Joint Appraisal report 2019

Country	Benin
Full JA or JA update[1]	☑ full JA ☐ JA update
Date and location of joint appraisal meeting	11 to 13 November 2019 in Cotonou
Participants / affiliation[2]	See appendix N°4
Reporting period	January - December 2018
Fiscal period[3]	January - December 2018
Comprehensive Multi Year Plan (cMYP) duration	2019 - 2023
Gavi transition / co-financing group	*Initial self-financing*

1. RENEWAL AND EXTENSION REQUESTS

Renewal applications were submitted on the country portal.

Vaccine (NVS) renewal request (by 15 May)	Yes ☐ **X**	No ☐	
Does the vaccine renewal request include a switch request?	Yes ☐	No ☐	N/A ☐ **X**
HSS renewal request	Yes ☐	No ☐ **X**	N/A ☐
CCEOP renewal request	Yes ☐	No ☐ **X**	N/A ☐

2. GAVI GRANT PORTFOLIO

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

Vaccines	Introduction Date	Coverage 2018 in % (WUENIC)	Target 2020	Observation
Yellow Fever	01-2002	71	90	
PENTA	06-2005	76	92	
PNEUMO	07-2011	73	92	
IPV	08-2015	60	90	
MR	12-2018	71	92	
ROTA	12-2019	N/A	92	
MR Campaign	03-2019	95.7	N/A	According to the draft post-campaign survey report

Existing financial support *(as of 31 November 2019 to be pre-filled by the Gavi secretariat)*

Grant	Channel	Period	First disbursement	Cumulative funding status @ June 2019				Compliance	
				Comm.	Appr.	Disb.	Util.	Fin.	Audit
HSS 2	Department	2014-2018	August 2014	8,374,704.00	7,623,453.29	4,984,780.16	3,589,341.93	N/A	Gavi audit report in progress
CCEOP	UNICEF SD	2018	2019	2,250,982	2,250,982	2,250,982	N/A	N/A	
MR (intro and campaign	UNICEF	2018	2018	3,349,103	3,349,103	3,349,103	N/A	N/A	
Rota	UNICEF	2019	2019	356,989	356,989	356,988.80	N/A	N/A	

[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.

Comments: Unapproved amount: US$751,250.71 (should be reprogrammed, the country has decided not to go through renewal process for the remaining amount but rather for the US$10million envelope available).
Balance in Gavi to be disbursed after signing a tripartite framework agreement with the Ministry and UNICEF: US$ 2,638,673.13

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

	Program	Intended application	Planned introduction
Indicative interest for the introduction of new vaccines or for the request for HSS support in Gavi	Men A routine	Approved in 2019	2020
	Men A campaign		2020/2021
	MR2	2020	2021
	HPV	2020	2021

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

Intermediate results indicator	Target 2018	Actual (WUENIC)	Target 2020
Penta1 and Penta3 dropout rates	5%	10%	10%
PCV1 and PCV3 abandonment rates	7%	13% (JRF)	10%
Drop-out rate Rota 1 and Rota last	10%	N/A	10%
Comments			

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

	Year	Funding			Current Staff	Filled Milestones
		Approved	Disbursed	Utilised*		
Total Traditional partners	**2018**	437,158	437,158	294,205		10 of 25
	2019	546,768	546,768	26,907		15 of 26
UNICEF	**2018**	336,450	336,450	186,447	1 of 1	5 of 13
	2019	290,304	290,304	26,907	-	4 of 9
WHO	**2018**	107,758	107,758	107,758	-	5 of 12
	2019	172,464	172,464	0	-	9 of 15
CDC	**2019**	84,000	84,000	-	-	2 of 2
TOTAL Expanded Partners	**2018**	404,167				
	2019	18,850				
CRS + URC	**2018**	394,742				**2 of 2**
Oslo	**2018**	9,425				**-**
	2019	18,850				**2 of 2**

**to July 31, 2019*

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

Since the last joint assessment in June 2017, the Government of Benin has been pursuing the administrative reforms initiated at the end of 2016. The reform at the Ministry of Health has provided for the following major changes:

- The adoption of Act No. 2018-34 of 5 October 2018 amending and supplementing Act No. 2001-09 of 21 June 2002 on the exercise of the right to strike in the Republic of Benin;

[4] Providing this information does not constitute any obligation for either the country or Gavi, it merely serves for information purposes.
Countries are encouraged to highlight in subsequent sections, and particular in the Action Plan in Section 7, key activities and potentially required technical assistance for the preparation of investment cases, applications and vaccine introductions, as applicable.

- The revision of the decree on the attributions, organization and functioning (AOF) of the Ministry of Health;
- The adoption by the Council of Ministers on 25 September 2019 of the recommendations of the commission in charge of health sector reforms, namely:
    - The creation of the National Authority for the Regulation of the Health Sector;
    - the creation of the National Council for Primary Health Care (CNSSP) ;
- The creation of the National Agency for Primary Health Care (ANSSP) by Presidential Decree 432 dated 2 October 2019 repealing the previous texts relating to the ANV-SSP.

The ANSSP's mission is to federate all components of primary health care within a single Agency. Pending the operationalization of the ANSSP, a decision dated 12 November 2019 by the Minister of Health authorized the ANV-SSP to continue its activities.

In addition, the Ministry of Health is committed to the transfer of skills and resources through the adoption of the Deconcentration and Decentralization Plan (P2D). In addition, the national community health policy is being reviewed with a view to reorganizing health activities at the community level.

At the macroeconomic level, Benin's real GDP growth rate in 2018 is estimated at 6.1 percent, compared to 5.5 percent in 2017. The reforms implemented have contributed to improving Benin's ranking in the World Bank's ***Doing Business*** 2017 report. From 155th place for 190 economies assessed in 2016 to 158th place in 2015, Benin moved up to 151st place in 2017.

Despite this performance, the country remains a poor country, with more than a third of its population living below the poverty line. In order to improve the living conditions of vulnerable populations, the Government has undertaken a vast programme called Assurance pour le Renforcement du Capital Humain (ARCH). It comprises 4 components, namely health insurance, micro-credit, vocational training and retirement insurance. The Health Insurance component was launched on a pilot basis in three health zones of the country (Abomey-Calavi - Sô Ava, Dassa Zoumé - Glazoué and Djougou - Copargo - Ouaké).

On the health front, the results of the Demographic and Health Survey V (DHS V 2017-2018) were published in April 2019 and show a decline in the main mortality indicators. The infant and child mortality rates of 96‰ and 55‰ respectively, live births in 2017, and a maternal mortality ratio of 391 deaths per 100,000 live births for the same period. As for immunisation, only 51% of children are fully vaccinated before their first birthday, while 11% have not received any vaccine at all.

The year 2018 was marked by a wave of epidemics: measles in 24 communes out of 77 with 1071 suspected cases including 493 confirmed in the laboratory and by epidemiological link and 1 death. This wave of epidemic spread in the first quarter of 2019 with 504 suspected cases was interrupted with the measles rubella campaign organized from 5 to 11 March 2019. In addition, since 6 August 2019, 3 cases of Poliovirus derived from circulating vaccine strain 2 (cVDPV2) have been detected in the communes of Kalalé and Parakou.

Potential future problems (risks)

A number of events could jeopardize the achievement of the program's objectives in the coming year.

- In the area of leadership and governance:
    - The transformation of the ANV-SSP into ANSSP with a risk of a decline in the position of vaccination in the Ministry of Health's organizational chart;
    - The Program's poor compliance with partners' fiduciary management requirements;
    - De-motivation of health care staff due to the removal of certain financial benefits;
- In the area of disease surveillance:
    - The persistence of the epidemic of circulating poliovirus derived from vaccine-derived type 2 vaccine strains;

- The outbreak of Lassa hemorrhagic fever;

- In the area of procurement:
  - Out of stock of BCG, Penta and IPV vaccines;
  - Insufficient maintenance of cold chain equipment (CCE);
- In the area of demand generation:
  - The accentuation of refusals to vaccinate;
- In the field of financing:
  - The continuous reduction of the share of the National Budget devoted to the management of the EPI;
  - Difficulties related to the formalities of removing shipments of vaccines and other vaccine inputs;
- In the field of security :
  - the outbreak of unrest following the 2020 communal and local elections.

The various risks mentioned above do not have the same probability of occurrence or the same consequences. The results of the risk analysis are presented in the annex. Based on this analysis, the major risks for the Programme in the coming year are as follows:

- The continuous reduction of the share of the National Budget devoted to the management of the EPI;
- Out of stock of certain antigens and vaccination consumables: BCG, Penta, IPV and BCG syringes;
- The occurrence of epidemics: cVDVP2, Lassa, Yellow Fever;
- The accentuation of refusals to vaccinate;
- The delay in the implementation of Gavi grant activities.

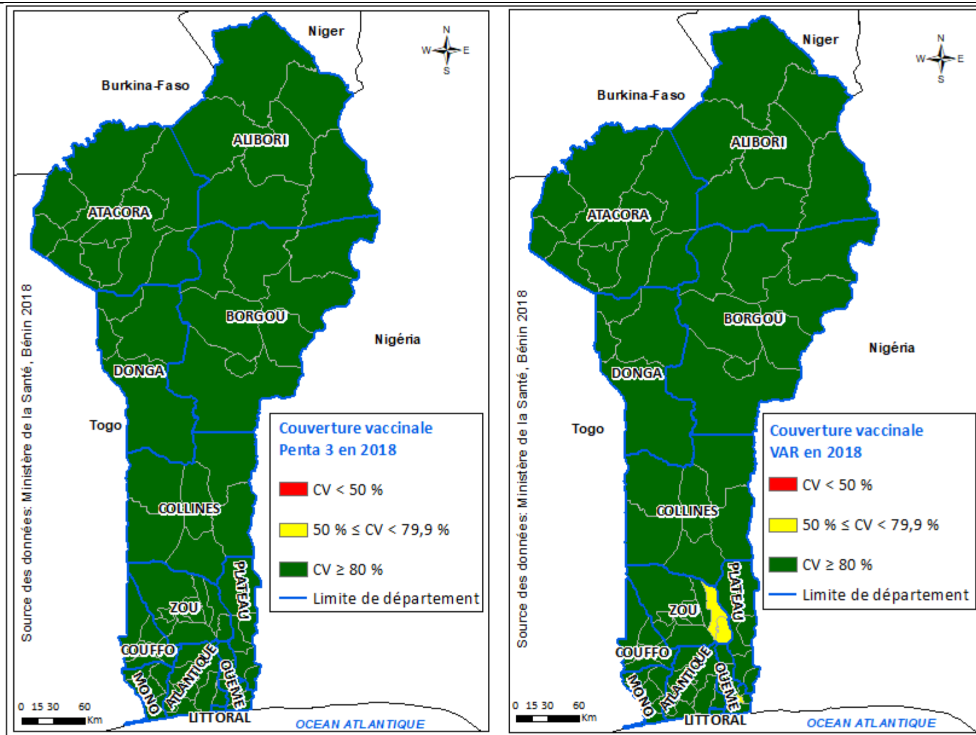
4. PERFORMANCE OF THE IMMUNISATION PROGRAMME

4.1. Coverage and equity of immunisation

Vaccination coverage

According to administrative data, the Penta3 (DTP-HepB-Hib) coverage achieved in 2018 is 107% for the whole country. However, when survey data (DHS 2017-2018) and WHO-UNICEF estimates are considered, it is 73% and 76% respectively.

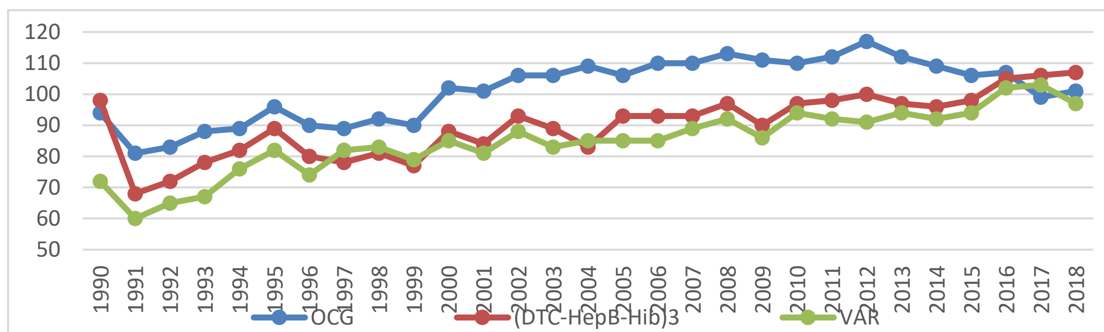
Regarding Measles coverage, the same trend is observed between administrative data and WHO-UNICEF survey data/estimates, with however 5 communes having an administrative coverage lower than 80% (Toviklin, Ouinhi, Zangnanado, Aguégués and Porto-Novo) out of the 77 in the country.



Source: ANV-SSP

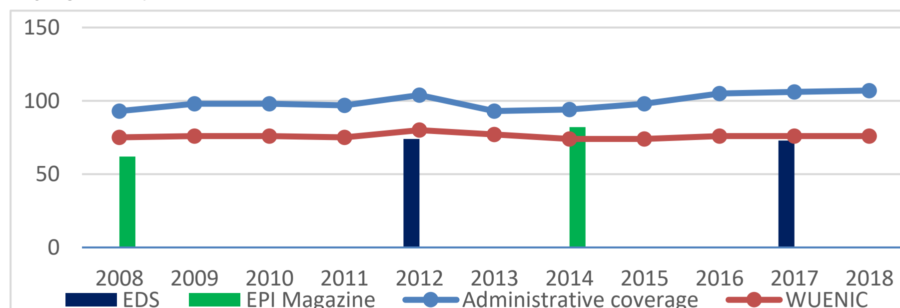
***Map N°1**: Administrative immunisation coverage in Penta3 and Measles by communes in 2018 in Benin*

Analysis of administrative immunisation coverage from 1990 to 2018 shows that it has not increased over the last ten years. This trend is the same when considering investigation data over the same period.



Source: ANV-SSP

***Graph N°1**: Evolution of* administrative *immunisation coverage of BCG, Penta 3 and Measles from 1990 to 2018 in Benin.*

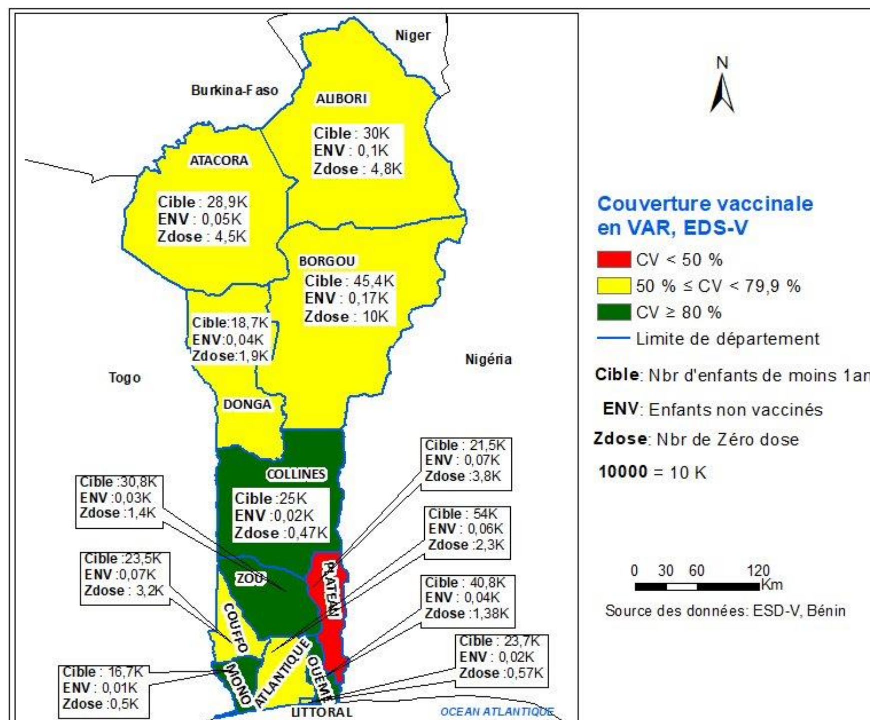


Source: WUENIC 2018

***Graph** N°2: Administrative immunisation coverage in Penta3 compared to survey and WUENIC coverage in Benin*

In view of the wide disparities between administrative and survey data, it was agreed to use EDS V data for further analysis and planning, although the latter are only available at the departmental

level. This survey reveals that 51% of children are fully vaccinated while 11% have not received any vaccine, especially in the departments of Borgou, Plateau, Alibori, Atacora, Couffo and Donga.



Source: EDS V (2017-2018)

***Map_N°2**: Measles immunisation coverage in comparison with the number of unvaccinated children, the number of zero doses and the number of children under 1 year of age per department in 2018 in Benin*

EDS V also reveals the following inequities:

- Penta3 immunisation coverage is higher in urban areas than in rural areas (78% vs. 70%),
- The last children from row 6 onwards are less vaccinated than the oldest children (67% vs. 77%),
- the children of the most educated mothers are better immunized than those of uneducated mothers,
- children from the poorest backgrounds are less vaccinated than those from the richest backgrounds (55% vs. 86%).

Women at the primary and higher levels immunize their children less than their counterparts at the secondary level, and no gender disparity was noted by the EDS V (73.5% coverage of Penta 3 among boys versus 72.5% among girls), Moreover, there are a large number of unvaccinated children in urban and peri-urban areas.

The analysis of equity in vaccination, carried out in 2017 by the ANV-SSP with the support of Unicef, made it possible to identify and estimate the population of the Communities with Little or No Services (CPPD): nomads / seasonal migrants, communities living in inaccessible / difficult access areas (black lands, swamps, flood zones, etc.), communities reluctant to vaccination (religion, prejudices about vaccination and its side effects, dissemination of false information on social networks). Their population was estimated at 468,339 inhabitants, including 15,632 children aged 0-11 months, out of a total of 3,529,370 inhabitants in the ten health zones covered by the analysis.

The reasons for not meeting the targets are as follows:

- Insufficient service offer

- No control over the denominator,
- Weak organization of services: child immunisation services are not offered in 27% of the SFs and fixed-strategy immunisation is not carried out on a daily basis in 68% of the SFs that offer it (SARA 2018); there are no strategies oriented towards reaching children in urban and peri-urban areas and in communities that are poorly or not served; there are no mechanisms for motivating the personnel involved in immunisation;
- Insufficient human resources;
- Deterioration/unavailability of Cold Chain equipment (20% of the country's ECDFs are compliant);
- Insufficient rolling stock for advanced strategies and supervision;
- Rupture of certain antigens and consumables (BCG, IPV, Penta, BCG syringes).

- Unstructured demand generation
  As recent data are not available, a Knowledge, Attitudes and Practices (KAP) survey will be carried out in 2020. However, according to the external review of the EPI 2014, the reasons for the non-immunisation of children are the lack of information and motivation of mothers. Based on data from the independent monitoring of the 2019 SIAs, the main reasons for non-immunisation are fear of AEFI, religious considerations and lack of targets. There is also a growing trend of hesitation to immunize due to the dissemination of false information on social networks.

In view of all the above, the ANV-SSP has started, with the support of Unicef, a process to relaunch immunisation based on the following 10 components:

1. strengthening coordination,
2. the strengthening of human resources,
3. adjustment of EPI targets,
4. targeting underserved or underserved communities,
5. micro-planning of corrective actions,
6. community involvement,
7. the introduction of a system for reminding people of their vaccination appointments by means of voice messages, which will eventually make it possible to have an electronic register,
8. Continuous monitoring of coverage for action,
9. the supply of equipment,
10. advocacy for scaling up.

The experimentation of this model has been underway since July 2019 in the 14 communes of Borgou and Alibori. It will be extended to all priority communes in the country, identified on the basis of the following parameters:

- Adjusted Penta3 coverage < 80%,
- Number of unvaccinated children Penta3 > 1500,
- Number of unimmunized children Measles > 1500,
- Penta1-3 drop-out rate > 10%.

Vaccine Preventable Disease (VPD) Surveillance

This analysis of performance indicators for surveillance of VPD focuses on PFA (French acronym), yellow fever, measles and rubella.

- **Monitoring PFA cases**

From 2016 to 2018, Benin recorded good performance at the national level with the achievement of the two main indicators (rate of non-polio PFA and proportion of PFA cases with 2 stool samples taken within 14 days). The same is true in the departments except in 2016 where the proportion of PFA cases with 2 stool samples taken within 14 days is less than 80%. Nevertheless, there are

disparities in communes where in 2018 six (06) communes out of the 77, or 8%, were unable to achieve the objective of a non-polio PFA rate (> 2) and 13 communes out of the 77, or 17%, were unable to achieve both of the two main PFA surveillance indicators at the same time.

Table N°1: *PFA surveillance performance in Benin from 2016 to 2018*

Departments	Notified cases			Non-polio PFA rate			Stool adequacy rate		
	2016	**2017**	**2018**	**2016**	**2017**	**2018**	**2016**	**2017**	**2018**
ALIBORI	16	20	11	3,3	3,9	2,1	100%	85%	91%
ATACORA	29	19	17	7,1	4,2	3,8	97%	100%	100%
ATLANTIC	20	28	31	2,9	4	4,3	85%	100%	97%
BORGOU	35	24	25	5,4	3,4	3,6	97%	96%	96%
COLLINES	13	17	14	3,5	4,4	3,6	92%	100%	86%
COUFFO	12	12	18	2,9	2,9	4,2	100%	100%	94%
DONGA	14	8	10	5	2,7	3,4	100%	100%	100%
LITTORAL	11	13	7	4,6	4,5	2,4	73%	100%	100%
MONO	14	20	13	5,6	7,8	5	86%	100%	92%
OUEME	15	18	29	3	3,2	5,2	93%	100%	93%
PLATFORM	11	13	13	3,6	4	3,9	91%	92%	92%
ZOU	26	21	21	6,1	4,7	4,6	96%	90%	86%
BENIN	**216**	**213**	**209**	**4,3**	**4**	**3,8**	**94%**	**97%**	**94%**

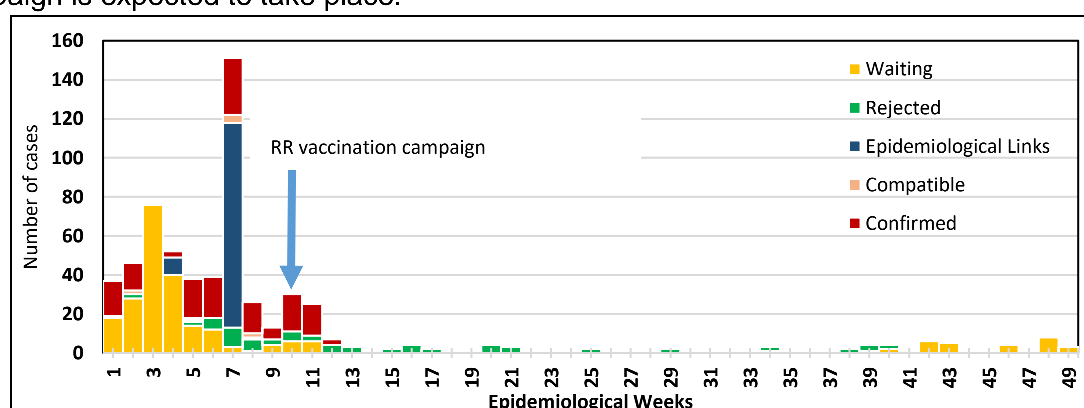
- **Measles surveillance**

Table N°2: *Evolution of measles cases in Benin from 2016 to 2019*

Years	Number of suspicious cases notified	Death	Cases confirmed by the lab	Confirmed epidemiologically linked	Compatible cases	Number of cases rejected by the lab	Results pending
2016	315	0	47	23	20	223	02
2017	429	01	77	20	17	236	79
2018	1,171	01	305	188	19	201	458
2019*	618	02	171	117	10	78	242

* Data from 1st to 49th epidemiological week

The number of measles cases reported in 2018 has tripled compared to 2017 when the MR campaign is expected to take place.



Graph N°3: *Evolution of notified measles cases per week of rash onset according to classifications, from the 1st to the 49th epidemiological week of 2019 in Benin*

The organization of the campaign in the 10th epidemiological week 2019 interrupted the transmission of the disease and a stabilization of cases until week 49.

- **Rubella surveillance**

Table N°3 *: Evolution of rubella cases in Benin from 2016 to 2019*

Years	Number of suspected measles cases	Death	Number of cases to be tested	Cases confirmed by the lab	Compatible cases	Number of negative rubella tests	Results pending
2016	315	00	223	03	183	180	42
2017	429	00	332	00	01	129	202
2018	1,114	00	678	12	11	119	536
2019*	329	00	329	00	00	07	322

* Data from the 1st to the 49th epidemiological week

NB: Only measles-negative cases will be tested for rubella.

From 2016 to 2018 Benin recorded 12 positive cases of rubella distributed in 10 communes, which are: Abomey-Calavi, Adjarra, Cotonou, Karimama, Ouaké, Ouidah, Pèrèrè, Savè; Tchaourou and Zangnanado.
The country is working to establish sentinel site surveillance for congenital rubella syndrome. The sites have been identified and the implementation plan is being finalized.

- **Yellow Fever Surveillance**

Table N°4 *: Indicators of yellow fever surveillance in Benin in 2018*

Departments	Notified cases	Communes that have notified suspicious cases		Deadline for transmission ≤ 3 days		% cases taken
		No.	%	No. of cases	%	
Alibori	6	3	50	6	100	100
Atacora	23	9	100	23	100	100
Atlantic	14	2	25	13	93	100
Borgou	11	8	100	11	100	100
Collines	4	4	67	3	75	100
Couffo	8	4	67	8	100	100
Donga	32	3	75	32	100	100
Littoral	31	1	100	30	97	100
Mono	8	3	50	7	88	100
Ouémé	10	5	56	10	100	100
Plateau	11	4	80	11	100	100
Zou	3	2	22	3	100	100
Benin	**161**	**48**	**62**	**157**	**98**	**100**

The proportion of municipalities reporting a suspicious case still needs to be improved. No suspected cases of yellow fever were reported during the period. The last outbreak was in 1996. However, particular attention must be paid to surveillance of this disease given the regional epidemic context and the country's risk analysis, which shows that some departments are at risk.

- **Surveillance for other vaccine-preventable diseases (Rotavirus Diarrhoea, Meningitis, Maternal and Neonatal Tetanus).**

Surveillance of Rotavirus diarrhoea in Benin has been carried out in sentinel sites since December 2012. The proportion of Rotavirus-related diarrhoea cases in children under five years of age has ranged from 28% to 59% since the beginning of this surveillance. Commonly encountered Rotavirus serotypes are G and P with a predominance of the G1P8 combination.

Since 2010, neonatal tetanus has been eliminated. However, the case-by-case monitoring system has some difficulties. Not all reported cases are documented
With the use of the MenAfriVac vaccine in a preventive campaign in 2012, the extent of the disease has been significantly reduced. Since this preventive campaign, only one case of meningococcal meningitis A has been confirmed in 2016. The predominance of germs is now marked by Streptococcus pneumoniae, Meningococcus types W135, X, C and the. The country conducts sentinel site surveillance for bacterial meningitis (streptococcus pneumoniae).

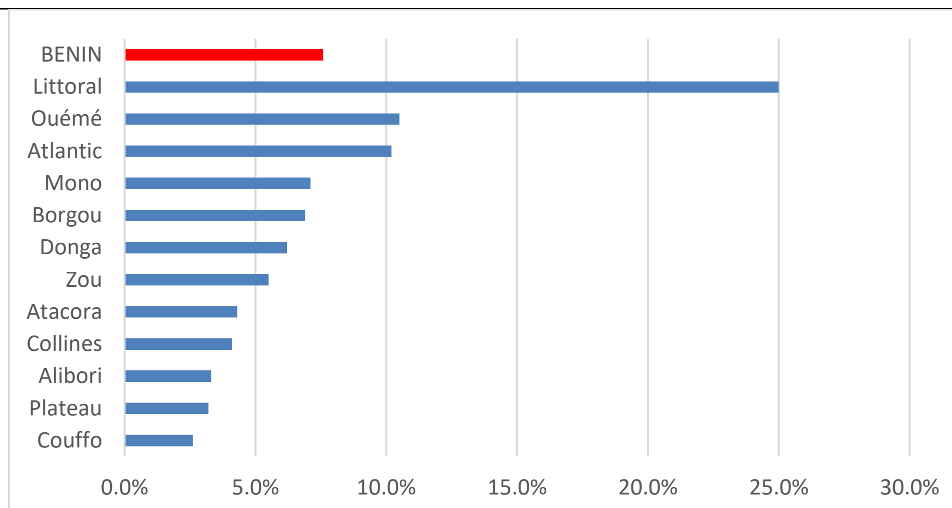
- **AEFI Monitoring**

The number of AEFI cases reported in the Joint Report (JRF) is 29, including 01 serious in 2017 and 52 in 2018, including 18 serious. The threshold of 10 cases per 100,000 surviving infants has thus been reached thanks to the system put in place. Indeed, an expert committee was created and formed on causal analysis. Similarly, monitoring focal points have been trained and equipped at all levels for reporting, system management and investigation of serious cases. For the specific case of the RR campaign of March 2019, the notification rate and the number of serious notified cases in relation to the total number of cases recorded reflect under-notification. While the expert causal analysis report noted that the reported deaths were more likely to have been the result of a delay in treatment. This indicates a focus on early reporting, notification and management of cases.
The MAPI monitoring system put in place made it possible to respond to the crisis experienced during the RR campaign in March 2019. However, the occurrences revealed the efforts required to maintain and improve it so that it can be used for routine immunisation and future SIAs.

4.2. Key drivers of sustainable coverage and equity

Health personnel

In Benin, vaccination services are offered through 769 public and private health centres out of 904 registered (85%). These services are integrated into care activities and there are no staff dedicated exclusively to immunisation, as this task is often entrusted to health care assistants by the Nurses.
Inadequate human resources for health remains a major concern. Indeed, according to the SARA 2018 survey, the density of key health professionals in 2017 was 7.6 per 10,000 inhabitants, compared to 7.8 in 2014. All of the country's departments except Littoral are still far from the target of 25 health professionals per 10,000 recommended by WHO (Graph N°3).
Staff capacity building needs for immunisation are not sufficiently covered. Indeed, according to the SARA 2018 survey, only 62% of establishments had staff trained on the EPI against 60% in 2015, with a variation from 12% (Ouémé) to 87% (Alibori).



Source: SARA 2018

***Graph N°4**: Density of health personnel per 10 000 inhabitants per department in 2017 according to the SARA 2018 survey.*

Supply chain

The country has planned the acquisition of 704 cold chain equipment over the period 2018-2020 through CCEOP. As of December 31 2019, 267 pieces of equipment have been announced for delivery out of the 484 planned for Year 1, the rest being delivered.

The maintenance plan is available but is not yet fully operational. Indeed, the maintenance management tools have not yet been finalized, preventive maintenance tasks and supervision missions remain insufficient.

The last Effective Vaccine Management (EVM) evaluation was conducted in September 2017 with technical support from WHO. This assessment revealed relatively poor performance across all components and at all levels of the supply chain. Only one criterion (E4: buildings, equipment and transport) out of the nine achieved an average score of 80% for the country as a whole, as shown in the table below.

***Table N°5** : Results of the Effective Vaccine Management Assessment of September 2017*

Criteria/Level	Average	National	Department	Sanitary zones	Health Centres
E1: Arrival/Receipt of vaccine	46%	46%			
E2: Temperature	68%	76%	64%	72%	64%
E3: Storage capacity	72%	100%	72%	80%	62%
E4: Buildings, equipment, transport	83%	77%	74%	80%	88%
E5: Maintenance	60%	75%	48%	71%	53%
E6: Stock management	57%	81%	69%	59%	51%
E7: Distribution	45%	47%	57%	33%	53%
E8: Vaccine management	76%	85%	85%	78%	71%
E9: GIS, support functions	58%	62%	65%	61%	53%

In general, progress between the 2012 and 2017 EVM assessments has been timid. While components E3 (Storage capacity) and E4 (Buildings, equipment and transport) have improved significantly, components E2 (Temperature), E5 (Maintenance), E6 (Stock management) and E8 (Vaccine management) have remained stationary. In contrast, components E1 (vaccine arrival/reception), E7 (distribution) and E9 (MIS and support functions) have regressed.

However, there has been a marked improvement in the scores of the criteria for health zones implementing DSLO compared to those not applying this distribution system.

The analysis of these results identified the strengths and weaknesses of the supply chain system and developed a budgeted improvement plan of 69 activities over a 5-year period. This plan describes the activities to be implemented to correct the shortcomings identified in 6 areas: system design, cold chain equipment, temperature control, distribution, human resources and data management.

At the end of 2018, the implementation point of the plan is as follows:

- At the central level: no activities have been completed, 20% of the activities are being implemented and 80% of the activities have not started.
- At departmental level: 3% of activities have been completed, 3% of activities are being implemented and 94% of activities have not started.
- At the level of the health zones and communes: no activities have been completed, 33% of the activities are being implemented and 67% of the activities have not started.
- At the level of the health facilities: no activities have been completed, 50% of the activities are being implemented and 50% of the activities have not started.

The main reason for the weak implementation of these activities is the delay in the validation of PITA activities on HSS.

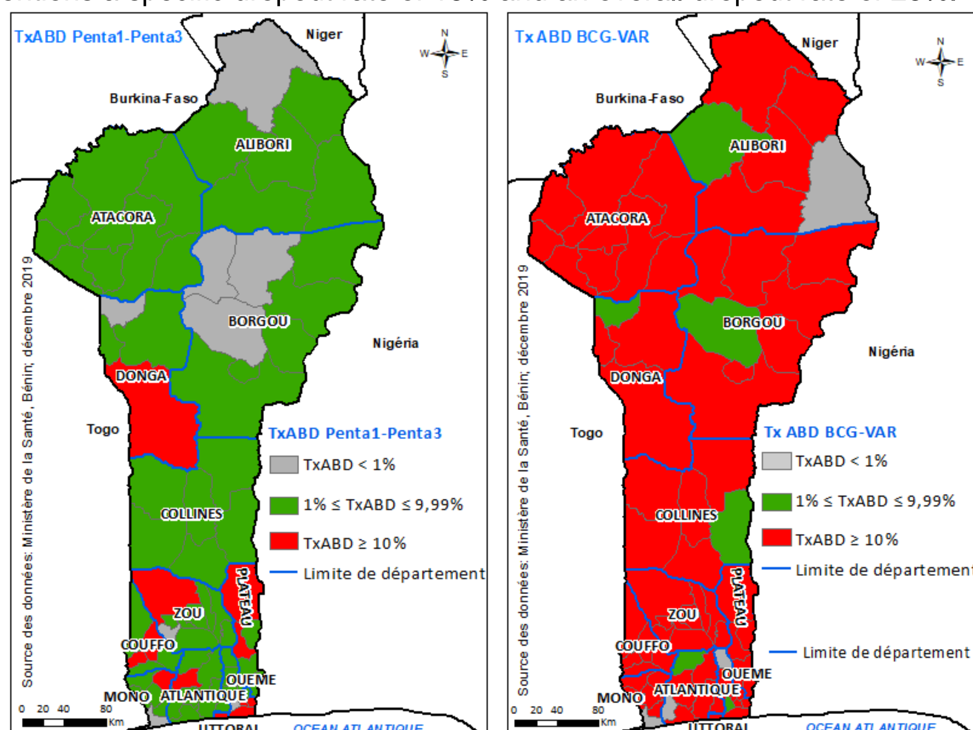
Steps are being taken by the country to accelerate the implementation of this plan. First, the activities recorded in this report have been incorporated into the ongoing cMYP 2019-2023. The plan then serves as a guide for annual planning of activities and as an advocacy tool for resource mobilization among partners. In 2019, as part of the implementation of this plan, it is planned that:

- Standard operating procedures for logistics management are implemented throughout the country,
- The optimized logistics system is extended to 5 new health zones in the country,
- Supply chain actors are trained on the filling of logistics management tools.

The country also plans to conduct a self-assessment of the EVM during the year 2020 to evaluate progress and adjust the current improvement plan.

Service Delivery and Demand Generation

In 2017, according to administrative data, 20% of municipalities have a Penta1 and Penta 3 drop-out rate of more than 10% compared to 13% in 2018. The same trend is noted in the results of EDS V, which mentions a specific dropout rate of 13% and an overall dropout rate of 23%.



Map N°3 *: Dropout rate between Penta1 and Penta3 and between BCG and Measles in 2018 in Benin*

The supply and demand shortfalls listed above are among the reasons for the high dropout rates. To improve the demand for immunisation within communities, the following strategies have been identified and are being implemented. It's about:

- the Decentralized Immunisation Initiative (DVI),
- the Community register for individual monitoring,
- the new child health record with the updated immunisation schedule,
- the Strategic Communications Plan (SCP).

Gender-related barriers faced by caregivers

There are no gender-related barriers to immunisation in Benin. The immunisation system is not yet sufficiently adapted to the constraints of mothers of children. There are no barriers or obstacles related to the gender of staff providing immunisation.

Data/information system

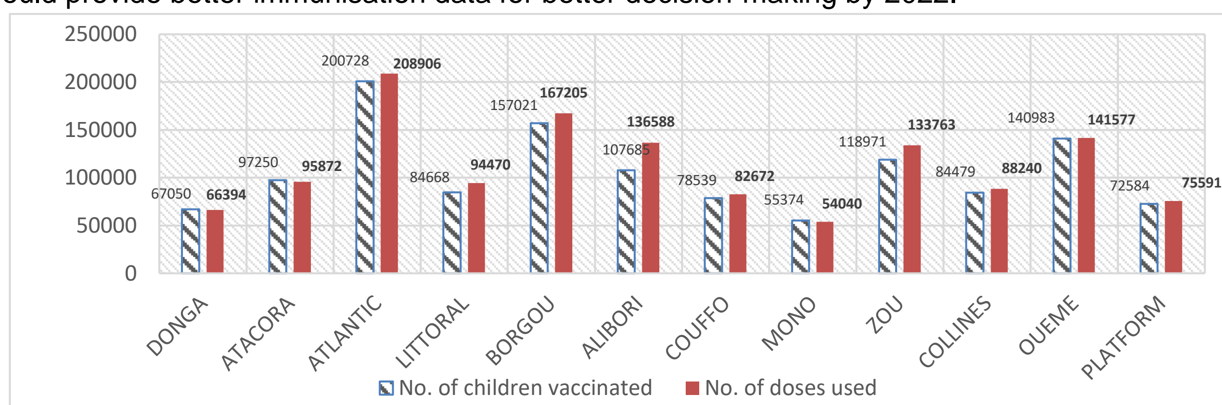
EPI data are collected at the level of all health structures involved in immunisation using the SNIGS supports. This data is fed back through online data entry at the level of all health zones (DHIS2), and data entry at the departmental level in the District Vaccine Data Management Tool (DVD-MT); this parallel data entry system generates data discrepancies.

Data quality is one of the main challenges facing Benin's EPI. While the completeness of administrative data is generally satisfactory (over 95%), the same cannot be said for the promptness, which remains low in some departments of the country.

In addition, Benin faces a real problem in estimating target populations for immunisation, which are most often underestimated; this contributes to the super rates. For example, for the Penta3 in 2018, administrative coverage is 108% while the WHO-UNICEF estimates and the coverage resulting from DHS V are 76% and 73% respectively; this corresponds to a gap of more than 20%, which seems constant over the last ten years (Graph N°2).

Moreover, triangulation of these data shows that there is a discrepancy between the doses administered of several antigens and the number of children vaccinated reported (Graph N°5).

In response to these data quality concerns, the ANV-SSP and the Department's Programming and Forecasting Branch have developed a Data Quality Improvement Plan (DQIP). Its implementation would provide better immunisation data for better decision-making by 2022.



Graph N°5*: Number of doses of Penta compared to the number of children vaccinated by department in 2018 in Benin*

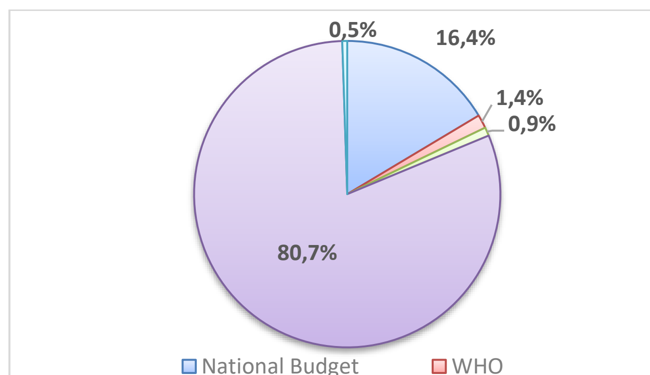
Leadership, management and coordination

The immunisation program is managed by the National Agency for Immunisation and Primary Health Care (ANV-SSP) with a Board of Directors that meets at least twice a year as its governance structure. This role is ensured at the intermediate level by the EPI technical coordination groups, and at the peripheral level by the Health Zone Management Teams. There are other technical

committees at the central level, apart from the ICC, namely: the National Committee of Experts for the Eradication of Poliomyelitis (CNEP), the National Certification Committee (CNC), the National Advisory Committee for Vaccination and Vaccines (CNCV-Benin) and the MAPI Management Committee. In addition, the ANV-SSP collaborates with all the Technical Departments of the Ministry of Health. Let us recall here that a new Agency (ANSSP) replaces the ANV-SSP which continues to manage the program while waiting for the new structure.
It should be noted that the various bodies mentioned above hold their sessions regularly. However, there is a low level of participation of the structures involved. Innovative mechanisms for mobilising the various players will have to be put in place to ensure the effective functioning of these bodies.
Generally speaking, the management and coordination of the programme can be summed up in the weak functionality of the accountability mechanisms and the weak exploitation of the results of supervision and monitoring at all levels (departmental central and peripheral).

4.3. Immunisation financing

In 2018, 81% of the funding of the ANV-SSP was provided by the Gavi Alliance, 16% by the country, and 3% by the other partners (WHO, Unicef and AMP). Gavi's significant contribution is essentially devoted to the purchase of vaccines, which alone accounts for 75%. It should be noted that these data do not take into account the financing of immunisation activities at the intermediate and operational levels, and the valuation of government investments. Financial arrangements are made on the basis of the information available in the cMYP, including funding from partners in a bottom-up planning approach coordinated by the DPP.



Source: Self-Assessment Report 2018

***Graph N°4**: Contribution of the different sources to the financing of the ANV-SSP in 2018*

With regard to the subsidies allocated to the ANV-SSP, transfer credits are opened on a quarterly basis; however, this transfer sometimes experiences delays that negatively impact the correct and timely execution of the PITA. Any mobilization of funds is subject to prior justification of funds previously received. Accordingly, managers are required to prepare and certify financial statements for the past fiscal year.

The constraints to the implementation of immunisation activities are essentially linked to the low allocation of internal budgetary resources within the ANV-SSP / MOH. Nevertheless, a budgetary regulation mechanism allows the Government to authorize the execution of the programme budget in excess of the appropriation. Delays in the payment of vaccine co-financing and non-compliance with the pre-financing mechanism remain major concerns related to programme performance.

The other bottlenecks are related to:

- the non-integration of EPI microplans in departmental work plans;
- the delay in the finalization and adoption of the PITA by the ANV-SSP;
- the delay in the justification of funds transferred to the deconcentrated and decentralized level;
- failure by stakeholders to comply with the timetable for the implementation of activities;
- the poor preparation for the transition from the management of the PRPSS to the ANV-SSP.

5. PERFORMANCE OF GAVI SUPPORT

5.1. Performance of Gavi HSS support

The year 2018 was marked by the transfer of the management of the grant from the Health System Performance Strengthening Program Management Unit (HSP/PRPSSU) to the ANV-SSP, which took place in mid-June.

In addition, the Programme Capacity Assessment (PCA) conducted in 2017, which resulted in the Grant Management Requirements (GMR in January 2018), recommended the establishment of a 24-month transitional mechanism through UNICEF, pending the strengthening of the management capacity of the ANV-SSP.

The poor preparation for the transition of the management of the PRPSS to the ANV-SSP resulted in the unavailability of a validated budget for the implementation of activities in 2018. It should be noted that as the RBF is scheduled to be terminated in June 2017, the planned funds should be reallocated to hedging and equity activities.

Four notices of no objection have been obtained from the Gavi Secretariat for training (STEP and LOGIVAC) and PRPSS closing expenses (payment of pending invoices).

Objective 1	
Objective of the HSS grant (as per the HSS proposal or PSR)	Strengthen the coverage and use of quality health services and immunisation in particular in two targeted health zones through the implementation of the RBF.
Priority geographies / population groups or constraints to C&E addressed by the objective	This objective targeted two health zones (Tchaourou and Sakété-Ifangni) selected both on the basis of weak health performance and complementarity with the support of other TFPs to the RBF.
% activities conducted / budget utilisation	0%
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	No activities were carried out because the action plan and detailed budget were not submitted on time and approved.
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **changes in technical assistance**[5]	• Deployment of the strategy "Reaching every child in Benin: Towards the elimination of the causes of inequity" in 49 priority communes selected according to composite criteria (Penta 3 coverage, Absolute number of children not covered by Measles 1st dose, Absolute number of Zero doses children, High dropout rate). Additional criteria for measles incidence were applied. GAVI funds will be directed to the 34 priority communes not covered by Unicef, which entirely finances 15 communes in the departments of Alibori, Borgou and Zou.

	• Support for the implementation of the RED/REC micro-plans refocused on equity in 49 communes. • Implementation of the VaxyRappel initiative in the Zogbodomey-Bohicon-Za Kpota pilot SZ • Development and implementation of the urban immunisation strategy • Support at the departmental level for the organization of quarterly supervision of the actors in the health zones on EPI management and surveillance (diseases under surveillance and MAPI). • Extension of the implementation of the IVD in 5 priority communes Tchaourou, Dassa, Glazoué, Sakété, Ifangni • Strengthening of the mechanism for detection, notification and management of MAPI • Printing of 500,000 copies of the health booklet (initial support to municipalities) • Organize targeted supervision missions from the national level to the departmental and decentralized levels. • Evaluation / Mini-survey of the deployment of the ACE Benin Equity approach • Development of the strategy for the "best communities" and model mothers of the year 2020 operation
Objective 2 :	
Objective of the HSS grant (as per the HSS proposal or PSR)	Strengthen cold chain capacity at the intermediate level and in the two targeted health zones as well as the effective management of vaccines.
Priority geographies / population groups or constraints to C&E addressed by the objective	This objective aims to remove the bottlenecks related to the insufficient cold chain capacity at the departmental and operational levels to conserve all EPI vaccines, as well as the shortcomings in the effective management of vaccines.
% activities conducted / budget utilisation	20%
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	• Training of 8 executives at the central level, 12 vaccine warehouse managers at the intermediate level and 16 EPI management managers at the peripheral level on strategic management and leadership (STEP training) • Strengthening the capacities of 2 ANV executives and 10 actors in charge of EPI logistics management at the intermediate and peripheral levels in immunisation logistics (short training)
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **changes in technical assistance**[5]	• Finalization of construction work and cold chain equipment purchases in progress • CCEOP co-investment payment: Year 1 already paid in 2019 • Purchase of additional FCEs (as the Year 2 OEAC is not yet funded) • • Development of tools for the maintenance of cold chain equipment • Strengthening the capacities of the actors on the maintenance of cold chain equipment • Annual physical inventory of ECDFs and rolling stock (in collaboration with the DAF and the DIEM of the MS) • Acquisition of rolling stock, computer equipment on the basis of the inventory • Extension of the optimized logistics system • Implementation of standard operating procedures for the GEV • GEV self-assessment
Objective 3 :	
Objective of the HSS grant (as per the HSS proposal or PSR)	Strengthen the NISGS and the use of data for monitoring and evaluation and strategic planning.

Priority geographies / population groups or constraints to C&E addressed by the objective	This objective aims to remove bottlenecks related to the poor performance of the health information system and the under-use of data for monitoring and evaluation and strategic planning.
% activities conducted / budget utilisation	0% i.e. no activities or expenditures carried out in 2018 to help remove bottlenecks related to the poor performance of the health information system and the under-use of data for monitoring and evaluation and strategic planning.
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	None
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **changes in technical assistance**[5]	• Establishment of a JWG on Monitoring and Evaluation (PM) • Organization of a harmonization of targets based on the results of counts carried out by other programs (NNLP, NMTNP, ...) PM • Elaboration of a georeferenced prospective health map • Finalization of the DHIS 2 transition process • Continuation with eLMIS as a computerized logistics information system (SIIL) • Organization of quarterly reviews in the communes, with management letters to the best agents. • Quarterly validation of vaccination and surveillance data • Organisation of quality control meetings (monitoring) of immunisation data, surveillance and implementation of the EPI/Equity microplans (quarterly at the health zone level and biannually at the departmental level) • Annual data review (Desk revue) • Organization of the semi-annual DQS and annual LQAS
Objective 4 :	
Objective of the HSS grant (as per the HSS proposal or PSR)	Program Management
Priority geographies / population groups or constraints to C&E addressed by the objective	NA
% activities conducted / budget utilisation	0%
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	None
Major activities planned for upcoming period	• Organization of monthly CFIC Technical Group meetings and teleconferences • Elaboration of the JSP integrating all the needs not covered by CCEOP and the TCA and taking into account the submissions foreseen in the current cMYP.

[5] 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 extend known to date - the type of TA required (staff, consultants, training, etc.), the provider of TA (core/expanded partner) the quantity/duration required, modality (embedded; sub-national; coaching; etc.), and any timeframes/deadlines. JA teams are reminded to both look back (TA which was not completed/successful in the past) and forward (planned vaccine introductions, campaigns, major upcoming HSS activities, etc.) when specifying TA priorities for the coming year. The TA menu of support is available as reference guide.

(mention significant changes / budget reallocations and associated **changes in technical assistance**[6]	• Advocacy with the authorities for the provision of health workers • Contractualization of the supply of vaccination services with private health structures • Establishment and monitoring of a national directory of immunizing agents • Capacity building of human resources in health facilities in priority communes (peer coaching, tutoring, mentoring) • Recruitment / equipment / transport of 3 doctors EPI support for priority departments • Operating costs at the ANV (internet connection, breaks for working sessions, ...)

5.2. Performance of vaccine support

The country annually renews its request for support for routine EPI support for new and under-used vaccines. Currently the country has in its pipeline as new vaccines, PCV 13, Penta, MR and Rota.
With regard to under-used vaccines, the country has Gavi's support for YF and IPV.
The major problem observed in the management of these vaccines is essentially the stock shortage at the central level with repercussions at the peripheral level. These ruptures are linked to both exogenous and endogenous causes.
The exogenous causes are essentially the tension observed at the international level on IPV and YF; the IPV is particularly aware of a situation of non-compliance with the procurement plan by the Unicef procurement division.
At the level of endogenous causes, the reasons for rupture can be summed up as follows:
Delay in the payment of co-financing leading to a delay in supply:
Weak control of targets in certain localities resulting in consumption in excess of provisions.
Shortcomings in the management of vaccines by actors at the peripheral level.
As a plan to remedy all these shortcomings, the country will have to:

- Securing financing for vaccine procurement;
- Review the strategy for identifying EPI targets and the quantification of vaccine needs
- To continue with the reinforcement of the capacity of the actors on vaccine management.

In December 2018, Benin, with technical and financial support from GAVI, WHO and UNICEF, introduced nationwide routine immunisation with measles and rubella (RR) vaccine in 9-month-old children. The activities carried out in the context of this introduction are:

- Elaboration of the plan for the introduction of the RR vaccine in the routine EPI
- Organization of a workshop to adapt the RR vaccine introduction modules and review the EPI management tools.
- Joint supervision (national and departmental levels) of health workers on the introduction of the MR vaccine into the routine EPI,

In addition, in April 2018, the country switched from the single-dose to the multi-dose form of PCV13 vaccine.
The MR vaccine was successfully introduced on December 3, 2018 into routine in all health facilities in Benin and good acceptance of the vaccine by mothers/care givers. No cases of serious post-vaccination adverse events (AEFI) have been reported. The implementation of the MR campaign in March 2019, on the other hand, was marked by the notification of cases of AEFI, of which about

[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 extend known to date - the type of TA required (staff, consultants, training, etc.), the provider of TA (core/expanded partner) the quantity/duration required, modality (embedded; sub-national; coaching; etc.), and any timeframes/deadlines. JA teams are reminded to both look back (TA which was not completed/successful in the past) and forward (planned vaccine introductions, campaigns, major upcoming HSS activities, etc.) when specifying TA priorities for the coming year. The TA menu of support is available as reference guide.

thirty were classified as serious, with 09 deaths, which were the cause of increased reluctance by the media. A crisis committee and the AEFI committee provided a response to the crisis.

5.3. Performance of the support to the CCEOP of Gavi

In November 2017, the country was approved for Gavi's support for the renewal of cold chain equipment (CCEOP). In this project, it is planned to purchase 704 pieces of chain equipment between 2018 and 2020 to replace the cold chain equipment stock, which is 80% obsolete and unsuitable.

With CCEOP procedures, the first equipment in the chain will be delivered in 2019.

5.4. Financial management performance

The GAVI Benin HSS2 grant approved for US$ 8,374,702.27 for the five-year period 2014-2018 complemented the contribution of the Government, the other partners (CTB/Enabel, WB and FM) in scaling up the RBF at the national level and also the support of the other EPI partners in achieving the immunisation coverage and equity objectives. A budget of US$ 1,587,656.96 was foreseen for the year 2018 to boost the activities of the PRPSS related to the objectives of Gavi, namely: Supply and commissioning of two positive cold chambers in the departments, in this case Mono-Couffo, which is sorely lacking, granting of FBR credit for the two health zones of Gavi based on performance, and consequently organizing training sessions to ensure good performance of the central and decentralized structures (EEZS, DDS, IGM, ANV-SSP, DNSP) that accompany the two Health Zones SAKIF and Tchaourou in their EPI activities. However, the abrupt cessation of PRPSS activities, which was forced to close on 31 December 2017, did not allow for the desired absorption of the cash grants put in place by Gavi Alliance. It should be noted that the expenses incurred amounting to US$ 211,181.67, i.e. 13.3%, to cover the costs of training on immunisation logistics, at the intermediate and peripheral levels, on the construction of cold room installation premises in Lokossa/Parakou and to pay the audit fees for the closing of the accounts of Gavi.

Nevertheless, within the framework of objective N°2 of HSS2, the ANV-SSP prompted the acquisition of Cold Chain Equipment and two 4X4Toyota vehicles for US$ 136,721.92 by Unicef technical services. This equipment has actually been received by the Agency. Thus, Gavi has contributed enormously to the improvement of the cold chain and of the entire vaccine logistics through, in particular, support for the deployment of the optimized logistics system at the operational level and the acquisition/installation of cold rooms at the departmental and central levels.

As for objective N°3, the support focused on the improvement of the health information system, i.e., the integration of the sub-systems in the DHIS2, the development of plans and strategic documents as well as the organization of surveys, supervision, validations and other activities to improve the quality of the data collected.
The overall absorption rate in 2018 is 22%, taking into account the acquisitions made by Unicef and paid directly by Gavi.

Moreover, at the end of the closing of the PRPSS accounts during August, the net balance of 951,949,099 FCFA, i.e. 1,903,898 USD was transferred from the Bank Of Africa account "N° 07262280009" entitled BENIN/GAVI HSS PROGRAMME to the account of the ANV-GAVI domiciled at Eco Bank.

The financial reports due for the financial year 2018 and as at 30 June 2019 were submitted to the Gavi Alliance secretariat together with the related bank statements. The audit reports due after the closure of the PRPSS 31-12-2017, i.e. for the period 2018-2019, were not submitted due to the poor mastery of Gavi procedures by the ANV-SSP.

The provision of a senior accountant by Unicef and financed by the 2018 and 2019 CAW made it possible to set up a financial and accounting management system using the PERFECTO software and to process financial information on Gavi and Unicef (income and expenditure of the CARR campaign and those related to the day-to-day running of the Agency). It is desirable that this new management system in place should be secured by setting limits on access to the system by accounting staff trained in its use with appropriate computer equipment. This new accounting system has a positive impact on the publication of financial statements by TFPs and also consolidated.

Two unaudited HSS2 financial reports covering the period 2014-2018 and the 1st semester of 2019 respectively were submitted on 6 January 2020 on the country portal. Arrangements are being made for the submission of unaudited financial reports for IPV, HPV, MR and Rota grants by the end of the 1st semester of 2020.
An external audit was carried out in 2019 by Unicef on the CARR campaign expenditures executed by the ANV-SSP and the operational levels (Departmental Health Directorates -DDS). This audit report on the Gavi grants managed by ANV-SSP and other UNICEF recipients is still pending at the Agency.

5.5. Transition plan monitoring

Not applicable as the country is not yet in transition.

5.6. Technical Assistance (TA) (Progress on ongoing Targeted Country Assistance Plan)

The summary of the implementation of activities on the TCA 2019 is as follows:

Activities	State of implementation	Comments
WHO		
Support Benin in the preparation and submission process FPP 2019 - 2023	Not realized	Reported
Integration of DVD-MT data into the DHIS2 database and data quality analysis and reporting tools. Training of departmental and municipal EPI managers in the use of DHIS2	Realized	The stakeholders are to be trained to use the tool
Preparation of the Men A submission and the second dose of Measles (MCV2)	Not realized	Process initiated but not completed
Measles-Rubella Campaign Evaluation Survey	Fully realized	Expected final report
Hold meetings to monitor PBM/Rotavirus surveillance indicators and build the capacity of stakeholders, then evaluate the Rotavirus, PBM sentinel sites and support the evaluation of the impact of the introduction of the Rotavirus vaccine	In progress	
Provide technical assistance in coordinating the implementation of the external review of the EPI.	Not realized	Cancelled
CDC Foundation		
Until 2018, Benin did not have laboratory confirmation capacity for bacterial meningitis pathogens. There is a need to strengthen the laboratory capacity for meningitis diagnostics at national and high-risk peripheral health centers (e.g., sites that contribute to IDSR), including training of technical personnel in bacteriology and reinforcing testing capacity. Specifically, CDC/DBD will: 1)	Ongoing	Start of implementation with installation of technical equipment/CDC

Reinforce culture capacity for meningitis testing at regional laboratories in high-risk areas, 2) Provide training meningitis specimen testing to laboratorians at regional laboratories; 3) Perform advanced molecular identification of the strains from clinical specimen and cultures to inform immunisation strategies		
UNICEF		
1. Technical support for the implementation of the action plan for the relaunch of routine immunisation for which UNICEF has the lead through micro-planning, monitoring of the implementation of immunisation sessions, the availability of vaccines and other inputs as well as the functionality of the CDF, monitoring of dashboards, regular analysis of performance; identification of the main bottlenecks; support for the identification of corrective actions for the removal of bottlenecks. 2. Technical support for the implementation of the plan for the elimination of measles from neonatal tetanus, the control of yellow fever, the eradication of poliomyelitis including the introduction of new vaccines	Realized	
Support for the implementation of the Optimized Logistics System in 3 new health zones in Borgou Support for the implementation of CCEOP at the national level (the country is aiming to achieve full coverage of the country by the SLO in 2019)	Partially achieved	
Support for monitoring and evaluation at the level of the National Immunisation Agency	Realized	
Support for the procurement process at the level of the National Immunisation Agency	Not realized	
Financial management support to the National Immunisation Agency	Realized	

6. UPDATE OF THE RESULTS OF THE PREVIOUS JOINT EVALUATION

Prioritized actions from previous Joint Appraisal	Current Status
NA NA	
Additional significant IRC/HLRP recommendations (if any)	**Current Status**
Joint Appraisal Report, or equivalent. This report will provide detailed information on progress towards achieving the milestones and targets against the baseline data for the indicators identified in the proposal. It will also include a financial report on the use of Gavi support for HSS (which may include a joint report from a pooled funding mechanism, if appropriate) and the use made of performance-related payments, which have been approved by the health sector (HSCC) or its equivalent.	**Deadline for receipt:** After the joint appraisal and maximum 1 month before the High Level Panel (HLRP) or Directors' Review (MD review) **Current status:** The 2018 Joint Appraisal was planned to be integrated into the harmonization workshop and the development of the new HSS application (Program Support Rationale). Given the context described above, the JA was held in November 2019.
Unaudited **interim financial reports.** Unless the Aide Memoire between Gavi and the country indicates otherwise, the country will be required to submit unaudited interim financial reports on	**Deadline for receipt:** April 30, 2018 July 31, 2018 October 30, 2018

HSS financial support no later than 30 days at the end of each 3 months of the period under review. Failure to submit reports on time could affect future funding.	January 31, 2018 **Current status:** Financial report for 2014-2018 and unaudited financial report for 1 semester 2019 has been submitted on the portal on January 6, 2020.

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

Grants	Key Activities	Comments
HSS2	- Extension of the Reach Every Child approach in Benin and strengthening of performance monitoring - Strengthening the cold chain and vaccine management - Improving data for decision making	- Approach includes 10 RED/REC components
CCEOP Year 1	Installation of ECFs and follow-up Implementation of the maintenance plan	
MenA: introduction and Campaign	- Introduction of the MenA vaccine followed 3 months later by the campaign	The country would like to conduct the campaign in November 2020.
Yellow Fever Diagnostic	Support in diagnostic materials for the National Reference Laboratory	
Routine HPV Submission	Scheduled for September 8	
MR 2 Submission	Scheduled for September 8	

Key finding / Action 1	Insufficient well-trained and motivated health HRs
Current response	- Organization of training sessions on immunisation and surveillance of VVMs for the benefit of agents at the operational level. - Establishment of a mechanism to motivate the agents of the most efficient health centres in terms of immunisation in collaboration with the EPI Foundation (congratulation letter, donation of equipment, etc.).
Agreed country actions	- Establishment of a directory of immunizing agents including private individuals and retirees. - Training/retraining/supervision of vaccinators - Establishment of an accountability framework - Development of the strategy for the "best communities" and model mothers of the year 2020 operation
Expected outputs/ results	- 75% of health workers trained - 70% supervision carried out at all levels - Accountability framework developed and implemented - Identification of a "best commune" by department and a "model mother" by district.
Associated timeline	2020-2021
Required resources / support and TA	WHO and UNICEF support for staff training MPA support for the implementation of the agent directory and accountability framework Support from the ENP Foundation for the implementation of the "Better City" and "Model Mother" Strategy
Key finding / Action 2	Relatively poor performance in implementing the components of the GEV
Current response	- Dynamisation of the technical group for logistics coordination and setting up of the CCEOP management team (PMT) - Rehabilitation and installation of a cold room on Gavi financing

	- Acquisition and installation of 604 ECFs, including 484 from CCEOP and 120 financed by OPC, RR campaign and UNICEF. - Development and commencement of implementation of standard operating procedures - Extension of the push model (DSLO) of vaccine distribution - Training of 2 managers in vaccine logistics and 20 agents on strategic management and leadership (STEP)
Agreed country actions	- Finalization of construction work and cold chain equipment purchases in progress - Purchase of additional FCEs (as the Year 2 OEAC is not yet funded) - Development of tools for the maintenance of cold chain equipment - Strengthening the capacities of the actors on the maintenance of cold chain equipment - Annual physical inventory of ECFs and rolling stock (in collaboration with the DAF and the DIEM of the MS) - Acquisition of rolling stock, computer equipment on the basis of the inventory - Extension of the optimized logistics system - Implementation of standard operating procedures for the GEV - GEV self-assessment
Expected outputs/ results	- All components of the GEV around 70-80%.
Associated timeline	2020 - 2021
Required resources / support and TA	UNICEF and MPA support
Key finding / Action 3	Adequate service supply and demand generation insufficient
Current response	- Deployment of the RED/REC approach with recalculation of targets, identification of unmet child gaps, development and implementation of detailed micro-plans and performance monitoring. - Decentralized Immunisation Initiative making the town halls in 5 communes responsible for their actions - Elaboration and start of implementation of the strategic communication plan - Involvement of Platform CSOs in community activities
Agreed country actions	- Deployment of the strategy "Reaching every child in Benin: towards the elimination of the causes of inequity" in 49 priority communes selected according to composite criteria - Support for the implementation of the RED/REC micro-plans refocused on equity in 49 communes. - Implementation of the VaxyRappel initiative in the Zogbodomey-Bohicon-Za Kpota pilot SZ - Development and implementation of the urban immunisation strategy - Contractualization of the supply of vaccination services with private health structures - Support at the departmental level for the organization of quarterly supervision of the actors in the health zones on EPI management and surveillance (diseases under surveillance and MAPI). - Extension of the implementation of the IVD in 5 priority communes Tchaourou, Dassa, Glazoué, Sakété, Ifangni - Strengthening of the mechanism for detection, notification and management of MAPI - Printing of 500,000 copies of the health booklet (initial support to municipalities) - Organize targeted supervision missions from the national level to the departmental and decentralized levels.
Expected outputs / results	- Number of children receiving Penta3 greater than 351,629 - Penta3 immunisation coverage in the 49 communes above 92% (confirmed by mini-surveys)

Associated timeline	2020- 2021
Required resources / support and TA	WHO, UNICEF, AMP and JSI
Key finding / Action 4	Unsatisfactory data quality
Current response	- Development and start of implementation of the data quality improvement plan - Transition of EPI data management from DVD-MT to DHIS2 - Weekly monitoring of the performance of municipalities
Agreed country actions	- Establishment of a TWG on Monitoring and Evaluation (PM) - Organization of a harmonization of targets based on the results of counts carried out by other programs (PNLP, PNLMTN, ...) PM - Elaboration of a georeferenced prospective health map - Finalization of the DHIS 2 transition process - Continuation with eLMIS as a computerized logistics information system (SIIL) - Organization of quarterly reviews in the communes, with management letters to the best agents. - Quarterly validation of vaccination and surveillance data - Organisation of quality control meetings (monitoring) of immunisation data, surveillance and implementation of the EPI/Equity microplans (quarterly at the health zone level and biannually at the departmental level) - Annual data review (Desk revue) - Organization of the semi-annual DQS and annual LQAS - Evaluation / Mini-survey of the deployment of the REC Benin Equity approach
Expected outputs / results	- Full data transition from DVD-MT to DHIS2 - Difference between administrative and survey data reduced to minus 10 points
Associated timeline	2020- 2021
Required resources / support and TA	WHO and University of Oslo support for transition to DHIS2 UNICEF support for weekly performance monitoring AMP support for the implementation of the data improvement plan
Key finding / Action 5	Leadership, management and coordination of the programme not yet optimal at all levels
Current response	- Revitalization of coordinating committees: ANV Board of Directors, ICC, Polio Committee, CNCV (NITAG) and AEFI Management Committee - Updating of the ANV-SSP organization chart with deployment of frameworks for the different missing services (procurement, monitoring and evaluation, ...). - Strengthening of the financial management system: procedures manual developed and validated by the Executive Board
Agreed country actions	- Organization of monthly ICC Technical Group meetings and teleconferences - Advocacy with the authorities for the provision of health workers - Establishment and monitoring of a national directory of immunizing agents - Capacity building of human resources in health facilities in priority communes (peer coaching, tutoring, mentoring) - Recruitment / equipment / transport of 3 doctors EPI support for priority departments
Expected Outputs/ results	- Annual PITA available at least 1 month in year n-1 and 80% implemented - Various functional committees and working groups with at least 80% of planned activities implemented - Establishment of an accountability framework
Associated timeline	2020-2021
Required resources / support and TA	- WHO and UNICEF support for strategic planning and monitoring - MPA for the establishment of an accountability framework
Key finding / Action 6	Dependence of the EPI on external funding
Current response	- Organization of the High-Level Roundtable for Immunisation Recovery and Financing October 2018

Agreed country actions	- Advocacy with the Ministry of Finance for an increase in the immunisation budget
Expected outputs / results	- EPI budget increase - Progressive pre-positioning of funds for vaccine procurement from UNICEF SD
Associated timeline	2020-2022
Required resources / support and TA	

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

The assessment process for the fourth joint assessment of Benin went through several stages, which can be presented as follows:

1) E-mail exchange with Gavi secretariat.

As part of the preparations for the assessment, there were exchanges of e-mails in which the Gavi secretariat sent several documents such as the guide and the outline of the 2019 report. In order to facilitate the production of report extracts from other countries, the following have been made available to us

2) Teleconference

It was organized between the Gavi secretariat and representatives of WHO, Unicef, AMP, ANV-SSP to exchange on TOR, agenda and comments on the shared draft EC report.

3) Preparation of the report

It was done in several phases, namely:

a) Presentation of the 2019 report guide and outline to all stakeholders
b) Establishment of a technical committee for drafting the report coordinated by the head of the monitoring-evaluation service.
c) Conducting several working sessions devoted to the drafting and validation of the various parts of the report, taking into account the guidelines in the guide made available to us in the country.
d) First draft of the report by the Drafting Committee set up
e) Discussion at the Inter Agency Coordinating Committee
f) Submission of the draft report to the joint evaluation
g) Organization of the workshop to finalize the report

9. ANNEX: No. 1: Compliance with Gavi reporting requirements

	Yes	No	Not applicable
Year-end Stock Level Report (due March 31)*		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 (draft)		
Campaign coverage surveys report	X (draft)		
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)	2014 Review		
Nationally representative coverage survey (conducted in the last five years)	SARA 2018)		
Annual progress update on the Effective Vaccine Management (EVM) Improvement Plan (EVMIP)	x		
(CCEOP): updated CCE inventory	X		
Post-Introduction Evaluation (PIE) (specify vaccines)			NA
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			
Cost analysis			
Adolescent Health Assessment Report			
Reporting by partners on TCA	X		

Annexe 2-recapitulatif recett

Annexe 3- matrice des risques ANV- SS

Annexe 4- liste des participants atelier E

Priorisation Communes BENIN_V