

Tanzania Joint appraisal report

Country	Tanzania
Reporting period	<i>1st January, 2014 to 31st June, 2015</i>
cMYP period	<i>2010 – 2015 (New CYMP for 2016-2020 is being developed)</i>
Fiscal period	<i>1st July, 2014 - 30th June, 2015</i>
Graduation date	<i>N/A</i>

1. EXECUTIVE SUMMARY

(MAXIMUM 2 PAGES)

1.1. GAVI grant portfolio overview

[With reference to the overall portfolio of GAVI grants in the country and the overall scope and funding of the national immunization programme, briefly describe how GAVI's vaccine and health systems strengthening support fits within the overall context of the national immunization programme and contributes to improved outcomes. Refer to the guidance for more details]

Vaccines introduced in Tanzania through Gavi support since 2001 include:

- Pentavalent (introduced 2009)
- PCV-13 (introduced 2013)
- Rotavirus (introduced 2013)
- Measles second dose (introduced 2014)
- HPV demo (commenced 2014)
- MR campaign (October 2014)

Since 2001 to 2015 Tanzania received a total grant from GAVI amounting **USD 286,339,988** of which USD 248,349,745 (86.7%) was for vaccine grant, and the remaining 37,754,865 was cash grants for vaccine introduction grants, health systems strengthening and immunisation system strengthening.

For the year 2014, country received total of USD 89,035,772 of which USD **67,291,128 (76%)** was for procurement of Pneumococcal, Penta, MR and Rota vaccines. Cash grants were also provided for measles second dose, MR, IPV, along with cash grants for HPV and operational costs for the MR campaign. The first HSS tranche was **USD 3,786,840** was also disbursed in January 2014.

Vaccine and cash support from GAVI are reflected in the national budget plan i.e. medium term expenditure framework (MTEF). Funds for vaccine co-financing and the full cost of traditional vaccine and related supplies are protected, to ensure constant availability of vaccines.

Tanzania defaulted on its Gavi co-financing payment for 2014 due to financial constraint coupled with unforeseeable emergencies in the health sector.

1.2. Summary of grant performance, challenges and key recommendations

Grant performance (programmatic and financial management of NVS and HSS grants)
<p><u>Achievements</u></p> <ul style="list-style-type: none"> • Improved immunizations coverage from 92% in 2013 to 97% (in 2014) (using DTP3 coverage as proxy indicator), this gain was observed in all other antigens except for MCV2: <ul style="list-style-type: none"> ○ Pentavalent coverage 2014: 97% ○ PCV-13 coverage 2014: 93% ○ Rotavirus coverage 2014: 97% ○ HPV year 1 coverage: 93% ○ MR campaign coverage: 97% ○ Measles second dose coverage 2014: 29% • Improved equity and awareness (reduced number of districts/council with vaccination coverage less than 80% reducing from 61 (2011) to 30 in 2014). • MCV2 coverage remain low as the introduction started in the mid of the year and uptake of vaccine in second year of life were not well conceptualized to the community. • Lack of clarity on denominator for MCV2 in the first year of introduction and unrealistic Official demographic in some districts resulted into high dropout rate for MCV1-MCV2
<p>Key recommended actions to achieve sustained coverage and equity (list the most important 3-5 actions)</p> <ul style="list-style-type: none"> • Conduct Reach Every Child strategy and Data Quality Self- Assessment to all low performing districts; • Intensify the routine immunization services and increase immunization services demands through community awareness creation campaigns; • Ensured regular availability of potent IVD vaccines in all health facilities providing vaccination services • Ensure availability of updated monitoring tools able to easily accommodate new vaccines and equity at HF level and electronic systems for immunization. • Increase capacity building for health workers providing immunization services at all levels

1.3. Requests to Gavi's High Level Review Panel

Grant Renewals

New and underused vaccine support

The following are new and under used vaccines supported by GAVI in Tanzania which are being requested for support in 2016;

- *MR, 10 dose(s) per vial, LYOPHILISED*
- *Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID*
- *DTP-HepB-Hib, 10 dose(s) per vial, LIQUID*
- *Rotavirus, 2-dose schedule*

Health systems strengthening support

- Disbursement of second tranche of HSS funding of \$ 3,635,922(already approved by previous HLRP).

1.4. Brief description of joint appraisal process

The Joint Appraisal was part of the comprehensive EPI review (a combined EPI review, PIE for HPV and MSD-2, Data Quality, Surveillance and Financing Review) which provided key information particularly for New Vaccine section of the Joint Appraisal. The purpose of combining the JA with the broader review was to reduce the burden of reviews on the country, to benefit from the broader EPI discussions which could feed into the JA, and to ensure maximum attendance of partners. The process and approach was felt to be successful. Prior to the in-country discussions, the IVD technical working group wrote a JA draft which was circulated to in-country, regional and international partners for comments.

There was involvement many key immunization stakeholders from in-country, regional and international partners during the EPI review/JA in-country discussions: IVD, UNICEF, WHO, CHAI, Gates, MCSP/JSI, CDC, GAVI Secretariat

The process included desk review of documents, field visits in 10 regions, interviews and discussions, along with plenary discussions with all partners. A separate side-discussion was held on GAVI HSS. The JA overview was presented to ICC on 23 July. A final version of the JA document incorporating findings/recommendations from the discussions held during the EPI/JA review week developed and circulated to ICC for remote review early September, for submission to GAVI by 15 Sept.

2. COUNTRY CONTEXT

(MAXIMUM 1-2 PAGES)

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

Tanzanian health policy reform vision is to improve the health and well-being of all Tanzanians with a focus on those most at risk and to encourage the health system to be more responsive

to the needs of the people. Immunization is one of the components in the National Package of Essential Health Interventions.

While some of health indicators have progressed positively in the past decade and achievement of MDG 4, and 6 realistically appears to be within reach.

Political commitment towards provision of immunization services is high as the services are provided free of charge both in the private and government health facilities.

Tanzania has seen 7% GDP growth over the last year, and is on positive economic trajectory. However, this is not accompanied by increased investment in health. Government expenditure on health in real terms and as a proportion of general government expenditure has declined since from 9.4% in 2012/13 to 7% in 2014, and from \$8.4 per capita in 2010/11 to 6.5 in 2013/14.

In country stakeholders expressed that Tanzania's EPI programme was a victim of its own success, and that the good progress towards MDG4 and high coverage for immunisation, has led to a perception amongst donors to shift their resources to other areas with more need

The government has secured "ring fencing" of resources for co-financing payment and is fully supporting the cost of traditional vaccines. The many new vaccines introduced in the past few years has also led to increased operational costs, for which need high level advocacy for maintaining investment to sustain the gains and achievements of the last decade.

In Tanzania there is no NITAG but there is Inter Agency Coordinating Committee (ICC) with members from all partners in health sector including Ministry of Finance, Ministry of Regional Administration and Local Government, Ministry of Education, President Office Public Service Management, WHO, UNICEF, USAID, Pediatric Association of Tanzania, Red Cross, KFW, CIDA, World Bank, CHAI, Christian Social Services commission, MSD, TFDA, APTHA. ICC is responsible with decision making in all technical and financial matters on the implementation of immunization services in Tanzania, including resource mobilization. The chairperson for ICC meeting is the permanent Secretary MOHSW.

The country was implementing immunization services basing on the CMYP for year 2010-2015. The programme with support from WHO, UNICEF, CHAI, and JSI - MCSP as from October 2015 will be developing new CMYP for year 2016 -2020 which is expected to ready for sharing by December 2015, and also to will establish NITAG.

Currently Men A, yellow fever and OCV are not under the immunization program, but dealt with epidemiology section. The issue of rolling out these vaccines in future will depend on the ability of the government in terms of financial resources and priorities.

Additional resource requirements for immunization services will be required due to increasing number of district from 142 of 2013 to 185 of 2015. GAVI HSS proposal was developed when the country was having 142 councils but to date the number of councils has increase to 185.

The country is planning to conduct national election in October 2015. and therefore there will be competing priorities which might affect release of enough funds for immunization for services timely.

The implementation of Global Initiatives as priority such as Measles Rubella initiative resulted into re-prioritizing activities for the country to be in line with Global community and therefore

some of the HSS activities were re-scheduled;

The influx of Burundi asylum seekers resulted to emerging of increased unplanned demands in emergency especially for immunization services including the informal refugees' communities in porous border. This created additional load to IVD officers which resulted in re-prioritizing of planned activities.

Delay in the implementation of some key activities such as refresher trainings which was planned to be integrated with IPV trainings as a strategy of leveraging resources and gain the synergy was affected by the delayed shipment of IPV vaccines.

During EPI review identified the following challenges;

- Prolonged procurement procedures affected the performances of activities which their effects are expected in sequential or precedence such as delayed realization of transport for outreach affects the completion of outreach services and so forth.
- Inadequate vehicles for distribution and supportive supervision at regional and council level especially the new ones. Impacted on the vaccination coverage for some of the district
- Inadequate cold chain equipment's for new district and health facilities and also for upcoming new vaccine introduction
- Availability of two data system (DVDMT and DHIS) for recording data on immunization services at district and health facility level impacted on data quality.

3. GRANT PERFORMANCE, CHALLENGES AND RENEWAL REQUESTS

(MAXIMUM 3-5 PAGES)

3.1. New and underused vaccine support

3.1.1. Grant performance and challenges

[Comment on all bolded areas listed in the table in this section of the guidance document]

Vaccines provided in Tanzania through Gavi support in 2014 were:

- Pentavalent (2014 coverage 97 %) drop out 10%
- PCV-13 (2014 coverage 93%), drop out 11%
- Rotavirus (2014 coverage 97%), drop out 8%
- Measles Second Dose (2014 coverage 29%)
- MR campaign (2014 coverage 97%)
- HPV demo first year (2014 coverage 93.3 % first round and 92.6% second round)

Measles Second Dose was introduced in June 2014 .The coverage for MCV-2 was 29% the challenges for the low coverage included, low Community awareness for immunization

services for children above 1 year . The community were very high aware for under 1 vaccination services than 2 yrs , leading to caretakers, community leaders, especially in hard-to-reach areas, not bringing their children for MCV2 at 18months of age. Also some health facilities either did not know the MCV2 target population leading to turning back the eligible children.

As we have introduced MR into Routine ,to increase coverage for MR2 specific communication strategies including printed materials & local media to increase demand for MR2 has being developed and distributed and also

Health workers have being sensitized to be proactive screening at health facility to look for children eligible for MR2

Measles Rubella vaccine was successfully introduced in October 2014 following wide age range integrated campaign targeting 21,159,629 under 15 years children and achieved coverage of 97 %.(20,529,629) The national wastage rate was 5%. After campaign MR vaccine was introduced into routine immunization scheduled. The remained 1,782,730 doses of MR vaccine from the campaign was later used in the routine.

Tanzania Red Cross Society has being involved in implementing Immunization services in Tanzania. By using red cross volunteers they conducted house to house social mobilization during implementation MR campaign and also they are conducting baby tracking services to track defaulters in regions of Tanga and Dar es salaam. We are planned for the second year to use them in training and mentoring of community health worker who will be recruited for defaulter tracing and support in outreach services and community mobilization. Likewise Tanzania lions club participated and supported in social mobilization during implementation of MR campaign and MR into routine. Also members of paediatric association are being used in surveillance for Vaccine preventable diseases (VPD) in conducting active search for VPD and strengthening routine immunization services.

The HPV demonstration project was implemented in Kilimanjaro region using schools based strategy. The distribution of the HPV vaccine was done five to seven days before the vaccination days. First round was conducted from 5th to 9th May 2014, and second round from 3rd to 7th November 2014. The target was to vaccinate 18,913 girls; whereby targeted 18,316 girls in schools and 597 girls out of school. The round one coverage for in school vaccination was 94% (17,222 girls) and out of school 69.7 % (416 girls), for second round was 93.8% (17,170 girls) and out of school 67.8 % (405 girls). The overall coverage for first and second round was 93.3% and 92.6 % respectively.

The class four was selected as a denominator for school based vaccination based on available data of more than 92% aged 9-13 years. The selected class four used during vaccination had challenge of missing eligible girls in older classes.

The second year implementation of HPV Demonstration project in 2015 the approach will be as of other routine vaccination mode of delivery (Fixed health facility and outreach services) targeting girls aged nine years.

Financial performance of vaccine cash grants

5 vaccine cash grants were provided to Tanzania by Gavi in 2014:

Cash grant	Amount provided	Amount spent in 2014	How balance to be used in 2015
HPV cash support	\$212,000	206,690.60	Monitoring implementation during 2nd year
MSD-2 VIG	\$1,626,000	1,328,022.06	Advocacy and community mobilization
MR campaign operational costs	\$12,791,693	12,579,933.39	Introduction of MR into routine
MR campaign VIG	1,546,500	74,291.30	Introduction of MR into routine
IPV VIG	1,599,000	0	Introduction of IPV into routine

The remaining balance of funds will be used to implement the following;

1. Support introduction of MR vaccines into routine immunization.
2. Support introduction of IPV vaccine into routine immunization
3. Support supervision for HPV demonstration second year implementation

Challenges

- Long procurement process; all procurement of equipment and other supply took a long procurement procedures.
- Delay in clearing of syringes at port impacted on timing of MR campaign
- Delay in receiving the IPV vaccines led to postponing some of IPV related activities from 2014 to late 2015

3.1.2. NVS renewal request / Future plans and priorities

[Comment on all bolded areas listed in the table in this section of the guidance document]

Tanzania is requesting the following vaccine renewals for 2016:

- *MR, 10 dose(s) per vial, LYOPHILISED – second dose only, Tanzania to cover full cost of 'R'*
- *Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID*
- *DTP-HepB-Hib, 10 dose(s) per vial, LIQUID*
- *Rotavirus, 2-dose schedule*

For year 2016 the programme is still using National Bureau of statistics data for immunization services, however we are still following up with NBS data for the district which data are not marching to expected targets.

The programme with support from WHO, UNICEF, CHAI, and JSI - MCSP is now in the process of developing the new CMYP for year 2016 -2020. The projected annual population growth rate is 2.7.

The country is expecting to apply for national introduction of HPV in 2016/17, after ending of HPV demonstration project.

The Country will prefer to use PCV 4-dose vial presentations by 2016/17 and therefore TA will be requested to support the transition from 1- dose vial to the 4-dose.

Currently Men A, yellow fever and OCV are not under the immunization program, but dealt with epidemiology section. The country would like to conduct Meningitis A disease burden and risk assessments which will support of whether to introduce Men A in campaign and routine introduction 2017/18.

3.2. Health systems strengthening (HSS) support

3.2.1. Grant performance and challenges

[Comment on all bolded areas listed in the table in this section of the guidance document]

Tanzania's HSS grant commenced in January 2014. For the year January 2014 to June 2015 EPI impeneted the following activities:

Review, Evaluate and Update the Reach Every district (RED)/Reach every child (REC) training manual and update of guidelines on immunization services was done .The review of EPI training guideline package will be concluded by end of October 2015.

Refresher training for 200 EPI Managers and 3000 Health workers at service delivery points, the activity was done in part. (9% of the allocated fund)

Operational costs was utilize at 29.4% ,the remaining funds have being committed to support functions of ICC, NPEC and technical working groups meetings as planned .

Support EPI officers to attend meetings (national and international) was implemented at 69%, the remaining funds are committed to support national meetings by October 2015

improved knowledge and skills for health workers and supervisors in the provision of quality immunizations services, where by total of 25,647 health workers at health facilities level and 1,521 supervisors were trained on basic immunizations services. This is estimated to cover almost 95% of existing health facilities.

EPI implementation review meeting and VPD zonal surveillance review meetings was conducted before June 2015 with 92.3% of the allocated funds utilized.

EPI data quality assessment was done 100% in the April-June 2015 quarter.

The procurement cold chain equipments, vehicles, motorbike, and bicycles was done through UNICEF before June 2015. The procured vehicles and motor bike and bicycles has being distributed to respective districts and facilities. The distribution was completed by 11th September 2015.

Immunization week-The activity was partly implemented (8.8%) the remaining part was committed for as part of the activity for 40 years EPI which was implemented on week of 7th September 2015

The programmatic challenges during implementation of Immunization activities includes;-

Challenges

1. creation of new districts and regions which require establishment of more vaccine stores created more demand and challenges the distribution of procured equipments
2. Shortage of human resources imparting implementation of activities timely
3. High turnover of trained health workers imparting implementation of activities timely
4. Inadequate vehicles for distribution of vaccines and support supervision impacted reaching intended targets in some districts

GAVI HSS funds has covered some by procurement 60 vehicles to support 60 councils out of 140 councils which are in great need of vehicles

Financial performance and challenges

GAVI HSS grant was approved in 2012 with a budget of \$15,944,246, but it was later changed to a total budget of \$13,512,765 to reflect the performance based financing nature of this grant. A revised budget of \$13,512,765 had never been developed and the best way of doing this was discussed during the Joint Appraisal. During the meeting, it was suggested that the HSS grant could be extended to June 2018 based on the reasons that, as the grant started late, it is felt that this will help it reach its objectives within 4.5 years and will help the grant fall in line with the Tanzania fiscal year (July-June).The revised budget has been since developed and shared with Gavi.

For the year 2014 country received GAVI HSS first tranche amounting USD 3,786,840. The actual expenditure from January 2014 to December 2014 was USD 2,528,509.99 and from January 2015 to June 2015 was 674,736.15 and committed to activities pending to be implemented soon was 53,755.12. The expenditure for January 2014 – June 2015 including

committed funds (ie. Those activities completed but bills not yet paid) is about 86% utilization rate.

Given that Tanzania is expecting to receive an additional \$800,000 as a PBF award, these funds are intended to be used to strengthen immunization system in areas of Cold Chain Expansion/operations, Demand Creation, Improvement of Data quality and Management and Capacity Building

3.2.2. Strategic focus of HSS grant

[Comment on the extent to which the HSS grant contributes to improve and sustain coverage and equity in access to immunisation. See guidance document for more details]

The immunization coverage for DTP3 has increased from 92% in 2013 to 97% in 2014. This gain was observed in all other antigens except for MCV2 which was introduced in June 2014. Improved equity has also been seen in 2014, with the number of districts/councils with vaccination coverage less than 80% reducing from 61 (2011) to 30 in 2014.

During EPI review in July 2015, recommendations were provided, HSS grant will support the programme to address the following key recommendation provided in the EPI review: Increase cold chain capacity in new facilities by procuring cold chain equipments

- Sustain and expand proven effective innovations for safe and potent vaccines such as Remote Temperature Monitoring Devices to district cold stores and real-time alarming at central and regional vaccine stores. This will be achieved by training and provision of data tools
- Explore IT solutions through VIMS to capture real-time stock availability at health facilities to improve stock decision making, Achieved by capacity building of RIVOs, data managers providing tools .
- Implement a system for preventative maintenance and repair at all levels through adequate availability of spare parts and toolkits and advocate to the existing technology
- Ensure provision for data management and use interventions that work and are affordable through traditional training, innovations such as micro-training videos, data use video games, What's App groups, others)
- Sustain and maintain quality of new vaccine surveillance and conduct midterm review (Rota and intussusceptions , PBM and CRS),

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

[Indicate request for a new tranche of HSS funds (and the associated amount) or no-cost extension, or any planned changes in terms of re-allocation or reprogramming. Also describe future HSS application plans]

Tanzania received its first tranche of HSS funds (\$3,786,840) in January 2014. As per the

submitted financial report for HSS activities (Jan 2014 – Jun 2015), Tanzania has already spent 86% of this first tranche of the HSS grant and the remaining have been committed for the scheduled activities. Therefore Tanzania is requesting year two tranche of GAVI HSS amounting to \$ 3,635,922 (already approved by previous HLRP) to be disbursed.

3.3. Graduation plan implementation *(if relevant)*

[Comment on all bolded areas listed in the table in this section of the guidance document]

Not Relevant for Tanzania, these will be explained in Financial Sustainability Plan

3.4. Financial management of all cash grants

[Comment on all bolded areas listed in the table in this section of the guidance document]

Gavi provided a total of \$21,562,033 in cash grants to Government of Tanzania in 2014 to cover both NVS and HSS. See sections 3.1 and 3.2 for comments on the expenditure of each cash grant.

GAVI monitoring review team visited Tanzania between 5th August and 14th August 2015, has gone through the GAVI financial statements and procedures and provided the necessary comments to work on as a country.

3.5. Recommended actions

- Technical review and consideration of future plans for introductions of new vaccines
- Consideration for long term sustainability of immunisation financing
- MOHSW to fast track ICC recommendation of repositioning vaccine handling, storage and distribution at national level for more efficient and cost effective management in order to reduce immunization cost per child

in addition the recommendation came up from the comprehensive review (July 2015) are;

- The country to work towards establishing a functional NITAG to provide evidence-based advise to the MOHSW and the ICC in developing national immunization policies and guidance

- IVD to be empowered to provide immunization services across the life course, and to take on responsibility for all vaccines including those against meningitis, yellow fever, cholera and a potential future malaria vaccines and to collaborate and coordinate better with relevant units within and outside the RHS Section of the MOHSW.
- Sustain and expand proven effective innovations for safe and potent vaccines such as Remote Temperature Monitoring Devices to district cold stores and real-time alarming at central and regional vaccine stores.
- Explore IT solutions through VIMS to capture real-time stock availability at health facilities to improve stock decision making.
- Implement a system for preventative maintenance and repair at all levels through allocation of adequate funds for spare parts and toolkits and advocate to the existing technology institutions to incorporate in their curriculum a module for cold chain equipment maintenance and repair.
- Establish accredited courses for vaccines and logistics management in East African health colleges and support Tanzanian candidates to pursue the courses.
- Advocate to global partners for supply of smaller dose vials of MCV and BCG to avoid high wastage rates
- Establish a surveillance technical working group which meets on a weekly basis that would facilitate data harmonisation and at lower levels establish a forum for IVD and IDSR to work together at all sub national levels In the meantime organize fortnightly data harmonization meetings on: AFP and measles (IVD and Lab AEFI (IVD and TFDA)
- Sustain and maintain quality of new vaccine surveillance and consider mid term review (Rota and intussusceptions , PBM and CRS)

4. TECHNICAL ASSISTANCE

(MAXIMUM 1 PAGE)

4.1 Current areas of activities and agency responsibilities

[Comment on technical assistance received and the responsibilities of the different agencies which provided the support. See guidance document for more details]

Technical Assistance was received from various Immunization Partners in each Area of Support. The scope include Technical Support and Capacity Building. These was done through the IVD Technical Working Group.

Area of Technical Assistant	Agencies provided Technical Assistant
Immunization service delivery and introduction of new vaccines	WHO, UNICEF, USAID
Cold chain and logistics	CHAI, WHO, UNICEF
Data management and use	WHO, CHAI, PATH
Surveillance and reporting	WHO
Communication and demand creation	UNICEF, USAID
Programme Management, Coordination and Policy Bodies	WHO, UNICEF, CHAI, PATH, USAID
Costing and financial sustainability	WHO

4.2 Future needs

[Comment on all bolded areas listed in the table in this section of the guidance document]

For future needs in 2016 we request support in the following areas

Area	Technical Assistant required	Duration
Immunization service delivery	Coverage improvement initiatives, introduction of new vaccines , planning and implementing SIAs, supportive supervision, capacity building	Day to Day Assistance
Cold chain and logistics	Improvement of cold chain management and vaccine management	Long term
Data management and use	Improvement of data management and use of new technologies	Day to Day Assistance
Surveillance and reporting	VPD Surveillance improvement and outbreak investigation and	Long term

	response	
Demand promotion and community mobilization	Advocacy, Communication and demand creation	Long term
Programme Management,	Implementation of the HSS grant, application support, Costing and financial sustainability, management support to ICC and NITAG, specific grant programme management	Day to Day Assistance

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

(MAX. 1 PAGE)

<p>Brief description of how the joint appraisal was endorsed by the relevant national coordination mechanism:</p> <p>The ICC first approved the APR (with the core data) in May 2015, then received the overview presentation of the JA findings on 23 July, and was asked for remote endorsement of the written JA document prior to submission to Gavi by 15th Sept 2015.</p>
<p>Issues raised during debrief of joint appraisal findings to national coordination mechanism:</p>
<p>NIL</p>

6. ANNEXES

[Please include the following Annexes when submitting the report, and any others as necessary]

- **Annex A. Key data** (this will be provided by the Gavi Secretariat)
- **Annex B. Status of implementation of the key actions from the last joint appraisal and any additional High Level Review Panel (HLRP) recommendations**

Key actions from the last appraisal or additional HLRP recommendations	Current status of implementation
Gender: Follow up on sex disaggregated data collection using the revised national HMIS data collection tools	Plans for streamlining the use of revised HMIS tool in transmission of vaccination data in line with VIMS are on way
Equity: Follow up on country plans to use post campaign immunisation coverage surveys and may engage health research institutions to conduct analytical coverage reports for the PBF performance component of HSS grant	Results from the post campaign coverage survey are used in the developing strategies for improving immunization coverage and quality. In this proposal IVD will liaise with Health Institutions in the planning and conducting PBF surveys

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

The Joint Appraisal was combined with a wider comprehensive review which included five reviews in one: traditional EPI review, PIE for MCV2 and HPV, data quality, surveillance and financing. The information emerging from the discussions fed directly into the Joint Appraisal process. The reviews were combined so as to reduce the burden on the country.

The review followed the below methods:

- Desk review of past assessments: Update status of previous recommendations
- Field review with 20 regional review teams (each comprising an external consultant, internal consultant and MOH staff member) conducting health facility staff and beneficiary interviews, vaccination record reviews, observations of cold chain and services.
- Debriefing: Synthesis of field and desk review findings into actionable recommendations for ICC

Participating Partner Agencies:

- WHO/HQ, WHO/AFRO, WHO CO, UNICEF/ESARO, UNICEF CO, CDC, BMGF, MCSP/JSI, CHAI, Gavi Secretariat

An overview of the EPI review / Joint Appraisal discussions was presented to the ICC on 23rd July. The final Joint Appraisal document was endorsed by the ICC

Team composed of GAVI and MOHSW members

The team conducted a consultation with a wider range of immunization stakeholders including WHO, CHAI, JSI, UNICEF, and Ministry of Health officials
The team had data collection tools (questionnaires, checklist, and focused group discussion guides)

The team also conducted verification of reports, technical reports
 They also conducted physical observations of procured equipment and materials, process documentation, bank reconciliation reports
 They summarized the findings and presented in an extended ICC including management team who reviewed the findings, comments and recommendations before submission to the GAVI secretariat

- **Annex D. HSS grant overview**

General information on the HSS grant							
1.1 HSS grant approval date		30 July 2012					
1.2 Date of reprogramming approved by IRC, if any		Not Applicable					
1.3 Total grant amount (US\$)		US\$ 13,512,765 with the PBF model					
1.4 Grant duration		Proposed to be extended to Jun 2018, making it 4.5 years					
1.5 Implementation year		This Report focuses on Jan 2014 – Jun 2015					
(US\$ in million)	2009	2010	2011	2012	2013	2014	2015
1.6 Grant approved as per Decision Letter				Originally approved with budget of \$15,944,246, later revised to \$13,512,765 under PBF mechanism			
1.7 Disbursement of tranches						\$3,786,840 – disbursed Jan 2014	
1.8 Annual expenditure						\$2,528,509.99 Expenditure Jan-December	\$674,736.15 expenditure January - June 2015 and \$ 53,755.12 committed for 2015
1.9 Delays in implementation (yes/no), with reasons		Delay in utilization was due to fact that GAVI HSS funds were received at the same time with NVS introduction grants (MSD, HPV and MR Campaign), the implementation were to be re-prioritized. Also there were					

	Long procurement process
1.10 Previous HSS grants (duration and amount approved)	NIL
1.11 List HSS grant objectives The following are the HSS grant objectives;	<ol style="list-style-type: none"> 1. Improved immunization outcomes (coverage & quality) in the context of integrated health services - National wide; 2. Increased community participation in the provision of immunization services, particularly in rural and hard to reach area and; 3. Improved cold chain capacity and management
1.12 Amount and scope of reprogramming (if relevant) There is no need of re-programming.	

Annex E. Best practices (OPTIONAL)

1. The Government was cognizant of the importance of the Immunization Program as a results internal funds release process were supportive and enhanced immediate release upon submission of request to MOF. Therefore this encourages the use of Government systems for the release of GAVI funds.
2. GAVI approval process could be streamlined so that could be clear to applicants for timely implementation of activities
3. Male involvement with growth monitoring and immunization sessions is emphasized, with men moving to the front of the queue when they bring the infant/child for these services .
4. In a few regions: caregivers receive non-monetary incentives for target populations who are up-to-date on vaccination (e.g. ITNs with measles and ANC contacts, school supplies when completing immunization and growth monitoring to 59 months)
5. Acknowledgement of CHWs who assist with defaulter tracking and outreach (e.g. recognition, excused from community work)