Joint appraisal report

When submitting this report, the country confirms that the grant performance framework has been reviewed as part of this joint appraisal. Performance against agreed metrics has been analysed, and explained where relevant.

Country	Mozambique
Reporting period	January – December 2015
Fiscal period	*January- December*
If the country reporting period deviates from the fiscal period, please provide a short explanation	*Not applicable*
Comprehensive Multi Year Plan (cMYP) duration	2015 – 2019
National Health Strategic Plan (NHSP) duration	2014 – 2019

1. SUMMARY OF RENEWAL REQUESTS

[These tables will be pre-populated by the Gavi Secretariat. If there are any changes to be made, this should be discussed as a group during the joint appraisal and flagged in the report – see the guidance document for more details]

Programme	Recommendation	Period	Target	Indicative amount paid by Country	Indicative amount paid by Gavi
NVS – *PCV in new presentation*	*Renewal*	*2017*	*1,091,841*	$ 391,000	$ 10,534,000
NVS pentavalent in existing presentation	*Renewal*	*2017*	*1,091,841*	$ 407,000	$ 2,121,500
NVS - MSD in existing presentation	*Renewal*	*2017*	*994,788*		$ 293,000
NVS – Rota in existing presentation	*Renewal*	*2017*	*1,011,389*	$ 235,500	$ 3,604,500
NVS- IPV in existing presentation	*Renewal*	*2017*	*812,449*		$ 1,940,500

Note: Gavi has already approved the 2nd year of HSS (US$4,739,840) which is not reported in this table

Indicate interest to introduce new vaccines or HSS with Gavi support*	Programme	Expected application year	Expected introduction year
	HPV national roll out	*Jan 2017*	*End 2017*
	CCEOP	*March 2017*	*2018*

**Not applicable for countries in final year of Gavi support*

2. COUNTRY CONTEXT *(maximum 1 page)*

This section does not need to be completed for joint appraisal update in interim years

[If relevant, comment only on any changes since the previous joint appraisal to key contextual factors that directly affect the performance of Gavi grants – see guidance document for more details]

The contextual factors that affected the performance of the Gavi grants in 2015 changed very little from those of the previous year. However the findings of the comprehensive program review, including RV PIE, surveillance, data quality which was led by WHO and conducted a couple of weeks before the JA, and the findings from the 2015 Annual Report of prospective Full Country Evaluation (FCE 2013 – 2016) helped to provide additional insight into these factors and allowed for their more in-depth understanding.

The active participation of the Ministry of Finance/Treasury, in the 2015 JA was pivotal to a better grasp of the financial management bottlenecks that caused prolonged delays in the disbursement of the HSS funds and other financial management bottlenecks. The mismatch between the increasing complexity of the immunization program and the required governance, HR and other structures to adequately meet the emerging demands remains a major contextual factor.

The main contextual factors are summarized under the following challenges:

1. Matching the increasing program complexity with required HR management capacity at all levels

While the complexity of the immunization program in Mozambique has increased over the last couple of years with the introduction of new life-saving vaccines, increasing donor investments in systems building and new global program goals and targets to be met, the program continues to operate in a context that is far from matching these needs:

- *Human resources.* PAV's HR plan may need updating in light of current needs and new competencies required to meet the emerging program demands, including the management capacity to manage large financial grants, that ensures close coordination with relevant stakeholders guided by adequately and functional constituted oversight bodies.

- *Financial management capacity.* The financial management constraints identified during the 2015 JA became even more pronounced during the process in 2016. It revealed that in addition to the inaccurate and absence of timely financial reporting due to the complex nature of MOF/MISAU procedures and PAV's limited financial management capacity, the bureaucracy around fund disbursement from the Ministry of Finance to line Ministries led to prolonged delay (more than 9 months) in release of the HSS funds from MoF to the MoH. As a consequence of this, there has been low fund utilization for this grant (11% at the end of June 2016). The JA made concrete recommendations for addressing this problem

- *Programme management capacity*

Several constraints in the national EPI limit the effectivity of programme management. While being relatively well staffed (13 people at central level) and facing relatively little turnover, the roles and responsibilities (TORs) of staff members are not well defined and implemented. This leads to non-clarity around roles, miscommunication within the team, and difficulties in executing the workload. Communication on the team's priorities, mandate and vision could be improved within the team. Team members appear to have little room for decision making and driving their tasks according to their capabilities. The program leadership seem to rely mostly on TA by partners to drive the programmatic priorities.

- ***Positioning the immunization program at a level that ensures visibility by government and other stakeholders to ensure coordination and oversight of the EPI and to attract the required resources in a sustainable manner***

While immunization remains a key priority for the government of Mozambique and all other stakeholders, coordination and oversight of the EPI and adequately positioning the program to attack the visibility required to mobilize required resources to meet the increasing needs of the program in a sustainable manner remains a challenge.

Oversight Structures: Immunization remains a priority for the GOM and relevant governance structures to support and provide oversight (ICC, NITAG, NCC, NPEC) the national immunization program in Mozambique exist, especially at the national levels. Program planning is linked with the goals and priorities of broader country development plans including, the National Development Plan (Vision 2025), and the Economic and Social Plan (PES) as well as the Medium-Term Expenditure Framework (MTEF). However, the gaps in governance for the program identified during the previous JA continue to exist and recommendations from the last JA have not been addressed. In particular this includes the sub-optimal oversight of the program by the ICC. The ICC meets at least twice per year, mostly to endorse reports and grant applications. There is little evidence of robust preparation for meetings with adequate documentations,, and lack of follow-through on decisions and recommendations taken. The mandate is rather narrow. Discussions rarely focus on topics beyond endorsement of Gavi grants but not issues that concern the overall EPI programme, such as resource mobilisation, advocacy, review of EPI planning and monitoring of EPI programme performance.
The technical oversight, accountable framework and quality assurance needed to guide program implementation are mostly lacking, such that risks to program implementation are not detected on time to ensure adequate mitigation measures.

Immunization Financing Sustainability
Immunization financing and expenditure tracking and reporting are crucial for successful implementation of activities. Government funding of immunization (vaccine purchase and operational activities) have been on the decline. The percentage Government funding of routing immunization declined from 34% in 2012 to 20% in 2015. Tracking and reporting immunization expenditure to meet programme requirements as well as reporting for Global Vaccine Action Plan (GVAP) and other international reporting commitment is not being done consistently.

2. GRANT PERFORMANCE AND CHALLENGES *(maximum 3-4 pages)*

Describe only what has changed since the previous year's joint appraisal. For those countries conducting the joint appraisal 'update', only include information relevant to upcoming needs and strategic actions described in section 5

a. New and underused vaccine (NVS) support

i. Grant performance, lessons and challenges

[Comment on the relevant bolded areas listed in the table in this section of the guidance document, e.g.: programmatic performance of each vaccine programme against approved targets and planned activities, including progress and bottlenecks in implementation; actual versus planned financial expenditure, associated challenges, proposals for using unspent funds, and complementarity between all cash grants]

Mozambique has introduced new and under-utilized vaccines over the last couple of years (Rota, MSD and IPV in 2015). While earlier vaccine introductions (PCV) showed rapid routinization, some contextual issues have challenged the same performance for recently introduced vaccines. These include delayed supply of IPV and Rotavirus vaccines to the country linked to global supply shortages and new and more complex in country importation procedures, as well as challenges in in country vaccine distribution linked to conditioned road traffic from the capital to the central and northern provinces.

Lessons from PIE continue to guide and improve on new vaccine introduction in the country. Key achievements for new vaccine introduction include:

- Rapid "routinization" of newly introduced vaccines (Pentavalent & PCV) with national coverage of 90% and most provinces attaining 80%, though gaps in coverage remain at the district level

- In order to address the effective vaccine management challenges identified during the recent 2015 EVM assessment and guarantee adequate cold chain capacity across all levels, adequately manage vaccines and supplies, which are maintained within the appropriate temperature ranges, the national program with support from technical partners developed a vision and strategic goals to form the basis for the comprehensive improvement plan for 2016-2020

- There are increasing efforts to strengthen the use of Community Health Workers (Agentes Polivalentes Elementares) and other community resources persons, including community leaders, in linking communities with health service delivery, thus raising their awareness and increase their uptake of immunization and other child survival interventions

- Increasingly, the creation of awareness around immunization during mass campaigns and new vaccine introduction is beginning to be leveraged for similar awareness and uptake of immunization services delivered through routine.

- New vaccine introduction providing the platform to strengthen immunization systems especially at the district and service delivery levels, strengthening HR capacity and cold chain capacity. NVI has also allowed for engagement of the program with other health programs, and with stakeholders within and outside the sector

Some of the current challenges include:

- Despite reported improvement in key EVMA scores, between the assessments in 2012 and 2015, key scores such as temperature monitoring, building, equipment and transport, maintenance, stock management, distribution and support functions remain weak in varying degrees at the different levels.

- Inadequate planning and resource constraints (finance, HR, logistics) remain major obstacles to the implementation of outreach services, which may be denying access and utilization of services by remote and under-served populations.

- As outreach and supportive supervision depend, in most parts on HSS funds, the prolonged delay in the disbursement of these funds to the operational level, and the sub-optimal capacity at districts and health facility levels to efficiently manage and report on use of scarce financial resources negatively impacted on attainment of program targets

- Global supply constraints of IPV and RV impacted on the delivery of these new vaccines with stock outs reported in a number of districts and HFs.

- The spread of the "Agentes Polivalentes Elementares" to support the linkage of services with the communities is not equitable and underserved remote populations that require this special strategy may be left out

Specific antigens introduced in 2015

Mozambique introduced rotavirus (RV) in September 2015, inactivated polio vaccine (IPV) and second dose measles vaccine (MSD) in November 2015. Technical decisions that drove the introduction of these vaccines were guided by the National Immunization Technical Advisory Group (NITAG), with disease burden for the African region used as the basis. The introduction of these new vaccines benefited from lessons from PIE for previously introduced new vaccine (Penta and PCV10).

The 2015 Annual Report of prospective Full Country Evaluations (2013 – 2016) provided an insight into the extent to which newly introduced vaccine are "routinized" into the system that ensures that coverage targets are reached and that the coverage figures are at par with those of other antigens provided during same visits. According to this report, the preparations for the introduction of the three new vaccines in 2015 were done at the same time, with training, social mobilization and other related activities harmonized. While this helped to rationalize and use scarce resources efficiently, the specificities in terms of training and social mobilization for the different vaccines were lost through the harmonization of activities and the use of the cascade training methodology , and this resulted in part to low coverage for the three vaccines.

1. RV

- Introduced in September 2015, admin data available through the JRF indicated 59% coverage for second dose RV with stock outs of vaccines in most districts mostly attributed to constraints in vaccine distribution
- "Routinization" of RV has been quite slow, with wide disparities between RV2 coverage and those of PCV2 and OPV2

2. IPV

- • Due to the vaccine being introduced in late 2015, annualized coverage data is not yet available. However, both the FCE conducted in 2015 and the EPI Review conducted in July/August 2016 indicated wide disparities in coverage with poor "routinization" due mainly to stock outs in many districts attributed to delay in the arrival of vaccine and the global supply constraints. There was wide disparity between IPV and Penta3 coverage in most of the districts.

3. MSD

Coverage data for MSD were not readily available for 2015 as introduction only took place in November 2015, but available data for the first trimester of 2016 indicates low coverage across several provinces, with coverage as low as 22% in one of the provinces, as the opportunity for immunization in the of 2nd year of life has not been maximally used..

- The joint training and social mobilization for IPV and MSD, as well as the long leg of time between the training and the vaccine introduction contributed for suboptimal clarity around the specific needs of the MSD (age group, 2nd year of life opportunities…). It is also recognized that a change in the attitudes and practices of parents around using

preventative child health services for children beyond one year of age will require more time and investment.

- The introduction of MSD, which is directed at an age group outside of the traditional PAV routine immunization age group was not reinforced by the supportive supervision required from the central and provincial levels

Previous introduced vaccines

3. PCV10

- The introduction of PCV10 in 2013 benefited immensely from the lessons learnt from the PIE conducted for Penta in 2012, with the vaccines becoming routinized quickly with the coverage of third dose of PCV reaching its planned target and at par with that of Penta3 and OPV3, and this has been maintained in most of the districts. According to the 2015 JRF, PCV10 coverage at national level was 92% and many of the districts reported coverage of ≥80%.
- However, inequity in service delivery in Zambézia province resulted in lower PCV coverage compared to other provinces
- There was minimal report of stock out of PCV10 in 2015

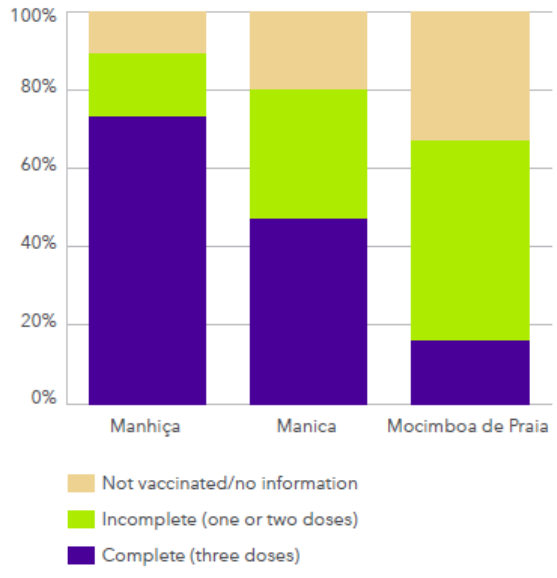
4. Pentavalent

- National coverage for Penta3 in 2015 was 92% with many of the districts attaining 80% or higher coverage.
- Minimal stock out of Penta was reported in 2015

5. HPV Demo

- A two-year human papillomavirus (HPV) vaccine demonstration project in Mozambique commenced in 2014 and continued into most part of 2015, with the project conducted in three sites: one Gavi-sponsored district, Manhiça, and two MoH -sponsored districts: Manica, located in the central region, and Mocímboa da Praia, located in the northern region of the country
- The demonstration project was successful in meeting the Gavi-demonstrated ability criteria of 50% coverage in the Gavi-supported Manhiça district, coverage of HPV vaccine in the two MoH sponsored districts, however, was notably lower due to challenges with demand generation and community mobilization.

Figure 4: HPV coverage in Mozambique



i. NVS future plans and priorities

[Comment on the relevant bolded areas listed in the table in this section of the guidance document, e.g.: for existing vaccines - reasonableness of targets for next implementation year, plans for any changes in presentation or type, risks to future implementation and mitigating actions; for new applications – any expected future applications (include in table 1 above), emerging new priorities for the national immunisation programme]

Targets for all new vaccines for 2017 and beyond have been set based on previous performances that take into consideration, the need to attain the GVAP targets at national and sub-national levels, while addressing equity in immunization service delivery to ensure that underserved and marginalized populations have access to, and utilize services.

However, attainment of coverage targets may be constrained by the lack of reliable denominators for computing coverage targets, and other data quality constraints. While there is a population census planned to take place in 2017, in the meantime MoH is proposing to use the district specific birth rate data provided by the National Bureau of Statistics (INE) to estimate the under 1 year children. In addition, MoH will train and request districts to implement regular quarterly DQS in order to incorporate necessary improvements to the quality of produced data.

Mozambique has requested in May 2016 to switch from PCV10 2ds to PCV13 4ds in 2017 based on NITAG recommendations (already mentioned in the 2015 JA report). Mozambique plans to conduct MR campaign in Q4/2017 and thereafter introduce this vaccine combo into the routine immunization schedule, including MR2 (application will be submitted in September 2016).

HPV introduction is also a priority for the country and application for national rollout shall be submitted to Gavi in 201, followed by NITAG recommendation.

Delays in the disbursement of Gavi grants for new vaccine introduction (VIG), long process for MoH to access funds from MoF and slow implementation of introduction activities are risks to new vaccine introduction, especially considering the constraints to introducing MCV2 which was marred by lack of adequate training and community awareness about the delivery of vaccines using the 2nd year of life opportunity.

Lessons from the recent comprehensive program review and the full country evaluation will help to mitigate some of the risks to new vaccine introduction.

b. Health systems strengthening (HSS) support

i. Strategic focus of HSS grant

[Comment on the extent to which the HSS grant contributes to improve coverage and equity in access to immunisation, and how it helps to address the technical, health systems and financial bottlenecks that might jeopardize the sustainability of these gains. See guidance document for more details]

Mozambique was approved for Health Systems Strengthening (HSS) support in July 2013, but implementation suffered delays due to the prioritization of new vaccines and ongoing communication challenges caused by turnover at both the National Immunization Program (NIP) and the Gavi Secretariat. Late submission and approval of the annual work plan and budget for the 1rst year of HSS in December 2014, and negotiations for the introduction of the Financial Management Requirements (FMR), finally signed in March 2015, caused additional delays.

Disbursement of the first tranche of the program funds occurred in July 2015, however there were delays in disbursing funds to the service delivery level. Despite these delays, there were some achievements:

- Central and provincial level teams strengthened and capacity built at both levels for financial management, including through the recruitment of one HSS focal person and a dedicated accountant, as per the FMR
- Infrastructure strengthening and procurement of supplies for the different levels ongoing
- UNICEF recruited HSS Advisor onboard and providing support for the management and monitoring of the grant implementation working closely with his counterpart in the MoH.
- Systems strengthening and service delivery activities supported by HSS funds are ongoing at the different levels
- Despite the delays in the disbursement of the grant, widespread improvement in routine immunization coverage reported

Besides the delays in the disbursement of funds, other constraints in the implementation of the HSS grant were reported:

- Low utilization of the grant (11% as of June 2016) due mostly to the delayed disbursement from MOF to MOH and the provincial level
- Lack of efficient and transparent use of the funds reported in some of the provinces and districts
- Difficulties and delays in clearing some of the procured items, and the distribution of cold chain equipment to the required levels
- weak financial management capacity and lack of timely accountability for used funds reported at the different levels
- in view of the delays in disbursement resulting in low utilization rate of the HSS grant, there is a need to re-allocate the funds meant for the second year of the grant, with the balance for the introduction of new vaccines (VIG)
- Challenges in obtaining actual costs for some of the operational activities and expenses that support other child health interventions integrated into immunization at the district and health facility levels

ii. Grant performance and challenges

[Comment on the relevant bolded areas listed in the table in this section of the guidance document, e.g.: achievements of targets and intermediate results; actual versus planned activity implementation and financial expenditure; use of PBF reward and budgets/plans; degree of participation of key stakeholders in implementation of HSS proposal; implementation bottlenecks and key challenges regarding financial management of HSS grant; compliance with data quality and survey requirements]

1. Overall program performance:

The introduction of new and under-utilized vaccines in Mozambique is being used to strengthen immunization systems, and to some extent, the overall health systems to improve immunization outcomes. The post introduction evaluations in between introductions are providing the opportunity to identify and address system gaps and bottlenecks.

Some of the key achievements of PAV to date include:

- In 2015, the admin reported national coverage for all the antigens including Gavi supported ones was ≥90% in line with the GVAP target except for MCV1, which was below 90%. The WUENIC estimates for the same period is < 90% for all the antigens

- The GVAP district coverage target (equity tracer) indicated that in 2015, 127/148 districts attained DTP3 coverage of ≥80%, a slight decline from 128/148 districts in the previous

year. Coverage of fully immunized children increased from 79% in 2013 to 82.4% in 2014 and dropout rate 9% for both 2015 and 2014..

- The positive outcomes of the HF-based RED/REC micro planning with the active engagement of communities in two districts aimed identifying and targeting hard-to-reach communities will contribute significantly to improving coverage and addressing inequity in immunization service delivery when scaled up to more provinces as planned by the program.

- There was some improvements in some core EVM scores in 2015 when compared to findings in the 2012 EVMA, though for some of the scores, no major improvements were recorded. The strong technical support provided by partners including UNICEF and VR contributed to the improvements.

- There is increasing effort to engage community resources persons including community leaders to mobilize communities for immunization and other child survival interventions with community health workers playing key roles.

- Though, not happening at the desired speed, the efforts to use community mobilization and partnership engagement generated during mass immunization campaigns and introduction of new vaccines, to strengthen routine immunization has taken off in most districts

In spite of the achievements, a number of weaknesses persist:

- Despite some improvement in some of the core EVMA scores, minimal improvement in other core scores such as temperature monitoring, building/infrastructure, equipment and transport, maintenance, stock management, distribution and support functions between the assessments in 2012 and 2015, means that immunization supply chain management continues to be constrained.

- The 2015 joint appraisal and the recent EPI comprehensive program review identified as some the major constraints to attaining program targets, the sub-optimal management of health services at district level and below; the lack of adequate human resources, limited supportive supervision of frontline staff, as well as the inadequate outreach activities for delivery of priority health services. These barriers in most part, remain unaddressed.

- Previous appraisal, reviews and evaluations of the program recommended that the weak health information system and quality of data be improved in order to allow for evidence-based planning and reliable assessment of program performance. Unfortunately, the recommendation were not implemented and wide disparities continue to be noticed between the different sources of coverage data (JRF, WUENIC, Coverage surveys). Due to the poor estimation of target populations, a number districts continue to report coverage figures of more than 100%

- The introduction of new vaccines requires that the AEFI systems in the country be strengthened, so that poorly managed cases of AEFI do not disrupt demand generation for uptake of the new vaccines. This important component of the program remains sub-optimal and efforts to use the pharmacovigilance unit of the MoH remains disjointed between the immunization program and department of pharmacy which hosts unit.

- The delivery of immunization services through health facilities and outreach (“brigadas moveis”) supported by “Agentes Polivalentes Elementares” (community health workers) is constrained in most districts by inadequate number of health workers, community health workers and lack of financial resources and transport, to adequately conduct planned sessions. Delays in the disbursement of HSS and low implementation rate contributed significantly to this problem.

iii. Describe any changes to HSS funding and plans for future HSS applications

[Present the rationale for a new tranche of HSS funds (and the associated amount as per table in section 1) or no-cost extension, or any planned changes in terms of re-allocation or reprogramming]

Due to the prolonged delays between initial disbursement in July 2015 and start of implementation in April 2016, which resulted in very low utilization rate, there will be the need to re-allocate the funds meant for the second year of the grant, which will be complemented with the balance of the the 2015 VIGs (rota, IPV and MSD).

The reallocation will also consider the recommendations from the EVMA, EVM IP and 2016 EPI review in order to strengthen coverage and equity; and include a tripartite agreement between UNICEG GoM and Gavi to transport, install cold chain equipment (procured last year through UNICEF SD) in regional vaccines warehouse (this equipment has been custom cleared in Q2 2016 and is currently stored in Maputo MOH warehouse).

HSS activities are incorporated in the annual PES (Plan Economico Social). This way, activities can be streamlined in the overall national workplan, which may help with speeding up fund transfer to districts.

c. Transition planning *(if relevant)*

[Comment on all bolded areas listed in the table in this section of the guidance document, e.g. progress of implementation of planned activities; implementation bottlenecks; changes required to the transition plan for coming years, including rationale and costing/proposed financing]

Not applicable

d. Financial management of all cash grants *(e.g. HSS, VIG, campaign operational cost grant, transition grant)*

[Comment on the bolded areas listed in the table in this section of the guidance document, e.g.: cash utilization performance and financial capacity constraints; modifications to financial management arrangements; major issues arising from cash programme audits or monitoring review; degree of compliance with Financial Management Requirements]

In 2015 total cash disbursed to Mozambique amounted US$5,514 mio for HSS including US$ 4,204 mio to MoH and US$ 1,309 mio for procurement (managed by UNICEF SD), and 2.595 mio for VIGs (Rota, MSD and IPV) to MoH. Annual financial reports for the VIGs and interim quarterly HSS report were submitted on 15.08. Further revision is required to comply with Gavi requirements.

In 2016, Gavi disbursed a total of US$15,269,021 to Mozambique as both cash (US$370,215, to UNICEF for procurement of vehicles) and non-cash (US$14,898,806) grants. A total of US$26,008,000 will be required for new vaccine procurement in 2017 with government expected to co-finance US$1,894,000 and Gavi paying US$24,114,000.

Financial management capacity at all levels remains a major challenge, though efforts to implement the recommendations from the previous JA to address financial management bottlenecks will seem to be improving the situation. To note the MOH complied with the FMR requirements appointing an HSS focal person and one Gavi grants dedicated accountant.

Delayed disbursement of funds to service delivery level and the ability for this level to efficiently use and account for funds used remained constrained and a bottleneck to implementing programmatic activities.

The 2015 FCE report attributed some of the challenges in financial management, to the complex financial processes required to integrate donor funds with government accounts (at MoF and MoH) , and to major delays in disbursement resulting from steps that depend on financial management staff outside of the jurisdiction of the national Directorate of Public Health.

The 2015 FCE report also noted constraints caused by the necessary involvement of actors outside of the NIP and Directorate of Public Health for major aspects of the financial process, coupled with limited financial management capacity of the EPI and the Directorates of Public Health and Administration and Finance.

3. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

[Status of top 5 prioritised strategic actions from previous joint appraisal and any additional IRC or HLRP recommendations (if relevant)]

Prioritised strategic actions from previous joint appraisal / HLRP process	Current status
Resolve bottlenecks that delay availability of HSS funds, update financial and programmatic reporting, and improve financial management capacity at PAV and sub-national levels by hiring a full-time Gavi HSS TA and a part-time (50%) financial officer.	A full-time HSS Advisor was recruited by UNICEF (as part of the TCA) and is currently working closely with the MoH to coordinate the management of HSS grants at the different levels A part-time Financial Officer to support financial management of the grant is was also assigned, hence while there has been some improvement in the overall management of the grant, especially at the national level, financial management bottlenecks and barriers still exist.
Conduct a comprehensive EPI review linked to the next JA that includes a thorough analysis of partners' activities, a joint comprehensive TA plan linked to EVM and JA priorities to assist PAV coordinate for complementarity	A comprehensive EPI program review coordinated by WHO was conducted in July 2015 with support of external technical partners. Key findings and recommendations from the review provided significant insight to the joint appraisal process, and basis for a number of the recommendations.
Develop a comprehensive improvement plan and monitor the implementation of a comprehensive EVM/IP (cEVM/IP) process.	A comprehensive EVM Improvement Plan (IP) was developed by UNICEF, supported by other technical partners, and formed the basis for the development of a vision and the strategic goals for the comprehensive immunization supply chain management strategic plan for 2016-2020. Costing for the strategic plan is being developed.
Design an integrated service approach to microplanning and a framework for taking microplanning and RED/REC brigades to scale	The tools and guidelines developed for the immunization equity based RED/REC micro planning and implementation in two pilot districts are being modified for integrated

	service delivery at scale
Review and update PAV HR plan to ensure it responds to current NVI and HSS needs, and feeds into the National HR Plan 2016-2025	This process is ongoing and is expected to be completed by the end of 2016
Develop a national advocacy plan that includes strengthening ICC's high level advocacy influence (e.g. revision of TORs, membership, planning support, decision making processes)	Not implemented

1. PRIORITISED COUNTRY NEEDS[1]

[Summarise the highest priority country needs and strategic actions that could significantly improve coverage, equity and financial sustainability; the timeline for completing the actions and the type of technical assistance needed if applicable – see guidance document for more details]

Prioritised needs and strategic actions	**Associated timeline for completing the actions**	**Does this require technical assistance?*** *(yes/no)* If yes, indicate type of assistance needed
A. GOVERNANCE, PROGRAM MANAGEMENT & SUSTAINABLE FINANCING 1. To understand and improve the flow of HSS funds and availability of operational funds at the health facility level 2. Generate additional tools to capture expenditures of funds at district and health facilities 3. Undertake ICC internal review to broaden mandate of ICC to oversight of entire EPI and resource mobilization 4. Improve functionality of the national EPI team by reviewing the organizational structure, roles and process of national EPI, conducting a managerial training for EPI manager and team leaders 5. Ensure integration and participation of EPI in the MoH initiative of domestic resources mobilization strategy	**2017**	**All activicties listed as priorities, will require TA, however the scope and specificities of the TA is still to be defined**

[1] Subsequent planning and discussions on Targeted Country Assistance will take place - detailed guidance on the process will be shared in May 2016.

B. IMMUNIZATION SUPPLY CHAIN MANAGEMENT 1. Implement the EVM improvement plan 2. Align EPI supply chain system design with CMAM PELF to accelerate integration **C. SERVICE DELIVERY** 1. Complete the RED/REC National plan 2. Continue with the scale up of RED/REC implementation prioritizing provinces and district with low performance 3. Ensure integration RED/REC integration in the District PES 4. Establish DHMT in selected district (pilot districts) to ensure financial and programmatic management **D. DEMAND CREATION & COMMUNITY LINK WITH SERVICES** 1. Update Health Promotion Strategy to include aspects to convince vaccine resistant groups – including community leaders – to fully utilize immunization services. 2. Engagement of community leaders in defaulter tracing, service utilization and promotion of benefits of immunization **E. DATA QUALITY IMPROVEMENT** 1**.** Develop and implement Data Quality improvement plans at all levels 2. Set standardized methodology to redefine denominators from national to district levels **F. VACCINE PREVENTABLE**		

DISEASE SURVEILLANCE 1. Provide support to plan and implement active surveillance and supervision with focus on low performing district 2. Scale up and strengthen surveillance of diseases targeted by New Vaccine (Rotavirus, Meningitis and Pneumococcus) to all provinces 3. Train and regularly update health care providers on detecting and reporting AEFI, and strengthen overall technical assistance on AEFI/ADR (adverse drug reactions)		

**Technical assistance not applicable for countries in final year of Gavi support*

2. ENDORSEMENT BY ICC, HSCC OR EQUIVALENT AND ADDITIONAL COMMENTS

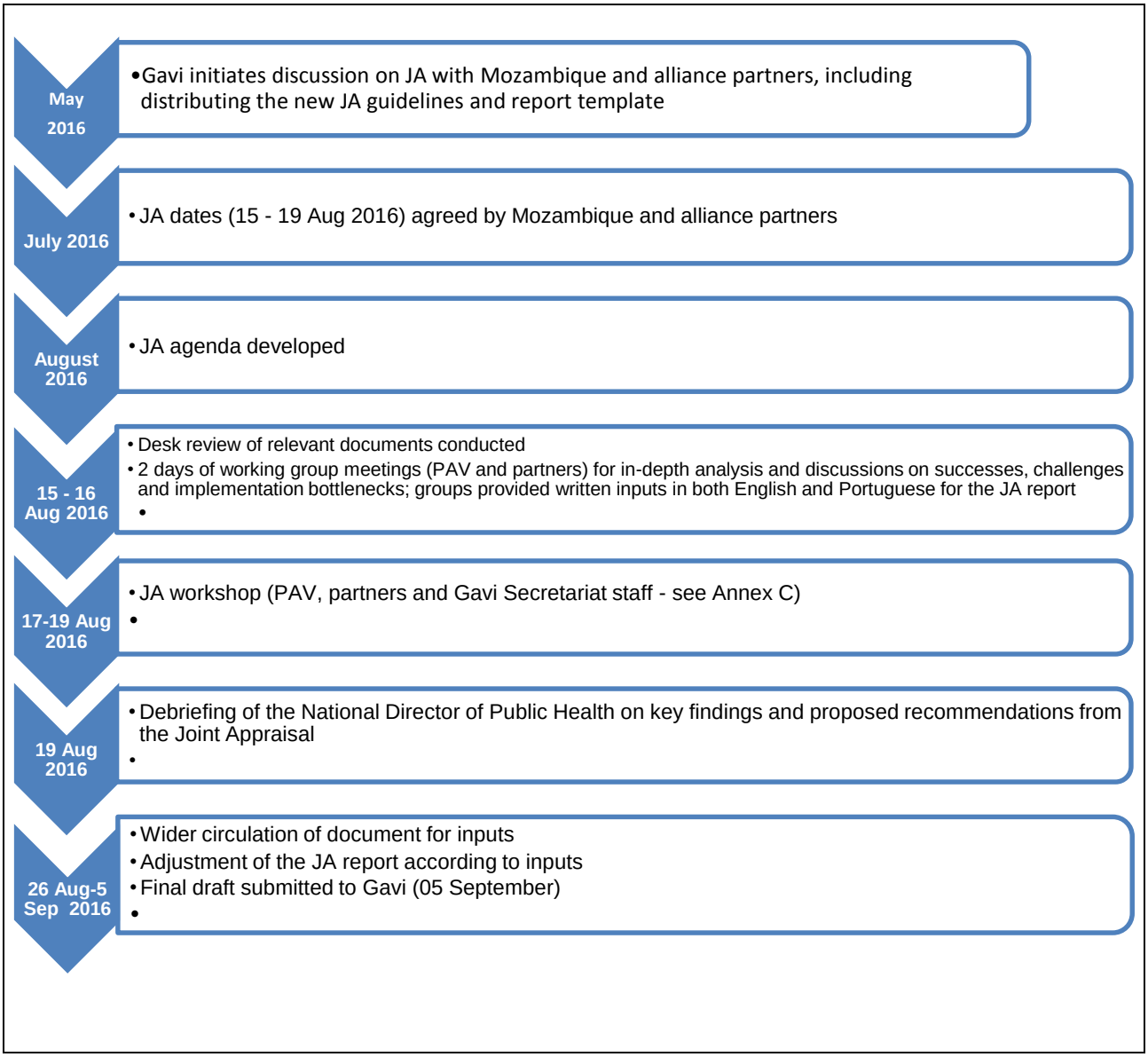
This section does not need to be completed for joint appraisal update in interim years, instead the EPI manager is expected to endorse the joint appraisal report.

Brief description of how the joint appraisal was endorsed by the relevant national coordination mechanism	The joint appraisal process and key results were presented to the ICC in the last day of the workshop (19/08/2016).
Issues raised during debrief of joint appraisal findings to national coordination mechanism	The ICC chair remains committed in ensuring that bottlenecks identified during the process are duly addressed.
Any additional comments from: • **Ministry of Health** • **Gavi Alliance partners** • **Gavi Senior Country Manager**	

3. ANNEXES

This section does not need to be completed for joint appraisal update in interim years. Please include the following Annexes when submitting the report, and any others as necessary

Annex A. Description of joint appraisal process (e.g. team composition, how information was gathered, how discussions were held)



Annex B: Changes to transition plan *(if relevant) Not applicable*

Changes proposed	Rationale for changes	Related cost (US$)	Source of funding for amended activities	Implementation agency	Expected result

Annex C:

Implementation status (milestones) of the TCA/PEF 2016 (only for WHO and UNICEF).

TCA Biannual Milestones	Milestone till June/2016	When was funding received from GAVI	Level of achievement of milestones
UNICEF	Joint Appraisal report timely available	March/ 2016	Concluded
	EVM Improvement plan and updated CC upgrade plan developed		EVM -IP in progress with costing will be submitted in Sep 2016
	REC scale up strategy developed		REC strategy scale is already prepared and to be submitted next month
WHO	EPI HR plan updated	24-Apr-16	1. On Track for completion in January 2017. **Comments:** In 2010 an exercise was conducted by WHO/HQ, AFRO, IST which provided benchmarking information for the optimal composition of an EPI Team, and provided outlines of TORs and skills for each position. A mapping of the existing HR situation in Mozambique has been done down to District level which now needs to be revised with updated information on the HR situation in 2016 down to Health Facility level. Next steps: Hire a local consultant to build on the 2010 exercise with updated information on existing HR capacity, compare this with the recommended HR capacity, and highlight the gaps and estimated costs in HR for follow up by MoH.
	ToRs for financial and operational sustainability plan implemented		2. On Track for completion in January 2017. **Comments:** Immunization Financing Review was conducted as part of the Comprehensive EPI & Surveillance review and PIE in July-August 2016. Draft report is available which will form part of the situation analysis for the Financial Sustainability Plan. Discussions to engage a National Health Economist in Mozambique

			to prepare Financial Sustainability Plan are underway. ToRs have been developed and a local consultant to carry out the work under the supervision of WHO Country Office and IST is being identified.
Funding received by WHO = $369,542. $84,499 for salary of an NPO, and $285,043 for actitivities.			
To date $107,000 spent.			
Recruitment of NPO: Tests and interviews will be concluded by 1st week of September. Expect candidate to be on board mid October 2016.			