



## Joint Appraisal Report 2017

<b>Country</b>	Honduras
<b>Full Joint Appraisal or Joint Appraisal update</b>	January to December 2016
<b>Date and location of Joint Appraisal meeting</b>	Tegucigalpa, 21 to 24 August 2017
<b>Participants / affiliation<sup>1</sup></b>	List attached
<b>Reporting period</b>	29 September 2017
<b>Fiscal period<sup>2</sup></b>	January to December 2016
<b>Comprehensive Multi Year Plan (cMYP) duration</b>	2016 to 2020

### 1. SUMMARY OF RENEWAL AND EXTENSION REQUESTS

#### 1.1. New and Underused Vaccines Support (NVS) renewal request(s)

Type of support (routine or campaign)	Vaccine	End year of support	Year of requested support	Target (Population to be vaccinated)	Indicative amount to be paid by country	Indicative amount to be paid by Gavi
NVS - routine	IPV	2018	2018	195,809	N/A	US\$ 251,500

#### 1.2. New and Underused Vaccines Support (NVS) extension request(s)

Type of Support	Vaccine	Start year	End year
N/A			

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

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

## 2. CHANGES IN COUNTRY CONTEXT SINCE LAST JOINT APPRAISAL

With regards to the country context presented in the 2015 report, there have been no changes directly affecting the performance of the Expanded Programme on Immunization (EPI). However, it may be underscored that the Framework Act on the Social Protection System defining a single universal health insurance model for the country was approved in May 2015. This Act establishes the elements considered essential to the performance of the National Health System (SNS), such as the set of guaranteed health services and their features (the CGPSS) and the definition of contributory and subsidised support. The Act stipulated the preparation of supplementary laws, among them the National Health System Act. Application of the new legal framework on health will involve significant changes in health service delivery, including immunisation services.

## 3. PERFORMANCE OF THE IMMUNISATION SYSTEM IN THE REPORTING PERIOD

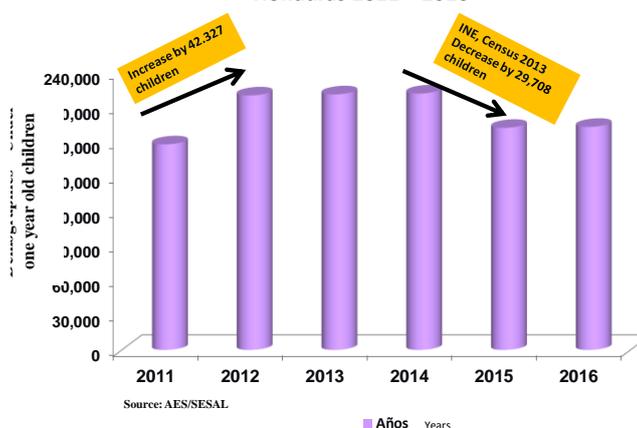
### 3.1. Coverage and equity of immunisation

The situational analysis of the EPI by areas is given below:

#### Immunisation coverage

- In 2007, the National Statistics Institute (*Instituto Nacional de Estadística*, INE), reviewed and adjusted the population count for children under 1 year of age and 1 to 4 years. However, the coverage rates achieved for all the vaccines have exceeded 100% since 2010, denoting a problem of demographic underestimation in the adjustment. Accordingly, the Statistics Department of the Secretariat of Health (*Secretaría de Salud*, SESAL), in consultation with the INE, made a recommendation to discontinue use of the population estimates for infants under one based on the 2007 revision, using instead the official projections from 2012 until the official data from the new Population and Housing Census of 2013 became available.
- In September 2015, the INE published the projections of the 2013 Census, estimating the population under 1 year of age for 2015 at 192,010 children and significantly reducing the 2001 Census projection by 29,708 children (Figure 1).

Chart 1. Official estimate of population under one year of age  
Honduras 2011 – 2016

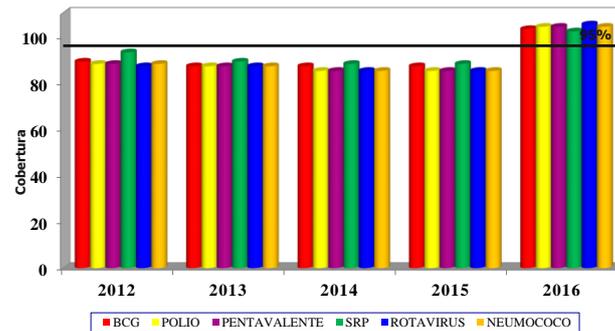


- On analysing the denominator for 1-year-old children by Health Region (HR) for 2014 (2001 Census) and 2015 (2013 Census), it is observed that three of the 20 HRs (Atlántida, Cortés and the Central District) show estimates without significant variations.

- In relation to the basic immunisation schedule, coverage rates achieved during the 2012-2014 period were lower than 90% for all the vaccines (BCG, polio, rotavirus, DPT-HepB-Hib, pneumococcal and MMR) administered to children under 2 years of age. In the 2015-2016 period, coverage rates above 95% were achieved for all the vaccines, and in 2016 exceeded 100% (Figure 2).

**Figure 2. Immunisation coverage in children under two years of age, Honduras 2012-2016**

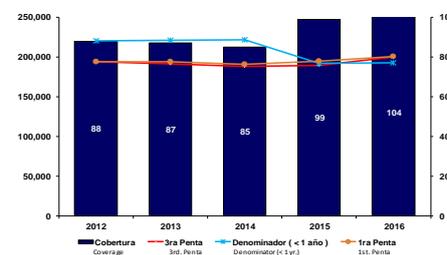
**Gráfico 2. Cobertura de vacunas en menores de dos años, Honduras 2012-2016**



Fuente: SIVAC/SESAL

- Taking the combined Pentavalent vaccine (DPT-HepB-Hib) as the tracking indicator for immunisation coverage in children under one, coverage rates below 90% were reported for the 2012-2014 period. For 2015 coverage was 99% and for 2016 over 100% (104%). This was associated with underestimation of the official INE denominator for children under one. Analysis of the numerator shows an increase by 10,485 doses with regards to 2015, denoting improvement in the enlistment of children under one, with the same tendency maintained for the other vaccines administered to children in this age group.
- Figure 3 shows overestimation of the denominator for the 2012-2014 period and underestimation starting from 2015, along with the fact that the numerator gap between first and third Pentavalent doses is not significant.

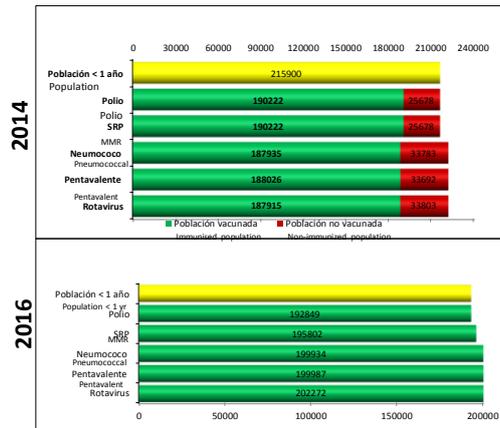
**Figure 3. Pentavalent immunisation coverage in children under one, first and third doses, and comparison with denominator, Honduras 2012-2016**



Source: SIVAC/SESAL

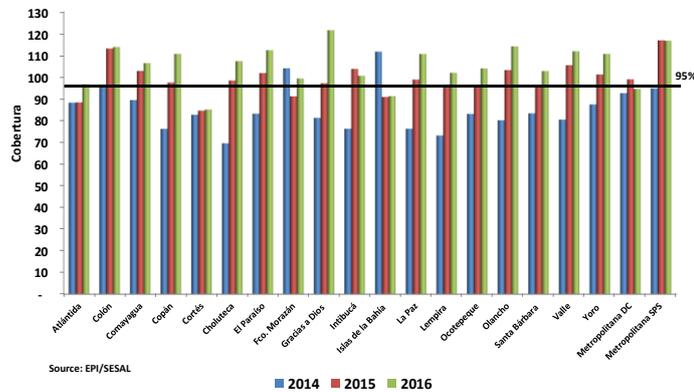
- The gap in children under one who were not immunised with Pentavalent was reduced to zero by 2016, in contrast with the 33,692 given for 2014 (Figure 4).

Figure 4. Number of children under one immunised as against the target set, Honduras 2014-2016

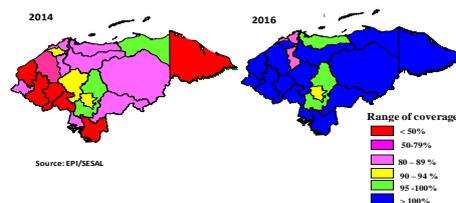


- A situational analysis of basic schedule immunisation coverage in children under two by HR shows that this is not homogeneous. Pentavalent immunisation coverage between 2014 and 2016 shows variability: 17/20 HRs (85%) did not achieve coverage rates  $\geq 95\%$  and were at risk in 2014, related to the overestimation of the denominator, except for the Islas de la Bahía, Colón and Francisco Morazán HRs. A total of 15/20 HRs achieved coverage rates  $\geq 95\%$  in 2015 and 17/20 HRs in 2016. The regions at risk during this period in descending order were Cortés, Islas de la Bahía and the Central District (Figure 5 and Map 1).

Figure 5. Coverage with Pentavalent vaccine in one-year-olds by Health Regions, Honduras 2014-2016



Map 1. Coverage with Pentavalent vaccine in children under one, by Health Regions, Honduras 2014 y 2016



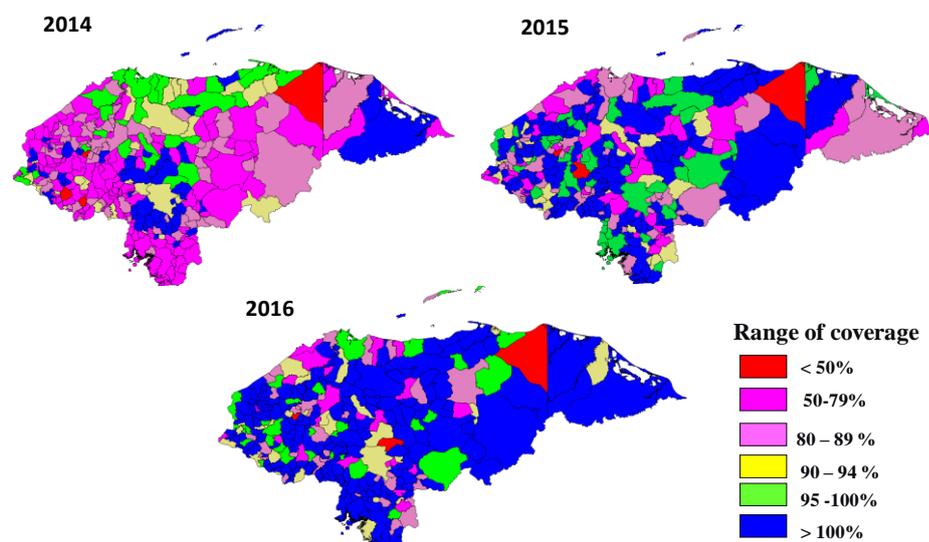
- With regards to immunisation coverage in children under two by municipality in the 2012-2014 period, the number of municipalities at risk due to coverage below 95% at the central level increased for all the vaccines, related to the problem of the overestimated denominator. In the

2015-2016 period, a decrease in the number of municipalities at risk for all the vaccines is observed, related to interventions such as immunisation drives in municipalities at risk funded by the Gavi HSS project and the fieldwork of the family health teams (*Equipos de Salud Familiar*, or ESFAM).

In terms of the Pentavalent vaccine, 26% of the municipalities achieved coverage rates  $\geq 95\%$  in 2015, and 70% in 2016 (Map 2).

- During the 2015-2016 period, the HRs at greatest risk with over 80% of their municipalities recording Pentavalent vaccine coverage below 80% were: Copán, Cortés, Choluteca, Gracias a Dios, Intibucá, Lempira, Ocotepeque, Olancho, Santa Bárbara and Valle.
- The calculation of the estimated population of infants under one by municipality continues to be a problem since analysis of the Pentavalent tracking indicator for 2016 shows 62% (185) of the municipalities with coverage above 100% of the target population, and a similar situation is observed with the other vaccines with the exception of MMR, for which it was slightly lower (165 municipalities).

**Map 2. Coverage with Pentavalent vaccine in children under one, by municipalities, Honduras 2014-2016**



- For 2016, in 28% (83/298) of the municipalities, health services, including immunisation, were delivered through decentralised administration (managers) such as: municipalities, federations of municipalities, community foundations and some NGOs, among other agents, with an increase of 2% in comparison with 2015. In these municipalities, 34% (28/83) posted coverage rates below 95% for Pentavalent. Given the modality of funding, 100% of the municipalities with managers would have been expected to achieve 95% coverage rates, a situation that was not observed. Hence, an analysis is required to differentiate the determining factors in order to define needed interventions. Taking into account the fact that the decentralised administration covers the poorest and most neglected municipalities, it would be interesting to ascertain the degree of immunisation coverage progress without the managers.

It should be mentioned that immunisation activities continue to be scheduled and implemented on the basis of the municipal structure, albeit not revolving around the integrated networks currently delimited and organised (69).

- Analysis for the period with regards to the number of children living in municipalities at risk with coverage < 95% (by using Pentavalent vaccine coverage as a tracer) change in coverage shows that the situation improved from being 77% in 2012 to 38% in 2016.

**Equity**

- With regards to equity in immunisation services, analysis of the Pentavalent coverage data for the population aged 12 to 23 months in the Health and Demography Surveys (ENDESA) for 2005-2006 and 2011-2012 shows that access to immunisation services is universal, regardless of sex, area of residence, mother's education and wealth quintile, and that coverage improved in the last survey (Table 1).

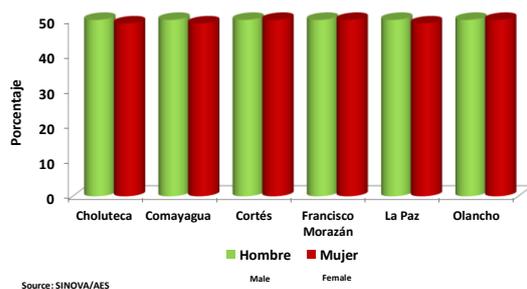
**Table 1. Immunisation coverage with Pentavalent vaccine in children under one by socio-economic characteristics, Honduras**

Characteristic	ENDESA	
	2005 - 2006	2011- 2012
<b>Sex</b>		
Male	92,6	95,5
Female	93	95
<b>Area of Residence</b>		
Urban	91,6	93,9
Rural	93,6	96,4
<b>Department</b>		
Atlántida	94,6	93,3
Colón	92,2	97,5
Comayagua	94,5	96,2
Copán	92,6	95,6
Cortés	92,5	92,8
San Pedro Sula	90,2	95,5
Resto de Cortes	93,8	91,1
Choluteca	96,3	98
El Paraíso	91,1	94,6
Francisco Morazán	90,4	95,5
Distrito Central	88	93,4
Resto de Francisco Morazan	95,2	98,7
Gracias a Dios	0	81,4
Intibucá	97,1	97,7
Islas de la Bahía	0	89,2
La Paz	93,5	99,5
Lempira	97,4	98,9
Ocotepeque	96,4	99,1
Olancho	94,6	96,5
Santa Bárbara	88,7	96,3
Valle	95,3	97
Yoro	88,8	93,2
<b>Mother's education</b>		
None	88,6	94,4
Primary 1- 3		95
Primary 4- 6	93,2	94,6
Secondary	94,7	95,9
Higher Education	81,9	97,3
<b>Wealth quintile</b>		
Lower	-	95,8
Second	-	94,7
Intermediate	-	92,7
Fourth	-	95,7
Higher	-	98,1

Source / ENDESA

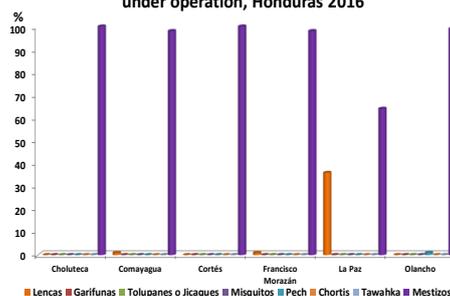
- In 2016, the data generated by the electronic nominal immunisation records called Nominal Immunisation System (*Sistema Nominal de Vacunación*, or SINOVA) for the six regions where it is implemented showed no gender differences in access to immunisation services, and generated information about immunisation access for different population groups (Figures 6 and 7).

**Figure 6. Children under five immunised with all the vaccines, by sex, in health regions, Honduras 2016**



Source: SINOVA/AES

**Figure 7. Children under five immunised with all the vaccines in selected health regions with SINOVA under operation, Honduras 2016**



Source: SINOVA/AES

**Vaccine-preventable disease (VPD) surveillance**

- Although there was a decrease in immunisation coverage rates during 2012-2014 related to the overestimation of denominators, the maintenance of immunisation coverage rates above 90% since 1991 has lowered the incidence rate of vaccine-preventable diseases (VPD), with the impact of immunisation activities summarised as follows:
- 35 years with no recorded cases of diphtheria (last case in 1981)
- 27 years with no recorded cases of poliomyelitis (last case in 1989)
- 19 years with no recorded cases of measles (last case in 1997)
- 15 years with no recorded cases of congenital rubella syndrome (last case in 2001)
- 12 years with no recorded cases of rubella (last case in 2004).
- Significant reduction in cases of neonatal tetanus, TB meningitis, meningitis due to HIB in children under five, rotavirus diarrhoea and mumps.
- Rubella and CRS certified as eradicated in 2015.
- Measles certified as eradicated in 2016. (Figures 8 and 9).

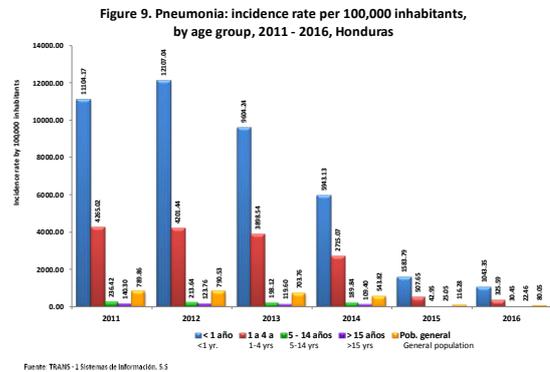
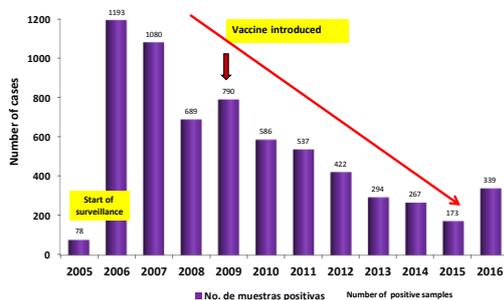


Figure 8. Confirmed cases of Rotavirus diarrhoea at hospital level per year, sentinel sites Honduras 2005 – 2016

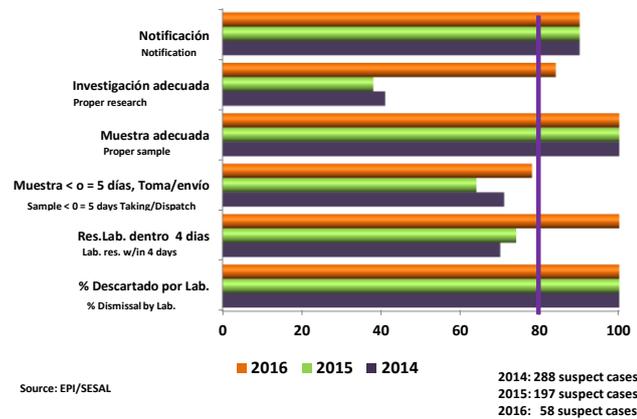


Fuente: UVS/SESAL

- Surveillance of suspected, probable and confirmed VPD cases is maintained at the central level. No outbreaks of VPD were reported in 2016.
- With regards to sustaining the eradication of measles and rubella (M/R) for the 2012-2016 period, the expected notification rate of 2 cases X 100,000 inhabitants was only attained in 2014 and 2015. One of the lowest rates (0.6 X 100,000 inhabitants) was reported in 2016. No HR has achieved the expected rate in municipalities with fewer or more than 100,000 inhabitants, raising problems in the performance of epidemiological surveillance, with silent HRs and municipalities in terms of notification.

• In terms of the fulfilment of surveillance indicators, an improvement in the indicator for proper investigation, sample taking and dispatch to the laboratory within five days was observed in 2016 with regards to the previous two years (Figure 10).

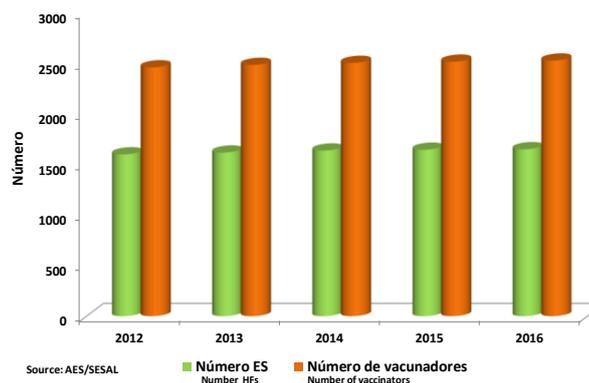
**Figure 10. Fulfilment of surveillance indicators for Measles/Rubella, Honduras, 2015-2016**



**Health system**

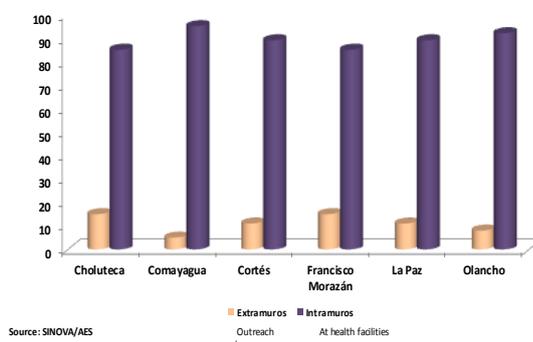
- The national health system offers immunisation services in the public subsector – composed of the SESAL and the Honduran Institute of Social Security (*Instituto Hondureño de Seguridad Social, IHSS*) – and the private subsector. The public subsector offers immunisation services to over 95% of the target population and private subsector provision is estimated at less than 1% in the main cities. In the rural areas, provision is by the public subsector.
- The public subsector service network, which offers the SESAL and IHSS immunisation services, increased from 1,598 health facilities (HFs) in 2012 to 1,649 in 2016; however, the number of personnel carrying out immunisation at central and HR levels has not changed and averages one vaccinator per rural health facility and two in some urban facilities for every HR (Figure 11).

**Figure 11. Health facilities offering immunisation services and human resources for immunisation, Honduras 2012-2016**



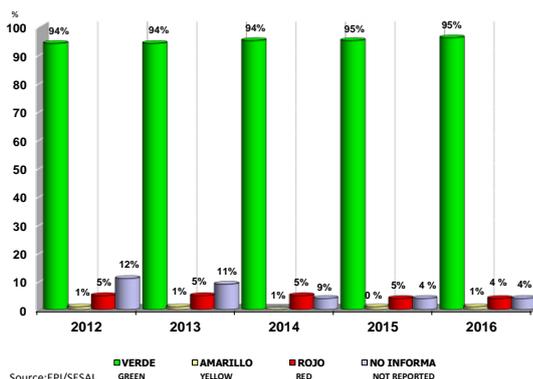
- This situation has weakened outreach immunisation activities in the sustained horizontal programme. SINOVA data from six HRs show that in 2016, at the typical immunisation site, 90% of children under five were immunised at a health facility and 10% in outreach (Figure 12).

**Figure 12. Children under five immunised by site in selected Health Regions with SINOVA operative, Honduras 2016**



- The cold chain is a fundamental component of immunisation service provision. During the 2012-2016 period, the cold chain at central level was kept 95% operational or in “green” status, thanks to the electrification of health facilities, the substitution of cold chain equipment, the maintenance and repair of equipment and improvement of communication channels (Figure 13).

**Figure 13. National cold chain operational status, Honduras 2012 al 2016**



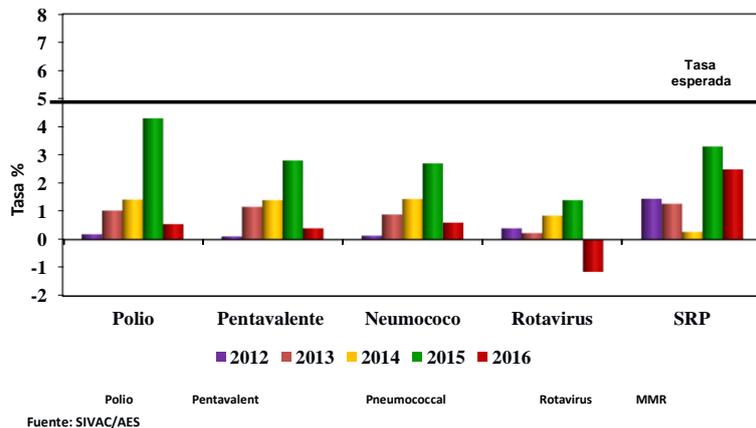
- Analysis of the cold chain status by HR in 2016 showed that health facilities with “green” cold chain equipment increased by 1% to 96% compared with 2015 while the percentage of health facilities categorised as “yellow” decreased to 0%. “Red” status continued for 4%, while the number of HFs not reporting cold chain status continued to account for 3%.
- In terms of equipment, approximately 99% of the absorption refrigerators operating with kerosene or LPG have been replaced by solar refrigerators installed in remote HFs. This equipment is efficient and reliable, requires little maintenance and is easy to operate since it does not need fuel to work. Horizontal electric (MK-204 and MK-304 Ice-Lined) refrigerators were also deployed to replace aging equipment and expand storage capacity in the different HFs and municipal vaccine warehouses, using national and Gavi-HSS project funds (see section 4.1, number 3). The policy is to replace existing domestic refrigerators with equipment pre-qualified by the WHO.
- Wastage rates have been kept within the expected values for vaccines in single-dose and multiple-dose presentations. In 2016, the wastage rate for IPV-5 doses was 14%, registering a decrease compared with the year of introduction.

**Demand**

- One of the indicators for measuring EPI efficiency is the dropout rate (desertion) for polio, DPT-HepB-Hib, rotavirus, pneumococcal and MMR vaccines. This rate was kept below 5% throughout the period, showing an improvement in the monitoring of immunisation subjects except for rotavirus in 2016, the rate for which was negative (-1.14%) due to the demand for second doses

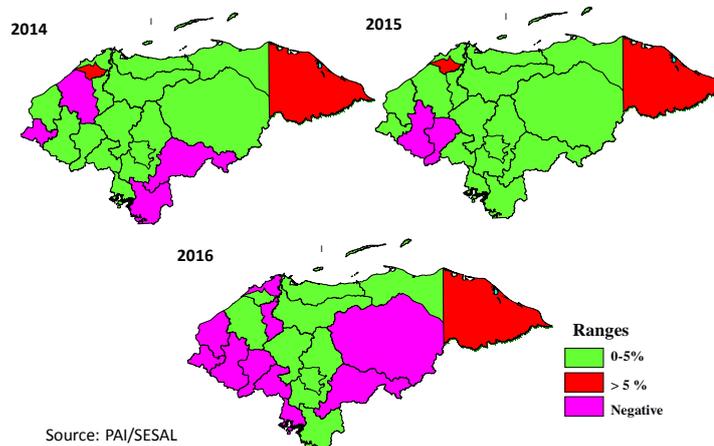
in public immunisation facilities for children who had started their schedule in the private sector. Notwithstanding this, the regions with the highest dropout rates (Copán, Cortés and Valle) have priority for interventions in 2017 (Figure 14).

**Figure 14. Drop-out rate for EPI vaccines in children under two, Honduras 2012- 2016**



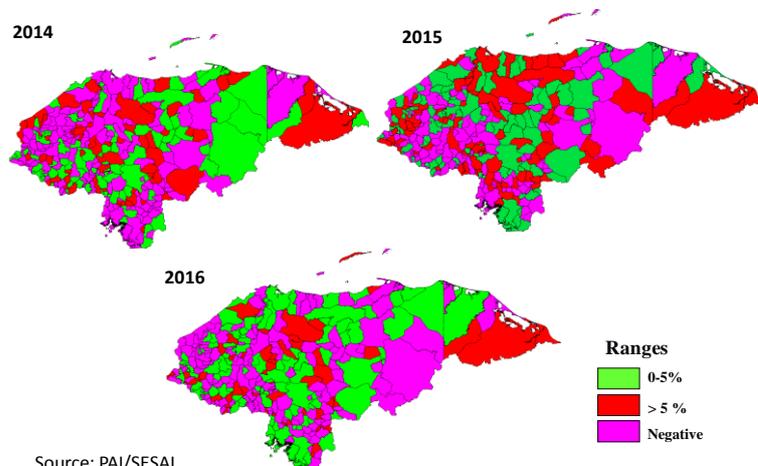
- By HR, Gracias a Dios had a dropout rate above 5% in 2016. Copán, Cortés, Ocotepeque, Lempira, Intibucá, La Paz, Valle, El Paraíso and Olancho had negative rates for Pentavalente (Map 3).

**Map 3. Pentavalent vaccine drop-out rate by Health Region, Honduras 2014- 2016**



- Of the 298 municipalities, a total of 43 exceeded the 5% dropout rate for Pentavalent in 2016, 13 of which are at greater risk due to rates of over 10%. These are concentrated in the HRs of: Choluteca (Duyure), El Paraíso (Guinope ay Potrerillos), Francisco Morazán (La Libertad), Gracias a Dios (Puerto Lempira, Wampusirpe), La Paz (Oporoto), Lempira (Guarita and San Juan Guarita), Ocotepeque (Concepción, Santa Fé and Lucerna) and Santa Bárbara (Gualala). They are evidence of lost immunisation opportunities (Map 4).

**Map 4. Pentavalent vaccine drop-out rate by municipality, Honduras 2014- 2016**



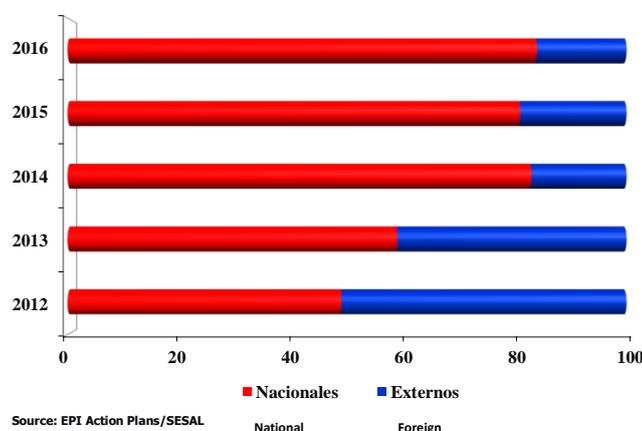
Source: PAI/SESAL

- The causes identified include the following: dropout rates of over 5% are linked to service delivery factors such as subject monitoring as well as spontaneous demand from the public. The negative dropout rates are linked to high internal migration among the population, much of it in coffee plantation HRs (Copán, Santa Bárbara, La Paz, El Paraíso) and in Olancho, where there is dense migration from other departments.

**Funding**

- Financing of the EPI is based on a multi-year plan prepared every five years. The current plan is for the 2016-2020 period. Annual action plans are discussed and negotiated with the members of the Inter-agency Health Cooperation Committee (IHCC), who have been supporting the programme for more than three decades, and new cooperation partners.
- During 2012-2016, an increase was seen in the national contribution, which has exceeded 80% since 2014, with the country already graduated from Gavi new vaccine introduction support. However, Honduras received support in 2016 in the form of 50% of the funding for the Human papillomavirus (HPV) vaccine for the first introduction year (Figure 15).

**Figure 15. National and foreign EPI funding, Honduras 2012-2016**



Source: EPI Action Plans/SESAL

- The SESAL has a firm commitment to free universal vaccine access, thanks to which it finances 100% of the traditional vaccines in the routine schedule as well as new vaccines introduced with Gavi support, except for Inactivated Poliovirus (IPV), which is a Gavi donation.

- In 2016, 84% of the budget required for operation of the EPI was financed from national funds, corresponding to the purchase of vaccines, syringes and safety boxes, travel expenses for the conduct of national immunisation, deparasitation day and the measles and rubella follow-up immunisation campaign, the purchase of cold chain equipment and accessories, spare parts and fuel for cold chain operation, and operating expenses for the partial operation of the central EPI. It is important to emphasise that the budget allocated to vaccines in relation to 2015 was increased for the purchase of HPV vaccine. Sixteen per cent was financed with external funds, with Gavi as the principal donor followed by PAHO/WHO, UNICEF and others, including IJSUD and NGO support.
- EPI budget implementation at the central level was above 95%.
- Analysis of the different areas reveals that in order to maintain its achievements and sustainability, the EPI needs to overcome various gaps and challenges related to: defining its organisational and budget structure in the context of health sector reform and the new Social Protection Act, the issue of denominators, service delivery and funding, among other matters.

See Annex 1, additional graphs.

### 3.2. Key drivers of low coverage / equity

Based on the analysis conducted during national and regional EPI evaluations and the supervision process, the following were identified as the principal factors behind immunisation coverage rates < 95%:

- **Underestimation of the population denominator for children under 1 year of age and aged 1 to 4 at the central level** and in the majority of the HRs, except for Atlántida, Cortés and the Central District. The number of different vaccine doses administered to the population under 1 year of age was higher than the official population estimates for this age group. The official national under-one population was 192,849 for 2016 while 200,799 first doses of Pentavalent were administered, with 7,950 more children than the 2013 Census had projected. A similar phenomenon was observed for all the vaccines administered to the same age group (polio, rotavirus and pneumococcal).  
Analysis of immunisation coverage rates by municipality showed that, in 2016, 62% (185) of the municipalities exceeded 100% coverage for Pentavalent due to problems in the underestimation of the population denominator given in the official INE estimates.
- **High dropout rates:** In the HR of Gracias a Dios and in the majority of municipalities, evidence of a lack of immunisation subject monitoring for first or second doses was found. This is one of the most geographically remote regions beset by problems in management, fuel funding and an additional language barrier.
- **Negative dropout rates:** These provide evidence of high internal migration among the population, particularly in coffee plantation HRs (Copán, Santa Bárbara, La Paz, El Paraíso) and in Olancho, where there is dense migration from other departments.
- **Scarcity of human resources for immunisation at the central level:** Analysis of the numbers of HFs offering immunisation services and human resources for immunisation in the 2012-2016 period shows that there has been a non-significant increase in the number of health facilities while the quantity of human resources remained the same. In rural HFs, a single employee provides care and delivers immunisation services in and out of the centre whereas in some urban HFs there is an average of two immunisation personnel. This has reduced the provision of systematic immunisation outreach in geographically remote areas, for both economic and cultural reasons. Over the last few years the immunisation schedule has expanded with the provision of new vaccines, but service delivery has not been strengthened with more human resources for immunisation at the local level, where the tendency of having a single employee per HF persists. In the context of the new health model, the family health teams represent an alternative to this problem. However, implementation is slow. There are currently 520 operating in 19 HRs, which

have contributed to improving immunisation coverage, except in the region of Gracias a Dios, where the strategy is not being implemented due to the lack of human resources.

- **Restricted service delivery timetables:** Immunisation services that are offered on an eight-hour schedule restrict the access of heads of families working to the same timetable.
- **Limited logistics** for mobilising immunisation personnel due to limited financing from national funds for vehicles, fuel and maintenance, among other things.
- **Areas of difficult access due to security problems** caused by the proliferation of *maras* and gangs in most of the departments and municipalities in the country, which has contributed to the decrease in the sustained horizontal programme immunisation outreach activities. It has limited the access of health personnel delivering the services and placed them at personal risk, along with the population unable to access services out of fear of being attacked.
- **Weak process of continuous education for permanent staff and new recruits.**
- **Poor supervision** of the local level by the municipal level, linked to different factors: the lack of clarity regarding the role of some authorities in the new organisational development framework, and the lack of human resources and transport, among other concerns.
- **Limited effective demand for immunisation services by the population:** This situation makes it mandatory to maintain house-to-house immunisation outreach in certain (metropolitan) HRs. Despite implementation of the national health promotion plan with Gavi HSS funding support, progress has been slow due to weak national and regional structures for follow-up and monitoring, lack of funds and the absence of population empowerment on the issue, among other concerns.
- Lack of surveillance regarding the fulfilment of decentralised management agreements, particularly regarding the cold chain and the information system.
- In the context of implementing organisational development at the regional level, the employee carrying out the functions of “Regional EPI Coordinator” was relocated in 2013 and given new functions, most of them in the Integrated Health Service Network (RISS) Department. Other employees nevertheless remain connected to the EPI. Capacity building and coordination with other regional offices has still not been achieved. In accordance with their new role, these offices are obliged to assume functions related to the EPI in planning, scheduling, the cold chain, the supply chain, training, monitoring, supervision and evaluation, among other responsibilities. At the same time, HRs such as Cortés, Santa Bárbara and Gracias a Dios have made frequent changes in said resources. In other HRs such as Ocotepeque and Gracias a Dios, the employee concerned has retired, weakening the sustainability of procedures.
- The lack of an accountability procedure with regards to management commitments in terms of outcomes.
- Lack of systematic immunisation data quality control by the regional Department of Planning and Data Management Area at the municipal level. The majority of the regions conduct checking activities on the information included in supervision; however, this process needs to be institutionalised periodically at the central level under the guidance of the Health Statistics Area (*Área Estadística de la Salud, AES*).

**Cold chain:**

- Limited funds, transport and fuel to conduct cold chain maintenance and supervision activities in the HRs despite funding with Gavi HSS funds having been planned in 2016; the funds were allocated late due to administrative delays.
- Lack of a person in charge of the cold chain in the Islas de la Bahía, Santa Bárbara and Central Metropolitan District HRs to provide timely equipment maintenance and repairs.
- Problems in the operation of the DULAS SOLAR brand solar refrigerators (deliveries from 2012), which are still operating and are being replaced by new equipment. The SUNFROST refrigerators (which have been in use for over 10 years) suffer leaks in the cooling system, mainly in the Gracias a Dios, Choluteca, Yoro and Colón HRs.
- Theft of solar panels and other solar refrigeration system components.

**Supply chain:**

- In the context of organisational development, the budget implementation unit has not been defined since 2014. This unit should ensure national funding for the operational functions of the National Vaccines Warehouse and the supply chain (vaccine, syringe, safety box and supply distribution from the central level to regional vaccine warehouses), which, according to the Regulations on Organisation and Functions of the SESAL central level, falls upon the Drugs and Supplies Logistics Unit. Even so, with the support of additional funds from the Gavi HSS project, partial operation has been achieved.

- Difficulties in sending vaccines to Gracias a Dios HR due to the limited capacity of existing airlines and the lack of sustainable funding. The region has thus obtained support from the Honduran Air Forces, without managing to guarantee timely distribution dates.
- Since the process of configuring the RISS is still under way, there are gaps in the understanding of operational guidelines and constraints at regional level, generating problems with EPI planning to organise and stock network/municipal vaccine stores.

### 3.3. Data

#### Background

The Data Management Unit (*Unidad de Gestión de la Información*, UGI) is the authority that runs the national information system, with the AES as the national authority relating to: standardisation of the health information system; the national compilation and consolidation of immunisation data through the Immunisation Information System (*Sistema de Información de Vacunación*, SIVAC); ongoing implementation of the SINOVA; and the official population estimates per HR and age group. The UGI also runs the system for controlling drug, vaccine and supply inventories (VSSM and wMSSM).

Data on the epidemiological surveillance of VPDs and Adverse Effects Following Immunisation (AEFIs) are collected and analysed at the EPI central level and at the Health Surveillance Unit (*Unidad de Vigilancia de la Salud*, UVS) regional level.

#### Key bottlenecks

- Coverage data
  - There are problems caused by the underestimates of population denominators at the central level and overestimates for infants aged under 1 year and from 1 to 4 years at the municipal level in some regions. The EPI has raised this issue with the AES, which in turn brought it to the attention of the INE through the UGI. Official communiqué No. 191-AES-2017 was received on 25 July 2017, proposing that new data would be obtained on levels of fertility and infant and child mortality with the conduct of ENDESA 2017-2018, and if these showed trends differing from those used to calculate the projections, these should be revised. AES has sent national guidelines to the HRs to enable them to make adjustments per age group in the municipal population estimates without modifying the total municipal population officially estimated by the INE, so as to correct the internal distribution of the target population.
  - With regards to numerators, reports are complete and data are timely. A majority of the HRs send in the forms (physically and electronically) with data on vaccine doses administered, during the first 10 days of the following month in keeping with a standard flow. There are problems in Gracias a Dios HR (physical and electronic dispatch) and Choluteca HR (electronic dispatch). In 2016, there was under-reporting of BCG doses administered at hospital level associated with the implementation of a new form that was not properly disseminated to the hospitals and network/municipalities by the HRs, particularly in the Central Metropolitan District and San Pedro Sula HRs, coupled with the use of obsolete forms in Valle HR.
  - As regards immunisation data quality, PAHO/WHO conducted a data quality assessment in 2015, resulting in the formulation of the improvement plan, implementation of which began in 2016 and is currently in progress. This has made limited headway due to administrative problems in the timely availability of funds. Immunisation data quality control was incorporated into the EPI supervision guide, which is used in the central level process of supervising HRs and in the HR process of supervising the local levels.
  - There are problems in securing the official forms for immunisation recording at the central level due to funding problems, which generates out-of-pocket expenses for the health staff. Moreover, in 2016 there were problems with the supply of SINOVA forms in a majority of the HRs where this is implemented.
  - There are problems at the national level with the permanent data input personnel required for SINOVA operation in the 10 HRs where this was implemented and functioning up to 2016. The majority of personnel are contract hires financed by national funds and some municipalities, which does not ensure their sustainability. At the same time there is a lack of funding to complete implementation in

five HRs (Metropolitan Central District, Atlántida, Yoro, Gracias a Dios and Colón) and to obtain equipment for SINOVA expansion to the municipal level.

- Key among the innovations is the implementation of the analysis tool for administrative coverage at the central and regional levels and in the municipalities of the Central District, San Pedro Sula and Cortés. Implementation was made possible with the technical support of PAHO/WHO for a national workshop and the dissemination of the coverage analysis tool, adapted by the UVS (the authority responsible for this process) and funded by the Gavi HSS project in terms of equipment and training at all levels. This tool has enabled the generation of analysis reports for timely decision-making. There were monitoring difficulties in some HRs (Valle, Ocotepeque, Santa Bárbara, Copán, Gracias a Dios and Colón), given staff changes, the lack of demand and of accountability, which do not allow for process continuity. Also identified as a problem was a lack of integration in the regional team between the staff responsible for immunisation and for epidemiology with regards to the conduct of analyses and decision-making in some HRs, aggravating matters. To consolidate use of the information, guidelines were defined to incorporate the graphs, maps and tables that the tool generates into evaluations at the central and HR level, and to systematise quarterly and six-monthly analysis reports.
- SINOVA generates analysis reports that are still not being widely used in decision-making and faster progress in this process is required in the regions where it is implemented.

### 3.4. Role and engagement of different stakeholders in the immunisation system

The SESAL has different coordinating bodies supporting immunisation, which have been operating for several decades. These include:

- **Inter-Agency Cooperation Committee on Health**, the coordinating body for technical and funding support and national and external resource mobilisation, which has played the role of guarantor for Gavi support to the country in different cooperation areas for over a decade. Civil society forms part of this.
- **National Immunisations Advisory Board (*Consejo Consultivo Nacional de Inmunizaciones, CCNI*)**, an independent technical consultation body that has played an important role in analysing the evidence for new vaccine introduction.
- **Other donors:** PAHO/WHO offer technical and funding assistance in different components based on the annual action plan for activities not financed by national funds. UNICEF, which has reduced its immunisation support for over a decade, currently provides technical assistance support for the communication and social mobilisation component.
- **Cross-sectoral health boards** are operative in every HR and enable resource mobilisation, particularly in terms of promotion, transport and other activities during immunisation days or campaigns. HPV immunisation has strengthened coordination with the Ministry of Education.
- **Municipal governments:** these support the SESAL at the central level on immunisation matters through payments for health staff in some facilities and data entry staff, and some other expenses.

## 4. PERFORMANCE OF GAVI GRANTS IN THE REPORTING PERIOD

### 4.1. Programmatic performance

In 2016, the SESAL received Gavi support in three project lines: new vaccines through the IPV vaccine donation, the HPV vaccine introduction grant, and HSS. How these contributed to EPI and health sector performance is described below.

#### **New vaccine introduction support**

##### **Inactivated poliovirus vaccine**

- In the context of the Polio Eradication and Endgame Strategic Plan 2013-2018, the country introduced one dose of IPV for the 2-month-old population in December 2015.
- In 2016, through the PAHO/WHO Revolving Fund, Honduras received 178,335 doses of IPV in a five-dose presentation. Coverage of 104% (200,720 doses/192,849) was achieved with the first dose of

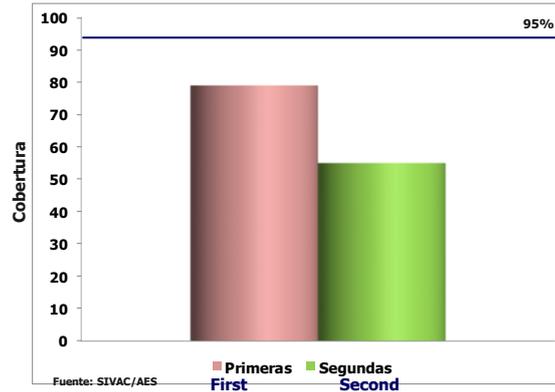
IPV, exceeding the target set, whereby the main achievement was ensuring the protection of the infant population against type-2 poliovirus.

- The wastage rate was 17%, a decrease compared with the 19% recorded in 2015, and not exceeding the rate projected.

**Human papillomavirus vaccine**

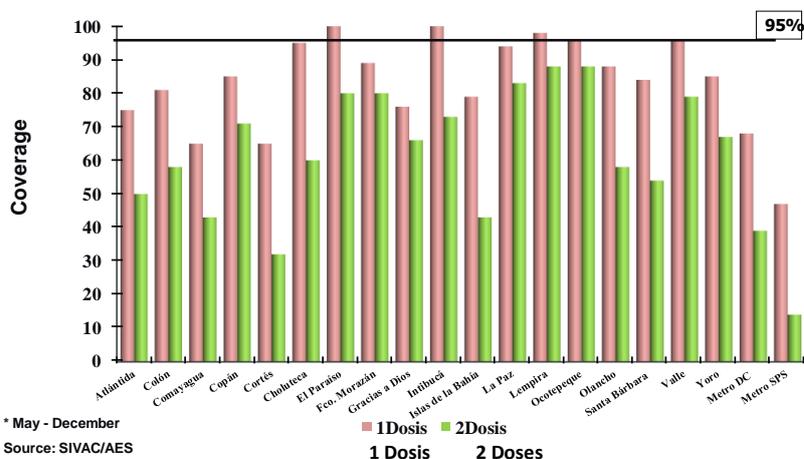
- The HPV vaccine for 11-year-old girls was introduced on a national scale on 16 May in a two-dose schedule, achieving coverage of 79% for the first dose (77,622/98,227) and 55% for the second dose (54,182/98,227). Immunisation was conducted by doing the rounds of basic education centres and on demand at health facilities for girls not in school (Figure 16).

**Figure 16. Coverage with first and second doses of HPV vaccine administered by month to 11-year-old girls, Honduras 2016**



- Only 6/20 HRs achieved coverage  $\geq$  95% for the first dose: Choluteca, El Paraíso, Intibucá, Lempira, Ocotepeque and Valle. None achieved 95% coverage for the second dose. Coverage was 80-89% for the HRs of El Paraíso, Francisco Morazán, La Paz, Lempira, Ocotepeque and Olancho. The remaining 14 HRs had coverage rates below 80%, with the lowest rates in San Pedro Sula metropolitan region (14%), Cortés (32%), RMDC (39%) and Islas de la Bahía and Comayagua (43%) (Figure 17).

**Figure 17. Coverage with first and second doses of HPV vaccine administered by health region to 11-year-old girls, Honduras 2016\***



- The targets of 96% for the first dose and 95% for the second dose were not achieved, with the main constraints identified as follows:
  - simultaneity with several immunisation activities that required planning, organisation and implementation, such as: the switch from the trivalent (tOPV) to bivalent (bOPV) oral poliovirus vaccine, National Immunisation and Deparasitation Day and HPV vaccine introduction;
  - late distribution of the HPV vaccine (12-13 May) by the National Vaccines Warehouse because of late dispatch by the PAHO/WHO Revolving Fund, due in turn to **vaccine manufacturer delays**;
  - publication of negative statements in the written media by the Auxiliary Bishop of the Catholic Church in Honduras (Diario La Tribuna dated 20/05/2016);
  - spread of negative information on AEFIs on social networks, mainly over the Facebook account of the College of Physicians of Honduras;
  - bilingual schools in examination period;
  - the refusal of the directors of some private schools to provide census information on 11-year-old girls due to security issues, hampering conduct of immunisation by health staff in these institutions
  - limited human resources for vaccine administration to systematise immunisation in basic education centres; and
  - some HRs reported overestimates of the official population of 11-year-old girls.

The main interventions conducted were:

- coordination with the Ministry of Education at the central level on all levels;
- the conduct of immunisation operations nationwide from November to December in search of girls who had received a first dose at the community level; and
- intensification of the communication strategy through participation in mass communications media (press conferences, forums, etc), with the involvement of the College of Physicians and the Paediatrics and Gynaecology Association, the broadcast of television spots, etc, to inform the population and professionals on the importance of immunisation.

**Health System Strengthening (HSS) support**

The period of actual implementation in 2016 was approximately eight months for central level units and six months for the 20 HRs due to PAHO/WHO delays in fund allocation.

The objectives formulated in the HSS grant focus on improving EPI performance in the health service network, strengthening institutional capabilities for overcoming the bottlenecks identified: insufficient human resources for immunisation, reduced social participation in the demand for immunisation services, the lack of nominal data on the immunised population, budget constraints for preventive cold chain

maintenance, poor vaccine and supply transport logistics, and a limited systematic analysis of immunisation data at regional, municipal and local levels.

Achievements against agreed-on objectives:

### **1. Strengthening the network of health services within the framework of the National Health Model**

The Honduran National Health Model focuses on RISS based on primary health care, which entails health care revolving around the person, the family, the community and the environment.

One hundred per cent of the HRs apply their management plans to RISS, exerting considerable efforts to implement these. To strengthen the lead regional teams, training workshops were held to develop RISS management skills to achieve harmonisation in the administration of health service delivery, facilitating understanding and consensus on the steps needed for network operation under a single management. Some HRs were visited to provide technical assistance to start up the Management Councils and the Network Coordinating Teams and to coordinate them for network operation.

Elsewhere, workshops were held on conceptual, methodological and practical elements for training regional facilitators to contribute to operating and strengthening the National Reference and Response System (*Sistema Nacional de Referencia y Respuesta*, SINARR), sharing news to encourage users to go to network HFs and strategies and instruments to make the SINARR and the monitoring and evaluation plan operative.

In addition, 100% of the HRs were trained on the implementation guidelines for the family health teams, reaching 153 teams of approximately 710 personnel, among them doctors, nursing graduates, promoters and nursing aides. Constraints to the sustainability of the family health teams include reduced permanent staff and high rotation levels.

Immunisation operations were also conducted in 186 municipalities identified as at risk, enlisting populations where immunisation is still pending. To validate immunisation coverage, rapid coverage monitoring was conducted for 93 cases.

### **2. Strengthening the EPI information sub-system**

Training for 50% of the HRs lined up for SINOVA implementation was achieved, reaching 143 personnel, among them doctors, nursing graduates and statisticians, to enable them to use and handle SINOVA application modules. The workshop on the modification of the forms with links to the EPI and the technical forms of the Information Management Area was conducted.

A total of 895 personnel were trained at municipal level to identify and amend the most common errors in SIVAC/SINOVA and TRANS, with regional level facilitation. Evaluation of SINOVA implementation was conducted for the regions of Francisco Morazán, Comayagua, La Paz, Olancho, Cortés and Choluteca, making it possible to identify the principal limiting factors: the lack of human resources for data input, low-quality internet connections, and the existence of several versions of the tool.

On the issue of handling vaccine and drug inventories, training for the regional and hospital teams on the use of the VSSM/wMSSM tool, handling Kardex, generating reports and other functions continued in 16 regional vaccine warehouses, 15 regional drug warehouses, 25 hospital stores and 25 pharmacies. In addition, an evaluation was conducted on the handling of the VSSM/wMSSM tool, identifying the limiting factors: high staff rotation and limited internet connections, computing equipment and consumables.

Visits for supervision purposes and for strengthening integrated UGI-EPI skills were conducted in 14 HRs.

### **3. Cold chain strengthening**

HRs managed to supervise the cold chain in a total of 783 HFs (51% of the total). Network diagnostics were drawn up and the measles and rubella follow-up campaign was supervised. Supervision was

conducted from the central level on 80% (16/20) of the HRs, making it possible to train the staff in effective vaccine management and see to equipment repair and maintenance.

Cold chain evaluation was also conducted on 100% of the HRs, resulting in the updating of the national cold chain status report, the management commitment plan and an updated cold chain diagnosis.

HRs were given cold chain equipment in the form of 20 solar refrigerators, 53 electric refrigerators and 30 freezers, as well as spare parts for cold chain equipment and vehicles for cold chain supervision maintenance.

With respect to the remodelling of the six priority vaccine warehouses, only the adjustment of the building plans and the hiring of a builder to undertake the activity were achieved. The long administrative process entailed at each stage by guidelines was one of the limiting factors identified.

#### **4. Increasing effective population demand for immunisation services**

The National Health Promotion Plan was disseminated with emphasis on the EPI in 73% (234/298) of the municipalities. Training was conducted for Social Communication Unit personnel in the 20 HRs on the subject of strategic communication, resulting in the generation of communication plans for sustained immunisation.

The technical proposal, protocol, data-gathering instruments and programme of activities for evaluating missed opportunities for immunisation were approved. It was not possible to draw up the data for the reporting period due to the following: the tender review process for the selection of a consultant lasted nine months and the signing of the contract was delayed by two and a half months. The delay in this activity postponed implementation of two priority activities: the design of the promotional campaign for immunisation and the recruitment of media due to the non-availability of results that would guide campaign design.

HRs were equipped with loudspeakers and audio equipment such as megaphones for immunisation outreach activities.

#### **5. Developing capabilities in epidemiological surveillance analysis, facilitating decision-making**

The updating, printing and dissemination of the guidelines for the installation of health situation rooms in the HRs was achieved. However, the generation of quarterly health situation reports remains pending. Limiting factors are the non-standard manner of analysing the health situation in the HRs and poor implementation of the integration teams from the perspective of the new organisational structure.

The research protocol for the Vaccine Temperature Monitoring Study on the Honduran cold chain was prepared and the vaccine distribution logistics managers were trained to ensure proper distribution of the vaccine cases with sensors to the health facilities selected in order to comply with the steps of the study. The investigation of suspected acute flaccid paralysis cases was supported to improve performance in terms of adequate research.

One hundred per cent of the HRs were supervised, reinforcing the definitions of VPD cases, updating performance in the timely notification of VPDs and strengthening surveillance of these. In addition, the strengthening of VPD surveillance was achieved through the delivery of national laboratory inputs for the confirmation or dismissal of suspected cases.

Training was also given to regional teams on the use of the immunisation coverage analysis tool, entering data from the 2010-2016 period. In 90% of the HRs, meetings were held to train personnel from the municipal level in the use of the tool established by the UVS and the EPI, achieving the comparative analysis of coverage rates by municipality and identifying municipalities at risk. Among the limiting factors identified is the fact that only 60% (12/20) of the HRs generated quarterly reports as of December 2016, related to the weakness of human resources in mastering information technology and the lack of monitoring, requests and accountability. In turn, HRs did not manage to hold quarterly meetings with the municipalities.

#### 4.2. Financial management performance (for all cash grants, such as HSS, vaccine introduction grants, campaign operational cost grants, transition grants, etc.)

##### Financial management

The HSS and Transition Plan grant funds are administered by the External Cooperation Fund Administration Unit (*Unidad Administradora de Fondos de Cooperación Externa*, UAFCE) of the Ministry of Health, under UAFCE's guidelines and manual of administrative procedures.

The funds are handled through a bank account at the Central Bank of Honduras exclusively for the HSS grant and another account at the *Banco de Occidente* for the Transition Plan project.

PAHO/WHO disburses the HSS funds to the 20 HRs while the funds for the six central level units are channelled through the UAFCE. This unit disburses the funds partially in accordance with the funding requests submitted by the implementing units from the central level, provided these meet the requirements of the budget ceiling approved for each unit and hand in their respective liquidation accounts.

Expense liquidations from the implementing units are submitted to UAFCE for review. Once they are admitted, a financial report is sent to the PAHO/WHO administration for review, approval and posting on the PMIS (financial platform).

Purchases for both the HSS and the Transition Plan are made by PAHO/WHO, based on the requests prepared by the central level implementing units in accordance with established plans. PAHO/WHO carries out the entire process of bidding, purchase order issuance, payment, and delivery of the products requested. Minor purchases corresponding to supplies required and service procurement for the conduct of training workshops are made by the UAFCE through the Purchasing Department, subject to the codes and procedures established in the country (Public Administration Act and State Procurement Act).

##### Financial implementation of the HSS grant

Grant No. 387020 for US\$ 3,349,311 was received in April 2015 and is administered through PAHO/WHO. Financial performance for the project is summarised based on the Official Financial Report:

Cumulative financial implementation of the HSS grant as of 31 December 2016 amounted to US\$ 1,600,447.29, representing 48%, which corresponds to the first disbursement. Operations began in May 2016 due to administrative delays in fund allocation by PAHO/WHO and a change in UAFCE authorisations. Implementation corresponds to the investment made over a six-month period.

Implementation is broken down as follows by expense category:

- An amount of US\$ 999,166.18 was spent on travel and training and supervision workshops, representing 53% of implementation as against the schedule, for an amount of US\$ 1,874,448.02.
- An amount of US\$ 601,281.11 went to purchases, representing 38% of implementation as against the schedule, for an amount of US\$ 1,564,863.27.

Cumulative financial implementation of the HSS grant as of **30 June 2017 amounted to US\$ 2,599,608.30**, representing 48% of the budget established for the total grant. An amount of US\$ 907,621.52 was implemented in purchases. Travel and training and supervision workshops account for a cumulative implementation of US\$ 1,691,986.87, which represents 31% of the overall budget established.

There are unsettled obligations in the amount of US\$ 875,194.70, which are entered in the PAHO administration platform (PMIS), representing 16% of the overall budget.

##### Financial implementation of the Transition Plan grant

The PAHO/WHO disburses the funds of the Transition Plan through the UAFCE, which later processes the funding requests for activity implementation sent by the EPI upon application, provided these comply with the approved budget ceiling.

Grant No. 387021 for US\$ 378,892.00 was received in March 2015 and is administered through PAHO/WHO. Financial performance for the project is summarised based on the Official Financial Report:

Financial implementation as of 31 December 2016 amounted to US\$ 183,447.87, representing 48% of the budget established for the grant. Operations began in March 2016 due to administrative delays in fund allocation by PAHO/WHO.

Implementation is broken down as follows by expense category:

- An amount of US\$ 161,100.92 was spent on travel and training and supervision workshops, representing 47% of implementation as against the schedule, for an amount of US\$ 343,892.00. Cumulative purchases amount to US\$ 22,346.95.

Cumulative financial implementation as of **30 June 2017 amounted to US\$ 234,787.90**, representing 62% of the budget established for the grant.

Implementation is broken down as follows by expense category:

- An amount of US\$ 198,236.97 was spent on travel and training and supervision workshops, representing 58% of implementation as against the schedule, in an amount of US\$ 343,892.00. Cumulative purchases add up to an amount of US\$ 36,550.93.

There are unsettled obligations in the amount of US\$ 18,855.50, which are entered in the PAHO administration platform (PMIS), representing 5% of the overall budget.

#### **Activities for 2017**

The UAFCE has been strengthened with a dedicated human resource for the project, the simplification of forms, improvement in coordination with the General Directorate of Health Service Networks (*Dirección General de Redes de Servicios de Salud*, DGRISS) and the Technical Project Management Unit (*Unidad técnica de Gestión de Proyectos*, UTGP) in order to define strategies contributing to better project performance. Administrative proceedings have been established for all purchases to be processed through the UAFCE.

#### **Audits**

PAHO handles all cash grants in Honduras. In keeping with the procedures and regulations of the United Nations, these are not subject to external auditing firms but rather to its internal audits and mechanisms as per the agreements signed between Gavi and PAHO.

There has been no amendment to the financial mechanism established for the grant.

#### **IPV introduction grant**

- Grant No. 387026 for US\$ 169,000 was received in August 2015 and is administered through PAHO/WHO. An amount of US\$ 109,160.94 was implemented through the EPI in 2015 and US\$ 53,540.89 in 2016, bringing implementation as of 31 December 2016 to 96% (US\$ 162,701.83) with a remaining balance of US\$ 6,278.17 for 2017.

#### **HPV grant**

- Grant No. 387029 for US\$ 247,000 was received in May 2016 and is administered through PAHO/WHO. An amount of US\$ 139,485.00 was implemented during the period from May to December 2016, bringing implementation as of 31 December 2016 to 57%, with a remaining balance of US\$ 107,494.95 for 2017.
- Timely implementation of the activities in the HPV vaccine introduction plan was supported by PAHO/WHO through a loan of regular funds, subject to the prior authorisation of the PAHO/WHO Regional Office and Gavi, in order to carry out the main activities of the plan. This situation restricted implementation to some activities programmed in the introduction plan.
- Actual implementation from the availability of funds onward in 2016 took four months (July to November), due to administrative procedures for requesting, allocation and administrative closure. In 2017, there were limiting circumstances for the implementation of the activities in the communication and social mobilisation component due to high management and technical personnel rotation in the SESAL Social Communications Unit. At the same time, due to the

urgency of introducing fractioned doses of Inactivated Poliovirus Vaccine (fIPV), some of the activities were rescheduled for the first half of 2018.

- Based on the above, an extension up to 30 June 2018 is requested from the Gavi High Level Panel.

The table below shows the implementation of the different grants according to the PAHO/WHO accounting system as of 31 December 2016:

Ejecución de financiamiento de Gavi de las diferentes líneas de apoyo a Honduras, 2016							
Línea de apoyo	Grant	Año recibo fondos	Monto aprobado en US\$	Monto ejecutado a dic 2016	%	Fecha límite de ejecución	Fuente información
Fortalecimiento de los Servicios de Salud (FSS)	387020	2015-2016	5450,935.00	1600,447.29	29%	31/12/2017	OPS
Plan de transición (PT)	387021	2015	378,912	195,787.53	52%	31/12/2017	OPS
Subsidio VPI	387026	2015	169,000	162,701.83	96%	Indefinido	OPS
Subsidio VPH	387029	2016	247,000	139,485.05	56%	Indefinido	OPS

### 4.3. Sustainability and (if applicable) transition planning

#### Progress in the implementation of planned activities:

The SESAL has a Transition Plan, supported by Gavi since 2015, which was extended up to 31 December 2017. The advances in implementation from January to December 2016 are set forth below:

- Finalising consultancy on the formulation of the Regulations to the Republic of Honduras Vaccine Act.
- Conduct of a second workshop on VPD laboratory surveillance standards for microbiologists from the regions and hospitals.
- Conduct of a training workshop in EPI standards for regional, network/municipal and local level health personnel from seven HRs: Comayagua, Francisco Morazán, Gracias a Dios, Cortés, Copán, Islas de la Bahía and Colón, from August to September 2016.
- EPI documents and key forms printed.
- National EPI evaluation meeting, with the participation of the 20 HRs and cooperation partners, 4-6 March 2016.
- Regional evaluation meetings on the EPI integrated into health services in 17/20 HRs for the July to November 2016 period, except for the Metropolitan Central District Region, La Paz and Choluteca, which did not implement the activity and reimbursed the funds due to the extension of the measles and rubella follow-up immunisation campaign.

#### Unforeseen circumstances in implementation and corrective measures:

- Due to the change in the PAHO/WHO financial platform there were delays in the allocation of funds, which held up the implementation of activities during the first quarter of 2016.
- As regards the approval of the Regulations to the Republic of Honduras Vaccine Act, the Directorate General for Standardisation (*Dirección General de Normalización*, DGN), through Official Communiqué No. 567-DGN-SS dated 24 May 2017, determined that, for the time being, it is not possible to issue a favourable opinion for their approval until it has found a legal opportunity to do so, once the supplementary laws are approved, in accordance with Article 58 of the Framework Act on the Social Protection System, which would enable deliberations on the case.  
The EPI sent an official communiqué to the DGN requesting reconsideration of the decision, but Official Communiqué No. 819-DGN-SS-2017 dated 27 July 2017 ratified the previous position.

#### Fulfilment of timelines

- The majority of activities in the plan have been rescheduled for 30 November 2017. However, despite the fact that programme and financial implementation improved substantially during the second quarter of 2017, difficulties in completing plan tasks are anticipated due to SESAL administrative delays related to the quick signing of requests, the change in authorisations and authorised signatures for cheques issued at the UAFCE, and the biennial closure at PAHO/WHO, which hampers the conduct of activities in December.

**Proposed change of activities**

- Given receipt of the unfavourable ruling on the Regulations to the Republic of Honduras Vaccine Act, the decision was made to print and publish the Vaccine Act without regulations.
- It is requested to reallocate US\$ 15,000 from the activity, “evaluation meetings on regional EPI integration with health services” to the activity, “EPI supervision in all components”.

Based on the aforementioned in terms of meeting timelines, a request is made to the High Level Review Panel for an extension up to 31 December 2018. Annex 3 presents a schedule of activities to extend and reassign.

**Additional preparatory activities for transition**

- SESAL signed a Technical Cooperation Agreement with PAHO/WHO in 2015 to administer the national counterpart for supplementing some activities in the HSS plan (this is a voluntary co-investment or match-funding for Gavi HSS on the part of the government).
- To date, it has made two cash transfers to PAHO/WHO for a total amount of US\$ 359,532.
- The steps required will be taken so that national counterpart transfers to fund priority activities will continue for three years (2018-2020) once HSS support has ended.

**4.4. Technical Assistance (TA)**

Gavi approved additional funds for the SESAL to support HPV immunisation in an amount of US\$ 100,000, of which US\$ 47,625 was notified as transferred to PAHO/WHO and US\$ 22,600 to UNICEF in May, both adding up to 75% of the total funds approved. Progress as of July 2017:

- 100% of the allocated funds processed with PAHO for immunisation operations, printed forms and materials.
- US\$ 6,536 processed with UNICEF by way of a consultancy for three months to evaluate and reformulate the HPV immunisation strategy, whereby implementation of the remainder is pending the outcomes of the consultancy for the design, printing and distribution of communication materials. Since the amount allocated for the consultancy is insufficient for the tenders received, UNICEF will supplement the funds required.

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

Prioritised actions from previous Joint Appraisal	Current status
Approval by the High Level Review Panel of an exceptional status for Honduras to extend the full implementation of funds up to December 2017.	<b>Approved</b>
Strengthening the administration of the HSS grant in PAHO/WHO in the following areas: human resources, disbursement, direct implementation, monitoring of financial performance, generation of detailed reports, exceptional status for the disbursement of 100% of the funds by letter of agreement and increased delegation of authority for the implementation of activities in the project.	<p><b>Completed</b></p> <p>The PAHO/WHO administrative team was strengthened by two SESAL employees, improving fund allocation to the HRs, the availability of breakdowns, approval of exceptional status for the disbursement of 100% of the letters of agreement upon submission of the partial liquidation of 50%, and increased delegation of authority.</p> <p>The systematic monitoring of financial implementation remains to be strengthened.</p>

<p>Development of a process of self-assessment, control and monitoring in the implementing units, with accountability from the senior level, supported by the technical and administrative coordinating authorities (DGRISS and UAFCE).</p>	<p><b>Partially completed</b></p> <p>The implementing units submit monthly and six-monthly reports for activity monitoring. However, there are implementing units who do not send in their reports regularly.</p> <p>There is support from the UTGP, which performs the monitoring and evaluation of implementing unit performance.</p> <p>Feedback is obtained from regional management through e-mails and higher-level channel communiqués (RISS Directorate General).</p> <p>It was agreed with the RISS Undersecretary and the Projects and Investments Undersecretary to submit periodic accountability reports.</p>
<p>Technical support from UPEG, UTGP and PAHO/WHO. Identification of alternatives or a structure for effective management of the project in SESAL.</p>	<p><b>In progress</b></p> <p>The UAFCE is reviewing its administrative processes in the framework of request and liquidation form simplification. It is expected to complete this process by the end of September.</p>
<p>Modification of the data denominators for the indicators in the WHO/UNICEF Joint Reporting Form (JRF) 2015 according to population data from the 2013 INE Census, for access to the Gavi award for high immunisation coverage.</p>	<p><b>Completed</b></p>
<p>Politically prioritising the official placement of the EPI within SESAL's organisational structure.</p>	<p><b>In progress</b></p> <p>Proposal for an organisational structure for EPI operation was prepared and consultations were held with the Ministry of Finance regarding the creation of an EPI budget structure through the UPEG, the guiding authority on institutional organisational development.</p>
<p>Ensuring the specific functions of the HSS-Gavi project's technical and administrative staff.</p>	<p><b>Completed</b></p>
<p>Application for technical support for the introduction of critical components of the HPV vaccine.</p>	<p><b>Completed</b></p>
<p><b>Additional significant IRC / HLRP recommendations (if applicable)</b></p>	<p><b>Current status</b></p>

*If findings have not been addressed and/or related actions have not taken place, provide a brief explanation and clarify whether this is being priorities in the new action plan (section 6 below).*

**6. ACTION PLAN: SUMMARY OF FINDINGS, ACTIONS AND TECHNICAL ASSISTANCE NEEDS IDENTIFIED AND AGREED DURING THE JOINT APPRAISAL**

**Overview of key activities planned for the next year:**

In view of operational planning for the grants and the constraints previously raised, more time is required for the implementation of some scheduled activities and the rescheduling of others, set forth in Annex 2 in the “Fund Reallocation Plan / Extension up to December 2018 and Timeline 2018”.

**Key activities of the Gavi HSS project requiring extension**

1. Installation of cold rooms in four vaccine warehouses (refurbishment in the third and fourth quarters of 2017) in the HRs of Atlántida, Copán, Choluteca and Comayagua, and one in the National Vaccines Warehouse.
2. Reproduction of communication materials for the promotional campaign on immunisation.
3. Broadcast of the promotional campaign on immunisation over mass media.
4. Completion of remaining acquisitions due to the timelines required for international purchases, customs processing and cold chain equipment distribution.

**Transition Plan**

1. Dissemination of the Vaccine Act
2. Training of health personnel in EPI standards
3. EPI supervision in all components (funds to be reallocated)
4. Information system, purchase of materials
5. National EPI evaluation and EPI evaluation in prioritised regions

Reallocation of funds is requested under Annex 3, “Extension Plan and Reallocation of Transition Plan Funds, Honduras 2018”.

**HPV introduction grant**

The HPV vaccine was introduced in May 2016 and the grant was received that same month. Actual implementation took four months in 2016. Extension up to 30 June 2018 is requested for the following activities:

1. Coordination meetings with key stakeholders.
2. Crisis plan updates and activities in defence of immunisation.
3. Training of newly recruited health personnel.
4. Mobilisation of immunisation teams.
5. Distribution of information system and promotional materials.
6. Supervision of HPV immunisation integrated with EPI supervision.
7. National evaluation of HPV immunisation progress integrated with national EPI supervision.

<b>Key finding 1</b>	Physical and financial implementation of the grants to date has improved relative to the last evaluation as a result of the coordination effort between those involved. Compliance with technical and administrative recommendations and political support. The current scenario in the institution is considered favourable to improving grant performance.
Agreed country actions	To conduct a more realistic strategic and operational planning exercise as well as to simplify administrative procedures.
Associated timeline	Second half of 2017
Technical assistance needs	Not applicable
<b>Key finding 2</b>	Based on the analysis of physical and financial grant implementation in the political, technical and administrative contexts, including changes in government management and the biennial closure of PAHO/WHO during the first half of 2018, an extension up to 30 September 2018 is required to conduct the activities and achieve the objectives projected.

Agreed country actions	To request the High Level Review Panel to make an exception for the country with regards to extending the timeline to 30 September 2018 for HSS and Transition Plan funds and additional TCA for HPV.
Associated timeline	Second half of 2017
Technical assistance needs	Not applicable
<b>Key finding 3</b>	Financial support for national counterpart funding (supplementary funds) is required to ensure the sustainability of Gavi grant achievements.
Agreed country actions	Raise the issue with SESAL authorities, formulate AOP-Budget for 2018-2020 and sign cooperation agreement with PAHO/WHO.
Associated timeline	Second half of 2017
Technical assistance needs	Not applicable
<b>Key finding 4</b>	
Agreed country actions	
Associated timeline	
Technical assistance needs	
<b>Key finding 5</b>	
Agreed country actions	
Associated timeline	
Technical assistance needs	

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

### **Dr. Francisco Cleaves, CCNI/CONEPO:**

He congratulated the EPI on its achievements. The data presented show that immunisation is functioning and is sustained by the country's excellent cold chain network. However, new problems have arisen with regards to the immunisation of 4 and 11-year-old children. He was referring to the fact that these 11-year-old children are abandoned, which is due to the type of health system in place, requiring new concepts. New ways of reaching this population successfully have to be sought, for instance, through the family health teams that are being trained.

There is a problem of education in general in families. Something different has to be done through the municipalities and principal cities. What has been done in immunisation up to the present has been done well.

### **Dr. Mario Castillo, Chair, APH:**

He congratulated the SESAL, the EPI and Gavi for their achievements. The APH will continue to support immunisation activities.

He said he has the same concern already raised by Dr Molina regarding a single immunisation card reflecting all the vaccines, instead of vaccines noted down for adolescents separately. He wants to know how 11-year-old girls are being immunised and whether immunisation cards are being kept.

He raised the difficulties that parents of patients encounter in replacing the cards since it is almost impossible to ask for replacements at health facilities.

He requested a meeting with the EPI to deal with the topic of a single card.

**Dr. Carlos Godoy Arteaga, Chair, CONEPO:**

He congratulated the EPI and her excellency, the Minister. It is a privilege in Latin America.

He recommended someone – a doctor or nursing professional – to approach mothers of new-born infants leaving the hospital for educational talks on BCG and the other vaccines on the immunisation schedule.

**Dr. Molina**

In response to the comments, she said:

- Among the main causes of coverage problems concerning booster doses of DPT at age 4 and HPV for girls aged 11 is the scarcity of human resources for immunisation to ensure systematic immunisation during periodic rounds at all educational centres. The problem is not with accepting or rejecting immunisation. The same assistant (working) on pre-clinical issues who offers consultations and immunisations at the immunisation clinic is the same resource obliged to go to the schools and seek out 11-year-old girls.
- With regards to adolescents, there are diverse health strategies, including promotion and information on immunisation for this group through adolescent-friendly venues, etc.  
The SESAL is totally willing to combine efforts with the APH towards use of a single immunisation card in the health system.
- We agree that there is a problem in the lack of health education. The national communication strategy on the topic of immunisation should be strengthened, requiring the strengthening of technical skills in institutions at all levels. The Vaccine Act legislates the co-responsibility of municipal authorities in the matter. Work is being done on an educational strategy to increase spontaneous demand among the population for immunisation services.

**Dr. Alvarado**

In response to the comments, she said:

The HSS investment in immunisation service promotion amounts to more than US\$ 450,000 and focuses on a campaign addressing both the public and health personnel as well as dissemination in the communications media.

**Homero Hernández, Senior Country Manager, Gavi:**

As regards HPV immunisation, he said it was a complex process, different from others, and that this does not only happen in Honduras but in all the countries where HPV is introduced. There will be many lessons learned and a forum for all the countries where these will be dealt with. The model is not perfect.

At the time there was a window of opportunity, there was co-investment, the country found itself forced to introduce the vaccine but not in the timeliest manner, since it would then have benefited from a domestic budget. Gavi is taking note to ensure countries are not put in a position of having to make hasty decisions of introducing vaccines in an untimely manner.

The EPI is a star programme and Honduras is a star country among the 73 countries comprising the beneficiary member states of the alliance. Gavi thanks Honduras personally and professionally. We are always learning. He acknowledged a strong political commitment from the different administration offices as compared with other countries.

The evidence is there and what is important is the development of the population. Doubtless the EPI is a gateway for improved health outcomes. There is high performance by the health workers at all levels, and for that reason they continue to progress.

**8. ANNEX**

**Annex 1: Figures**

**Annex 2: Fund Reallocation Plan / Extension up to December 2018 and HSS Timeline 2018**

**Annex 3: Timeline of Activities - Transition Plan 2018**

	Yes	No	Not applicable
<b>Grant Performance Framework (GPF)</b> reporting against all due indicators			
<b>Financial Reports</b>			
Periodic financial reports	X		
Annual financial statement	X		
Annual financial audit report	X		
<b>End of year stock level report</b>	X		
<b>Campaign reports</b>			X
<b>Immunisation financing and expenditure information</b>	X		
<b>Data quality and survey reporting</b>			
Annual desk review			X
Data quality improvement plan (DQIP)			X
If yes to DQIP, reporting on progress against it	X		
In-depth data assessment (conducted in the last five years)			X
Nationally representative coverage survey (conducted in the last five years)			X
<b>Annual progress update on the Effective Vaccine Management (EVM) improvement plan</b>	X		
<b>Post Introduction Evaluation (PIE)</b>	X		
<b>Measles-rubella 5 year plan</b>			X
<b>Operational plan for the immunisation program</b>	X		
<b>HSS end of grant evaluation report</b>			X
<b>HPV specific reports</b>	X TCA platform		
<b>Transition Plan</b>			X

*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.*