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 analyzed, and explained where relevant.

Country	ZIMBABWE
Reporting period	***2015***
Fiscal period	***2015***
If the country reporting period deviates from the fiscal period, please provide a short explanation	***Not Applicable***
Comprehensive Multi Year Plan (cMYP) duration	***2016-2020 Annex 4***
National Health Strategic Plan (NHSP) duration	***2016-2020***

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-Penta existing presentation	*Extension*	*2017-2019*	*442,736*	*US$407,000(2017)*	*US$2,121,500(2017)*
NVS– *PCV in existing presentation*	*Extension*	*2017-2019*	*442,736*	*US$391,000(2017)*	*US$6,449.000(2017)*
NVS – *MR in existing presentation*	*Extension*	*2017-2019*	*XX*	*US$-N/A*	*US$293,000(2017)*
NVS – *Rota in existing presentation*	*Extension*	*2017-2019*	*442,736*	*US$235,500(2017)*	*US$2,409,000(2017)*
HSS *–2016 and 2017 Budget*	*Renewal*	*2016-2017*	*N/A*	*N/A*	*US$1,757,427(2016 and 2017)*

NB: The country cMYP initially submitted to GAVI runs from 2016 – 2019 and financial support is secured. The cMYP has since been updated to 2020 in line with the new NHS however no funding is secured for this additional year. The country will still require financial and technical assistance for the year 2020.

Indicate interest to introduce new vaccines or HSS with Gavi support*	Programme	Expected application year	Expected introduction year
	HPV Vaccine national roll out	2016	2017
	CCEOP	2017	2017
	HSS	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]

General Context

Zimbabwe's health situation and health system context cannot be understood unless referenced to wider political and macro-economic context (Health Sector Review, 2010). Following independence and an initial period of growth of the economy and the PHC system, an economic recession occurred from the 1990s leading to a dramatic decline in Gross Domestic Product (GDP) of 37% and an associated sharp decline in life expectancy from 66 to 42 years (Health Sector Review 2010). In 2009, economic growth rates declined to minus 14% (cMYP 2015). The under-5 mortality rate is estimated at 69/ 1,000 live births (ZDHS 2015), which represents a decline from the rate of 75/ 1 000 live births recorded in the 2014 MICS. Refer to ZDHS **Annex 9**.

Socio-Economic Situation

The economic growth slowed down in 2015 to 1.5% from the projected 4.2%. (GoZ Budget Statement 2016) The re-forecasted 2016 economic growth is projected at 2.7%. The prospects are that the economy will remain sluggish in the short to medium term and total tax revenues will generally remain at about 27% of GDP (Public Expenditure Review (PER) 2015). The fiscal trends and projections are important indicators of the government's capacity to allocate financial resources to the health sector. The country has a large debt of nearly $10b that needs to be serviced. Unemployment levels remain high with the majority of the people now in informal employment. The GNI per capita is at USD850 according to the World Bank data 2016. This macro-economic environment requires innovation and effective partnerships between government and various partners including communities in both funding and providing health services to the population.

Health System Context

The Government of Zimbabwe through the Ministry of Health and Child Care desires to have the highest possible level of health and quality of life for all its citizens, attained through the combined efforts of individuals, communities, organizations and the Government, which will allow them to participate fully in the socio-economic development of the country. Guided by its mandate and in line with the Results Based Management framework, the Ministry of Health and Child Care has therefore defined the following: Key Result Areas (KRAs) are- (1) Improving the health status of the population (2) Improving the quality of care and Health Systems Strengthening (National Health Strategy 2016 - 2020).

Health care is provided by public facilities, non-profit groups, church organizations, company-operated clinics (such as those of mining companies), and for-profit clinics. Zimbabwe's health delivery services are decentralized, with health care provided at primary, secondary, tertiary, and quaternary levels (HSS Proposal 2012). Refer to National Health Strategy **Annex 7**

Immunisation Program Context

The Expanded Program on Immunization is a Unit within the Ministry of Health and Child Care (MOHCC). The program operates under the concept of the Primary Health Care which the Government of Zimbabwe adopted in 1980.The EPI Unit falls under the Nursing Directorate, Community Health Services department. The program is one of the key interventions aiming at reducing vaccine preventable diseases thereby contributing to SDG3 Target2, that of "by 2030 end preventable deaths of newborns and children under five years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12/1000 live births and under 5 mortality to at least as low as 25/1000". The MOHCC provides policy formulation and guidance on all health issues in the country. The EPI works in collaboration with partners who are coordinated by the Inter Agency Coordinating Committee (ICC).The ICC has two main roles, that is, mobilizing resources and providing an independent oversight to EPI operations. There are several technical committees complementing the ICC one of which is the National Immunization Technical Advisory Group (NITAG). NITAG was established in 2011 to provide technical guidance on immunization policies including introduction of new vaccines and operational research among others. NITAG members were trained on their terms of reference for two days by SIVAC in July 2016 and the procedure manual was developed. The work plan for 2016-2017 has been developed and different Technical Working Groups (TWG) are being formed. Currently the NITAG is focusing on the switch from single dose to four dose PCV13, HepB vaccine at birth or zero dose and change from TT to Td vaccine.

The cold chain system is a four tiered system, including central, provincial, district vaccine stores and health facilities. The AEFI surveillance system is well established. The Medicines Control Authority of Zimbabwe (MCAZ) has in place a National Pharmaco-vigilance Committee to review, classify and respond to drug reactions including vaccines. Human resources management and continuing training are a major component of current EPI operations, in order to mitigate the challenge of high staff turnover and the requirement to place and retain nurses with EPI skills, and vaccine management and surveillance capacity in the Central EPI Unit.

Demand creation for EPI services is not only supported by health workers but also supported through volunteer community health workers and partnerships with NGOs/CBOs. There are other specific strategies such as the lead mothers and fathers who mobilize other caregivers to bring their children for vaccination and the on- going dialogue with private practitioners and religious leaders to include immunization in their services, just to mention a few.

Coverage and Equity

Zimbabwe is currently implementing the RED/REC Strategy, and conducted a routine immunization coverage survey in October 2015. The results indicated the following:

- Penta3 coverage among male and female recipients in the survey was 95.6 and 95.9% respectively.
- Children whose mothers have secondary or higher education have access to multi-media about benefits of vaccinations and have chances of being fully immunized(FIC-81.5%), compared with children whose mothers have primary education (FIC- 74.3%), can read/write (FIC – 70.6%) and illiterate (FIC – 76.1%).
- The rates of fully immunized indicator for the children are almost the same for Unemployed, Other Employed and Self-employed groups (79.0%, 79.5% and 77.8% respectively). Only the children whose caretakers belong to Government employees group have slightly lower rate: 74.1%.
- The analyses show that children of caretakers of "Catholic", "Protestant", "Pentecostal" and "Moslem" faith followers have the highest FIC (86-93%) and Vitamin A supplementation rates in all provinces (except in Mashonaland Central Province) compared with "Apostolic", "Other" and "No religion" groups (77-82%). However, there was a remarkable increase in the rate of fully immunized children of apostolic faith followers recorded in this survey- 81%, compared with the same in 2010 survey (58%).Although there has been this remarkable improvements in the above indicators, the rural-urban coverage still show some disparities. According to MICS 2014, measles coverage was 90.3% urban and 86.5% rural; DTP3 92.4% urban 85.4% rural; FIC 85.3% urban and 78.4% rural. Therefore there is a need to continue to employ strategies to bridge this gap.
- Routine measles containing vaccine (MCV 1) is 93.5% (Routine Immunization Survey 2015), campaign administrative coverage 102% and post campaign coverage survey 94%. Zimbabwe has a special interest for close monitoring vaccination coverage of measles due to serious outbreaks of the disease in Southern Africa during the past decade. **With *93.5%* national coverage by measles vaccine, evidenced by the current survey, the country is very close to WHO African Regional strategic target calling for *at least 95%* coverage at national and sub-national levels by 2020.** However, according to WHO/UNICEF estimates 2015, measles was at 80%. Refer to Annex C for sub-national Maps

Immunization financing

The immunization programme has a comprehensive Multi-Year Plan (2016-2020) that guides EPI operations aligned to the National Health Strategy. The cMYP details budget requirements, secured and probable funding for the programme. The current position is that vaccines and supplies financing are mainly supported by partners through donor basket funding and procured by UNICEF for traditional vaccines and GAVI for New and Underused vaccines with government co-financing. Outreach activities are being funded through the Health Development Fund (HDF), a multi-donor basket fund administered by UNICEF. In addition, the USAID/MCHIP, LIONS Clubs, Rotarians, WHO and Civil Society are also funding immunization activities. The Government is meeting all other recurrent operational costs such as staff salaries and infrastructure maintenance. The Government has consistently met its new vaccine co-financing commitment through funds secured from MOF. Overall expenditures for 2015;

MR Campaign, MSD and MR/MSD VIG USD3,608.840

Expenditure for the three grants was consolidated as a result of integration of activities.

3. 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

3.1. New and underused vaccine (NVS) support

3.1.1. 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]

The country received USD3 442 500 for Measles Rubella operational support costs, USD410,500 for Measles Rubella Vaccine Introduction Grant (VIG), USD410,500 for Measles Second Dose VIG and USD367,000 for Inactivated Polio Vaccine VIG from GAVI. The MR vaccine was introduced through a national catch up campaign in September 2015 targeting 5.2 million children aged 9 months to 14 years. Coverage of the catch-up campaign was 102% administrative and 94% post campaign survey results.

There is a balance of USD799,264 from the aggregated above funding and this includes VIG for IPV that remained unused due to global shortage of the vaccine. There is also a balance of USD111, 868 for Rotavirus VIG from year 2014.The Ministry is proposing to use the balance of $799 264 on training of a core team of facilitators in EPI, writing team for documentation of best practice, mentoring, supportive supervision, outreach work, peer reviews, quarterly review meetings, and dissemination of survey/assessments results, procurement of Cold-Rooms protective clothing and uniforms for CVS security guards. The country hopes to undertake these activities by end of 2017.

The challenges included the shifting of the MR campaign from June 2015 to September/October 2015 due to the late confirmation and release of funding by GAVI. The postponement of the campaign affected other planned activities meant for the 3rd and 4th quarters of 2015 such as training of vaccine storekeepers on computerized stock management tool (SMT) and planned supportive visits. The VIG for IPV was received together with MSD and MR campaign grants and yet the arrival of IPV vaccine has been postponed indefinitely due to global supply shortage. The plan was to integrate operational activities for the three interventions since they were to be introduced at the same time but the IPV component was left out. However, IEC materials and branded t-shirts for awareness raising and social mobilization for IPV were produced for introduction of the new vaccine. These are yet to be distributed. There could be possible inadequate funding for IPV implementation as it will now be a standalone activity.

A communication plan for demand creation was developed and implemented during the MR campaign to mobilise communities. Mass media was carried out using print and electronic media and during preparation for the campaign. All health workers were trained and oriented in IPC. The Vaccine Acceptability Assessment recommended that there should be continuous dialogue with religious leaders to enhance more acceptance and this is being done. It also recommended that CBOs and NGOs should be trained in IPC for future campaigns. The country plans to train CBOs in eighteen low performing districts by the end of 2016. The AEFI Communication Guideline and training of the media on crisis communication have not yet been done. Due to late disbursement of funds from GAVI, the data collection tools could not be updated in time before introduction of the new vaccines and as a result MSD data could not be disaggregated. The updated tools have been available since the first quarter of 2016.

3.1.2. 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 immunization programme]

The country is planning to apply for national rollout of the Human Papilloma Virus vaccine in 2017 after a successful demonstration project in two districts, Marondera and Beitbridge. The plan is to submit the application for the January 2017 window for possible rollout in September same year. Zimbabwe is currently implementing the extended HPV vaccination demo in the same two districts.

The country awaits the IPV introduction pending availability on the global market.

3.2. Health systems strengthening (HSS) support

3.2.1. Strategic focus of HSS grant

[Comment on the extent to which the HSS grant contributes to improve coverage and equity in access to immunization, 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]

Achievements of targets and of intermediate results, and feasibility of targets set in the original proposal

The country managed to achieve 87% vaccination coverage for DTP3, which is below the target set in the M&E framework by a five percentage point. Main reasons for the slight decline in coverage compared to 91% in 2014 and failure to meet the target include pulling out of local partners who used to support outreach vaccination in districts, late accounting of funds by districts thereby affecting timely release of funds for outreach work and competing priorities where attention is being paid to programs attracting subsidies for health facilities. The reduction in funds allocated for EPI outreach in the Health Development Fund managed by UNICEF coupled with late release of funds also contributed to the decline in coverage e.g. only one disbursement was done in 2015 instead of four. The country last qualified for Performance bonus in 2014.

Actual versus planned activity implementation, based on approved work plan

One major change brought in 2015 was that GAVI decided to bring all cash grants for Zimbabwe through the pooled HDF from 2016 onward hence this report is for funds brought direct to GOZ. UNICEF takes responsibility for the management of these funds through HDF. The bulk of the budget under HSS funding in 2015 was to go towards procurement of vehicles for vaccine delivery and for outreach work. The MOHCC transferred USD1, 696,200 and requested WHO to procure 9 vaccine delivery trucks, 24 Toyota Land Cruisers (5 vehicles ISS) and 73 laptops. The laptops were handed over to MOHCC in March 2016 while the vehicles are expected in the country in September 2016. There was a balance of USD132,853 at MOHCC as of June 2016. Some of the activities planned for 2015 were rescheduled to 2016 because of delayed utilization. These activities include; procurement of training materials, vehicles, SDD refrigerators, computers and accessories for training. These are in process of procurement.

Degree of participation of key stakeholders in the implementation of the HSS proposal, including civil society organizations

Key stakeholders involved in the HSS grant implementation included WHO, UNICEF, USAID/MCHIP and members of ICC and the CCM, drawn from various organizations including CSOs. The GAVI HSS has a component to fund capacity building of CSOs to enhance community dialogue in eighteen low performing districts. The CSOs will be recruited and trained 3rd and 4th quarters of 2016. The CSOs will be working with VHWs to mobilize communities for immunisation activities, registration of children and vaccination defaulter tracking.

Implementation Bottlenecks, Corrective Actions, and Lessons Learned to Improve Future Performance

Among the major bottlenecks was limited staff in the EPI Unit and administrative capacity within the MOHCC. The high prices of vehicles in the country above the UN catalogue pricing affected timely utilization of the funds.

However, this has since been addressed through recruitment of additional staff at national EPI unit and the engagement of WHO to take up the procurement process.

Compliance with Data Quality and Survey Requirements

The Ministry is complying with data quality requirements with routine administrative data being submitted to national level on monthly basis. The last DQS was carried out in 2013 and it did not show any significant disparities between administrative and DQS findings. This was further corroborated by the 2015 Provincial level Routine EPI Coverage Survey that confirmed sufficient consistency between administrative reports on immunization coverage and survey coverage rates; evidence of a functional reporting system.

The country conducted Rota Post Introduction Evaluation (**Annex 3**) in March 2015 and HPV Post Introduction Evaluations **(Annex 6**) in June 2015 and developed recommendations based on findings. Most of the recommendations have been addressed. A Cold Chain Assessment was conducted end of 2015 and the country is in the process of developing a 5 Year Cold Chain Equipment Replacement plan. It is hoped that when this replacement plan is complete, the country will ride on the GAVI Cold Chain Equipment Optimization Platform. An Effective Vaccine Management Assessment (EVMA) was conducted in 2016 and an improvement plan developed. Some of the recommendations have since been implemented while funds are being mobilized for other activities that require funding. Refer to EVMA Report **Annex 8.**

Follow-up on Recommendations from Any Available HSS Evaluation Report

The Ministry should make frantic efforts to improve utilization of the GAVI HSS grant which has been lying idle for more than a year. The main reason for this deficiency was that the GAVI funds were initially deposited into MOF and the MOHCC had challenges in accessing the funds. (MOHCC Finance to expand)

The slow implementation of HSS activities was a result of delays in cash releases from the MOF. MOHCC and MOF then agreed to have the bulk funds transferred to the MOHCC's Health services Fund (HSF). This position has since changed as the HSS funding utilization has increased to 92% taking into considerations funds that have been disbursed to WHO for procurement of vehicles. The Ministry is in the process of reprogramming the use of the balance of USD 132,853 together with other remaining GAVI funds under VIG and MR Campaign.

Overall Programmatic Capacity of Entity Managing HSS Grants

The capacity of the EPI Unit has improved in terms of organizational capacity building activities, recruitment and promotions. MOHCC has made procurement reforms to improve the overall management of procurement system in the Ministry part of which includes procurement plans for programmes. The Ministry has now also come up with a SOP of how DSAs for workshops and trainings are going to be processed. These will only be processed after evidence of completed sign in sheets as well as the submission of that particular activity report. This was done to try and address some gaps and inconsistencies that were observed in the Audit Report on GAVI Grants that was conducted in 2015.

The Ministry is hopeful that the final Audit recommendations will be addressed and implemented under the umbrella of the Audit and Risk Management Committee established by MOHCC in 2015.

FINANCIAL PERFORMANCE AND CHALLENGES*:*

Actual versus planned financial expenditure, based on approved budgets

The country had about USD1,73 million for HSS in 2015 and the implementation level stands at 92% taking into account funds disbursed to WHO for procurement of vehicles and computers. However, the available balance of funds with MOHCC have not been accessible since November 2015 to date and will not be accessible until the audit reports are finalized by GAVI.

Any key challenges regarding the financial management of HSS grant

There was a delay in cash release, of HSS funds from Treasury for the period January to June 2015, however the bulk of the funds have been released with the exception of USD230,000.

Overall Financial Capacity of Entity Managing HSS Grants

The Ministry of Health and Child Care has the capacity and staff with adequate financial management skills to manage the HSS grant, and with support from the Permanent Secretary's office, and with continued systems improvement the Ministry is able to manage this grant. Furthermore it is hoped that the HSS grant for capacity development will enhance the accounts department financial management skills. However, initially when the funds were received activities for MR, MSD and IPV were integrated, which led to consolidated requests of funds hence making it difficult to produce disaggregated financial reports. Attention is being given to the irregularities that were highlighted in the audit report.

Financial reporting by the MOHCC and the HDF

In 2016 and 2017 funds are managed both by the MOHCC (for HSS disbursements made in 2014 and 2015 and for VIGs and Op costs disbursed in 2015) and by the HDF (HSS and PBF funds transferred in 2016). HDF reporting follows different rules as stipulated in Gavi-UNICEF grant agreement and UNICEF (that manages and administers the HDF) will only provide a yearly financial report in 2016.

Cash program audit

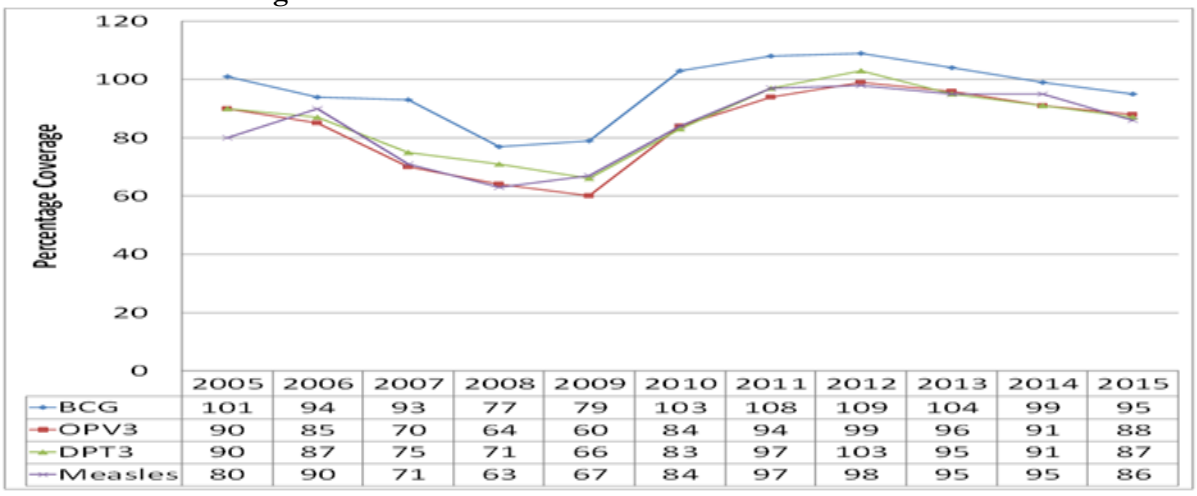
Gavi conducted a cash program audit (CPA) in 2016 on GAVI cash grants received by Zimbabwe since 2012. This audit built on a financial verification of the 2015 cash grants (VIG MR, VIG MSD and MR op costs) realized by PwC at the end of 2015. Further financial verification at district levels were conducted by the MOHCC (department of internal audit) between July and August on utilization of 2015 cash grants to complement the CPA. Furthermore the external audit is scheduled to start GAVI Audit on 01 October 2016. The Ministry responded last August to the Gavi audit observations. Gavi is still to state on this and send the final audit report with recommended actions. It is expected when the final recommendations come they will be implemented under the umbrella of the Audit and Risk Management Committee established by MOHCC in 2015.

3.2.2. 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]***

Achievements

Immunization Coverage:



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
BCG	101	94	93	77	79	103	108	109	104	99	95
OPV3	90	85	70	64	60	84	94	99	96	91	88
DPT3	90	87	75	71	66	83	97	103	95	91	87
Measles	80	90	71	63	67	84	97	98	95	95	86

There was a general slight decline in vaccination coverage as depicted by the proxy indicator where DTP3 was 87% in 2015 compared to 91% in 2014. The decline is attributable to reduced outreach work due to late disbursement of funds into HDF by donors, late accounting for funds by provinces, reduced budget for

outreach and the pulling of local partners who were supporting outreach work. Despite this, there has been a steady improvement in immunization coverage particularly over the last 4 years, with DTP3 coverage being maintained above 90% between 2011 and 2014 (WHO UNICEF Estimates). WHO estimates for PCV3 in 2014 were 91% (WHO UNICEF Estimates). Prior to 2010, DTP3 coverage ranged between 65% and 75% for a period of 10 years, so these recent coverage improvements point to a sustainable turn around in EPI performance in Zimbabwe. Targets have also been updated in 2013 based on 2012 census figures, replacing the former population estimates based on the previous census in 2002. The last coverage survey was in 2015, where 87% was reported for DTP3 (contrasting with a 95% official estimate for DTP3. The sustained high coverage has resulted in reduction of VPDs. The last measles outbreak was in 2010, where 9696 cases reported. There were zero confirmed measles cases reported in 2015 with good measles surveillance performance. The measles case detection rate was 2.5 and 86% of districts had at least one case of blood specimen in 2015. However nine districts did not report any case and two provinces (Masvingo and Mat South) had measles case detection rate below 2. There was a significant reduction of reported confirmed cases of rubella from 1130 in 2014 to 24 in 2015. Only 10 out of 63 districts were above 95% coverage for MCV1.

Immunization Continuing Training:
The country took advantage of available funding for new vaccine introduction to strengthen other routine EPI operational areas such as disease surveillance, AEFIs monitoring, cold chain and vaccine management, data management, advocacy and communication. The integrated implementation of trainings for MR, MSD, IPV and Switch saved on time affording more time for health workers to implement activities.

Cold Chain & Vaccine Management:
There were no major problems experienced with the cold chain during the period under review based on the 2015 Cold Chain Assessment. GAVI support for new and underused vaccines and related supplies in 2015 was consistent with all funds released on time and supplies coming into the country on time. There were no stock outs of GAVI supported vaccines and supplies at central level during period under review. Any vaccine stock outs experienced for these vaccines at lower levels were a result of other factors such as poor forecasting and/or lack of transport. According to Routine Immunisation Coverage Survey 2015, children vaccine failure due to vaccines not available constituted 14.7%. However, the country experienced stock outs of BCG, tOPV, TT and DTP (18 months booster) vaccines due to various reasons such as late release of funds by donor and shortage in the global markets.

Human Resources Management:
While the country still has the human resources capacity to deliver the EPI services, as outlined in the general and health system context, human resources management has had challenges. There is inadequate quality supportive supervision by district to health facilities because of staff shortages, staff turnover and competing programmes. Despite the ongoing training programs, there are knowledge gaps in some health workers in disease surveillance and data management.

However, the country appreciates the support extended by GAVI in funding critical posts of Stores Officer, Stores Assistant, Cold Chain Technician, Program Assistant and four Security Guards at EPI Central Vaccine Store. The appointments were made on condition that the posts would be absorbed by Government at the expiry of GAVI support.

Program Assessments and Reviews
The country conducted a Cold Chain Assessment (CCA) in 2015 the results of which will inform the development of a 5 Year Cold Chain Equipment Replacement Plan 2016 – 2020. Development of the report has been delayed because of technical issues with data capture. The CCA report is being finalized and the equipment replacement plan is still under development. The country also conducted an Effective Vaccine Management Assessment (EVMA) in July 2016. A draft report and budgeted improvement plan is now available. A comprehensive EPI review integrated with EPI surveillance and post introduction evaluation (PIE) of Measles Rubella was conducted in July 2016. Refer to EVMA Report **Annex 8 and EVMA Improvement Plan Annex 5**

a. Major Findings from EVMA

The EVMA found that the country has adequate vaccine storage capacity at all levels, availability of a "state of the art" Central Vaccine Stores constructed through government funding, use of computerized stock management at central and provincial levels and use of standard manual stock management tools at district and service delivery level among other many achievements. Some of the weaknesses noted included; the Central and provincial vaccine stores cold rooms are not equipped with appropriate continuous temperature monitoring devices, temperature mapping has not been done on all cold rooms, unavailability of standard operating procedures for vaccine management, critical stock levels of vaccines and supplies breached at most facilities, stock outs of some vaccines and inconsistent updating of stock records within a day of stock transaction. The assessment also noted that although computers for vaccine management are available at district level they are not being used because users have not been trained. There are no standard issue/receipt vouchers for vaccines and supplies at provincial and district vaccine stores. Health care workers' knowledge was minimal on some vaccine management aspects and technologies e.g. the shake test, calculation of vaccine wastage, forecasting vaccine and supplies requirements and use of fridge and freeze tags.

b. Major Findings from Comprehensive EPI Review

EPI performance in Zimbabwe is of high quality / coverage and the country is on track to achieve GVAP goals despite the current economic challenges. The introduction of new vaccines was successful and did not affect the Immunization system; rather it augmented the knowledge of health workers through refresher training. The VPD surveillance system is well established and functioning well.

The review recognized that the MoHCC has done outstanding efforts to implement recommendations of the 2009 external EPI program review. However, the following recommendationshad not been implemented:

- Relocate EPI Unit to Preventive Services Directorate: ongoing
- Fill in vacant posts (many EPI positions in acting capacity including the EPI Manager post)
- Undertake district-specific EPI coverage survey (done at provincial level only)
- Include cold chain preventive maintenance in EPI budget

The ICC has limited oversight support required for adequate program management.

The current staffing level for the program is inadequate (86% of Provinces, 65% Districts and 78% of HFs reported inadequate human resource and in some cases, one nurse was running a clinic. Human resource shortage is prevalent at all levels (more pronounced at HFs) and may have consequences on quality of service unless gaps are filled.

There are some persistent underperforming districts in AFP and surveillance that pose a challenge in timely detection of importations. The accumulation of unimmunized children against measles may cause an outbreak if a case is imported in to such communities. Data collection and reporting is going on well; however, data analysis and use for action needs to be strengthened. Government expenditure on health is low (9%) of the national Gross Domestic Product (GDP) and EPI is mainly supported by partners' funds. Limited funding is resulting in cancellation of immunization services and adequate funds should be allocated to the program so that high coverage rates that reduced Infant and Under five years mortality rates in the country can be sustained. Refer to **Annex 10**

Key Recommendations from 2016 EPI Review

- Government to allocate adequate funds to EPI program; and partners should continue ongoing support to the immunization program in Zimbabwe.
- Staff motivation packages e.g. timely promotions, recognition of good work performance awards should be implemented in order to retain the existing scarce human resources. (MOHCC and partners)
- Intensify targeted supportive supervision to underperforming districts (high unimmunized children, high dropout rate and with surveillance gaps) and provide required financial and technical support to close gaps. (all levels)
- The government of Zimbabwe should gradually start funding procurement of traditional vaccines
- The MOHCC and partners should support the ZEPI program to procure and install temperature monitoring devices for vaccine cold rooms at national and provincial level.

- The country should be supported in implementation of the cold chain replacement plan 2017-2021
- The MOHCC should significantly increase funding for vaccine delivery and cold chain maintenance
- The MOHCC should consider creation of key positions of vaccine store keeper and Cold chain technician at provincial level in view of the value of the vaccines
- The MOHCC and partners should develop, implement and monitor EVMA improvement plan.

3.2.3. 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]

The country proposes to reprogram HSS funds for items 1.1.1; 1.1.2.1 and 1.1.2.3as follows;

1.1.1. To install EPI standby generators procured through UNICEF, construct Midlands Vaccine Stores and Dry store for Central Vaccine Store

1.1.2.6 To develop/finalize, print, distribute SOPs and train for effective vaccine management to bridge gaps identified in EVMA and Comprehensive EPI Review.

1.1.2.3 Procurement of Continuous Temperature monitoring Devices and computers for Cold Rooms (12 sets), Procurement of Spare cooling units for cold rooms (2 units), Procurement of Fridge Tags (4,000)

REPROGRAMMING OF HSS FUNDS

CURRENT BUDGET LINE	**TOTAL BUDGET**	**NEW ACTIVITIES**	**RATIONALE**
Provide all identified Provincial and District Vaccine Stores with stand-by generators	$326,163	Install new generators, construct Midlands Provincial vaccine Store and central level dry stores	Generators were procured by UNICEF
Insure 104 battery free solar refrigerators	$145,600	Insurance of the Central Vaccine stores, To develop/finalize, print, distribute SOPs and train for effective vaccine management to bridge gaps identified in EVMA and Comprehensive EPI Review.	Its more critical to ensure the vaccine stores as it is costly to restore and replace destroyed vaccines and cold rooms
Insure 29 generators	$48,720	Procurement of Continuous Temperature monitoring Devices and computers for Cold Rooms (12 sets), Procurement of Spare cooling units for cold rooms (2 units), Procurement of Fridge Tags (4,000)	It is more important to have continuous temperature monitoring devices and spare cooling units than insuring stand by generators

3.3. 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

3.4. 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]

The Finance department managed all the grants in line with both the GAVI and treasury instructions. The MOHCC has taken all the recommendations from the 2015 GAVI audit and these are being implemented. It has been decided at the end of 2015 that all cash grants to be disbursed to the country from 2016 will go through the HDF, therefore specific financial management arrangements will prevail as UNICEF coordinates and administers the HDF activities and funds.

4. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

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

Prioritized strategic actions from previous joint appraisal/HLRP process	Current status
1. Strengthening of EPI management capacity through development of technical proposal to unfreeze and fill essential EPI management posts (cMYP 2015 pp 24)	In-process
2. Development of technical proposal/or advocacy strategy to secure finance for immunisation operations and outreach funding (through HTF & HSS)	Currently, 45 Districts funded by HDF and 18 by HSS.
3.Development of more detailed financial sustainability plan/advocacy strategy for immunization financing (advocacy through parliamentary portfolio committee cMYP 2015)	In process
4.Expedite procurement of vehicles to support outreach services	Implemented. Procurement done through WHO, vehicles expected September 2016.
5.External audit of GAVI HSS funds	Implementation starting 01 October 2016
6. Utilization of balance of VIG	To reprogram the funds once cleared by GAVI

5. PRIORITISED COUNTRY NEEDS[1]

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

Incentives for EPI Staff at Central Level	Jan –Dec 2017	Financial Support
Development of job aids	Quarter 1,2 2017	Financial and Technical Support

[Summarize 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]

Prioritized needs and strategic actions	*Associated timeline for completing the actions*	*Does this require technical assistance?* (yes/no) If yes, indicate type of assistance needed*
Capacity Building		
Training on financial management at central, provincial and district levels	Quarters 1&2 2017	Financial and Technical Support
Re orientation of ICC members	Quarter 2,3 2017	Financial and Technical support
Support operational costs of ZIMNITAG	Quarters 1,2,3,4 2017	Financial and Technical Support
RED REC training	Quarter 1,2,3,4 2017	Financial and Technical Support
Pre-service curriculum development and training for doctors and nurses on EPI Training of Tutors and lecturers on EPI to update them on new technologies and innovation on EPI	Quarter 3,4 2017	Financial and Technical Support
EVM training for health workers and vaccine store keepers including new technologies	Quarter 4 2016 Quarter 1 2017	Financial and Technical Support
Training of cold chain technicians	Quarter12 2017	Financial and Technical Support
Communications		
Development of a 5-year communication Strategy	Quarter 2,3,4 2017	Financial and Technical Support
Engagement of CBOs in Social Mobilisation	Quarter 1,2,3,4 2017	Financial and Technical Support
Training of Media on crisis communication	Quarter 2,3,4 2017	Financial and Technical Support
Orientation of Religious leaders on EPI and Surveillance	Quarter 1,2,3,4 2017	Financial and Technical Support
Training HWs on IPC	Quarter 1,2,3,4 2017	Financial and Technical Support
Development of AEFI Communication Guideline	Quarter 2,3,4 2017	Financial and Technical Support
Programme Management		
Annual updating of the cMYP	Quarter 1 2017	Financial and Technical Support
Policy documents development/update: measles elimination strategy plan, measles elimination surveillance, communication strategy, EPI policy, NNT sustainability plan,	Quarter 1,2 2017	Financial and Technical Support
Documentation team to document good practices on EPI	Quarter 1,2,3,4 2017	Financial and Technical Support
Temperature mapping study	Quarter 4 2016	Technical Support
Development of EVM SOPs	Quarter1, 2 2017	Financial and Technical Support

Surveillance		
Surveillance training- AFP, Measles (elimination mode), AEFI	Quarter1 2017	Financial and Technical Support
Surveillance quarterly review meetings	Quarter1, 2,3,4 2017	Financial and Technical Support
Monitoring and Evaluation		
DQS scheduled 2017 and Improvement plan	Quarter 2 2017	Financial and Technical Support
Injection safety assessment	Quarter 3 2017	Financial and Technical Support
IPV and HPV PIE	2018	Financial and Technical Support
Supervision	Quarter1, 2,3,4 2017	Financial and Technical Support
Service Delivery		
Introduction of new vaccine – IPV	Quarter 4 2017	Financial and Technical Support
Introduction of new vaccine – HPV	Quarter 1 2018	Financial and Technical Support

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

6. ENDORSEMENT BY ICC, HSCC OR EQUIVALENTAND 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 document had been shared before the meeting for members to go through. A day's meeting was convened with full ICC representation who went through the document word by word achieving consensus.
Issues raised during debrief of joint appraisal findings to national coordination mechanism	• Financing of traditional vaccines by government of Zimbabwe, • Human resources shortage and skills, • Documentation, • Data management, • Co-financing advocacy, • Operational research and innovations, • Development of Policy briefs • Private sector participation
Any additional comments from: • **Ministry of Health** • **Gavi Alliance partners** • **Gavi Senior Country Manager**	• Strengthen the ICC committee through reengagement of high profile members. • Increase advocacy on resource mobilization for EPI

7. 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)

MOHCC (EPI Policy and Planning, Finance, Audit), WHO, UNICEF, USAID/MCHIP and GAVI participated in the JAR writing. From 10 to 12 August, the MOHCC organized a 3 day workshop with participation of

MOHCC (EPI Policy and Planning, Finance, Audit), WHO, UNICEF, MCHIP and GAVI participated in the JAR writing

The following evidence was used to inform the 2016 JA:

EVMA 2016,

EPI Comprehensive Review 2016 findings,

JA report 2015,

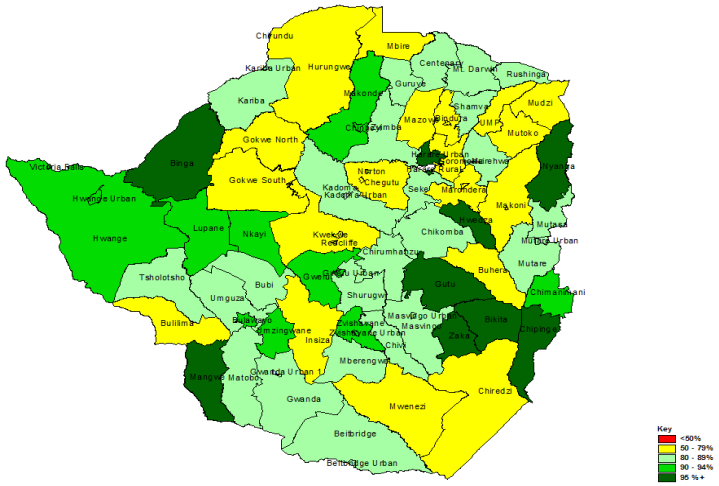
Information was gathered from desk reviews and discussions among stakeholders. Discussions were conducted by way of meetings where all stakeholders participated. The draft document was also circulated to stakeholders by email for comments and suggestions.

Annex B: Changes to transition plan *(if relevant)*

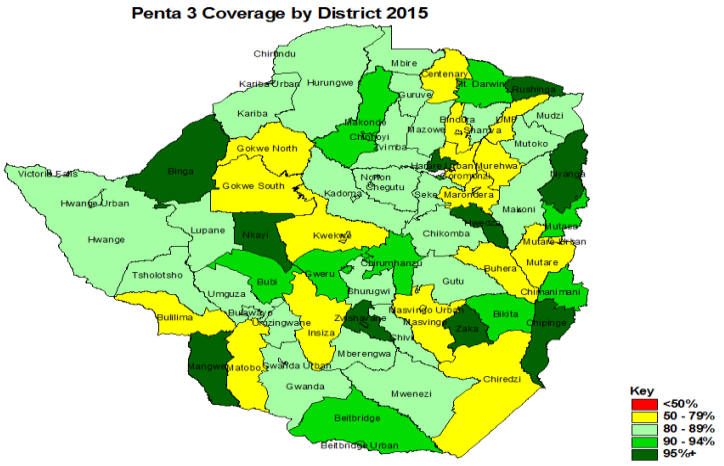
Changes proposed	Rationale for changes	Related cost (US$)	Source of funding for amended activities	Implementation agency	Expected result

Annex C: DTP3, OPV3 & MCV 1 Coverage by District

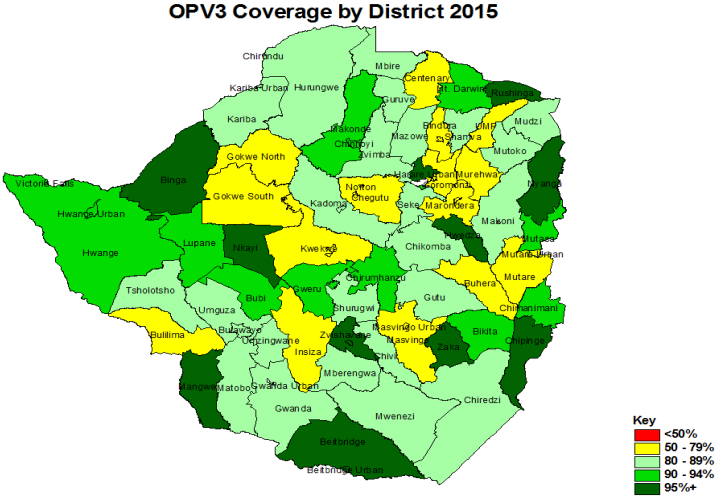
Measles First Dose Coverage by District 2015



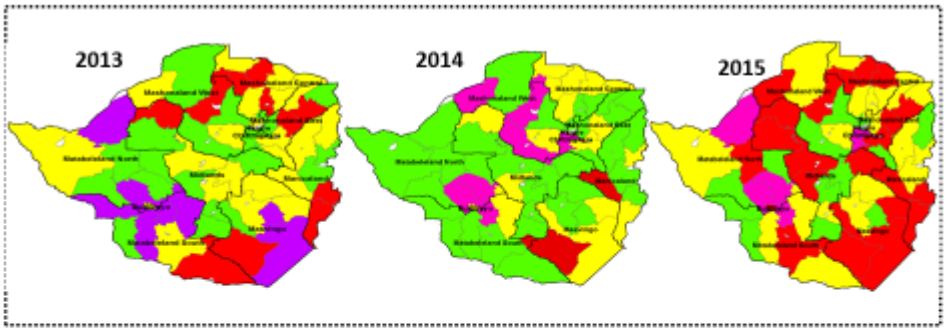
Penta 3 Coverage by District 2015



OPV3 Coverage by District 2015



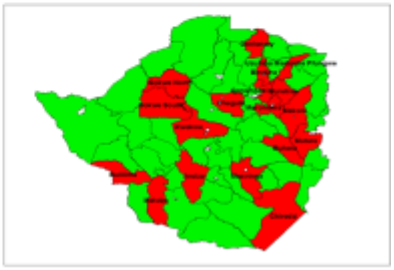
Penta 1 – 3 drop out rate 2013 – 2015 (source: admin coverage)



Key	2013	2014	2015
Negative	8(13%)	7(11%)	5(8%)
< 5%	19(30%)	35(55%)	14(22%)
5 to 10 %	25(40%)	19(30%)	21(33%)
> 10%	11(17%)	2(3%)	23(37%)

Districts by Penta 3 coverage 2015

Source: JRF : red < 80% coverage



Annex 1-ICC Signatures

Annex 11-ICC Minutes Endorsing the JA