermittent Technical Assistant for evaluation (operational research for the urban strategy). • Financial resources.
Key finding / Action 4	**Resumption of immunisation in hard-to-reach areas**
Current response	Project drawn up and submitted to Gavi; awaiting approval.
Agreed country actions	• Use of ICTs for target identification in hard-to-reach zones. • Catching up targets aged 12 to 23 months who are un- or incompletely immunised. • Organising IIAs. • Establishing partnerships with communities and armed groups. • Strengthening the supply chain.
Expected outputs / results	• Immunisation coverage and vaccine equity improved in hard-to-reach zones
Associated timeline	• September 2019 to December 2020.
Required resources	• WHO and UNICEF staff and 1 WHO and 1 UNICEF consultant for 3 months. • Consultant for support in new submission (Gavi HSS3). • Support to the civil society platform. • Financial resources. • Cold chain equipment.
Key finding / Action 5	**Introduction of new vaccine (rotavirus) and strengthening surveillance of vaccine-preventable diseases**
Current response	• Updated introduction plan. • Strengthened sentinel surveillance of diarrhoea at the paediatric complex and at national reference laboratories. • Rotavirus vaccine has been chosen (Rotarix). • Surveillance of vaccine-preventable diseases.
Agreed country actions	• Introduce rotavirus vaccine. • Strengthen rotavirus surveillance.

Expected outputs / results	• Effective introduction of the rotavirus vaccine into routine EPI. • Vaccine-preventable disease surveillance data are available and of good quality.
Associated timeline	• January to June 2020.
Required resources	• 2 international Technical Assistants (1 for laboratories). • 1 national Technical Assistant. • Financial resources. • Material resources.
Key finding / Action 6	**Strengthening of the vaccine supply chain**
Current response	Submission of the CCEOP approved by Gavi, installation sites evaluated, equipment deployment plan developed, supplier selected; country awaiting equipment. Endorsement of recommendations on supply-chain modelling.
Agreed country actions	• Implementation of the equipment deployment plan. • Four regional warehouses (HRs 2, 3, 4 and 6) made operational and warehouse cold chains strengthened at the district level. • Purchase of extra equipment from the additional HSS fund. • Mapping of the central-level cold rooms. • Capacity building for human resources, including training of the head of the logistics department in immunisation logistics (LOGIVAC) • Work with the BMGF to benefit from the availability of vaccine carriers (Indigo).
Expected outputs / results	• Availability and better management of EPI inputs.
Associated timeline	• September 2019 to December 2020.
Required resources	• 1 international Technical Assistant for the implementation plan for cold chain remodelling and cold room mapping. • LOGIVAC classroom training for supply-chain managers and maintenance staff in the country. • Financial resources.

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

The 2019 joint appraisal process began on 13 June 2019, at a meeting organised by the Directorate of Research, Studies and Planning and involving the main stakeholders (DPI, DREP, DSSP, WHO, UNICEF and AEDES) to discuss the working methodology and the share the form to be filled in by the responsible parties. After setting up a technical group and subgroups per central technical directorate, the appraisal process continued with the following:

- Briefing of the MoH on the ToR;
- Work on filling out the form by the HSS, DSSP and EPI subgroups;
- Technical meetings to monitor the process, with the three directorates involved;
- Pooling the work of the three technical directorates;
- Sending of the information letters to the authorities;
- Preparation and organisation of the joint appraisal workshop.

The joint appraisal report was reviewed during a two-day workshop, with the participation of the prime minster's office, national experts from ministerial departments (Health, Finance, Planning, Faculty of Health Sciences-FACSS), civil society and NGOs. A mission of external evaluators also participated in the workshop, consisting of WHO and UNICEF experts from the IST, AFRO and regional offices and headquarters.

Four working groups were created to examine the different parts of the report. The working group reports were presented and endorsed in plenary.

The various amendments were compiled by the editing team and the final report was submitted for ICC approval before being officially sent to Gavi's IRC.

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
End of year stock level report (due 31 March) *	X		
Grant Performance Framework (GPF) * reporting against all due indicators	X		
Financial Reports *			
Periodic financial reports	X		
Annual financial statement	X		
Annual financial audit report		X	
Campaign reports *			
Supplementary Immunisation Activity technical report		X	
Campaign coverage survey report		X	
Immunisation financing and expenditure information	X		
Data quality and survey reporting			
Annual data quality desk review	X		
Data improvement plan (DIP)	X		
Progress report on data improvement plan implementation		X	
In-depth data assessment (conducted in the last five years)	X		
Nationally representative coverage survey (conducted in the last five years)		X	
Annual progress update on the Effective Vaccine Management (EVM) improvement plan		X	
CCEOP: updated CCE inventory		X	
Post Introduction Evaluation (PIE) (specify vaccines):		X	
Measles & rubella situation analysis and 5 year plan		X	
Operational plan for the immunisation programme	X		
HSS end of grant evaluation report			X
HPV demonstration programme evaluations			X
Coverage Survey		X	
Costing analysis		X	
Adolescent Health Assessment report		X	
Reporting by partners on TCA			

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.
