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	Uganda
Reporting period	*January to December 2015*
Fiscal period	*January to December 2015*
If the country reporting period deviates from the fiscal period, please provide a short explanation	*Uganda Fiscal year is July to June*
Comprehensive Multi Year Plan (cMYP) duration	*2016 to 2020*
National Health Strategic Plan (NHSP) duration	*2015/16-2019/20*

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]

Table 1: Vaccine renewal and co-financing

Programme	Recommendation	Period	Target	Indicative amount paid by Country	Indicative amount paid by Gavi
NVS – *PCV in existing presentation*	*Extension*	*2017*	*1,644,143*	*$1,016,000*	*$15,240,000*
NVS – Pentavalent in existing presentation	*Extension*	*2017*	*1,644,143*	*$* 1,050,000	*$* 7,019,500
NVS – IPV in existing presentation	*Renewal*	*2017*	*1,644,143*	*$0*	*$3,572,500*
NVS – HPV in existing presentation	*Extension*	*2017*	*814,025*	*$484,500*	*$10,807,500*

Indicate interest to introduce new vaccines or HSS with Gavi support*	Programme	Expected application year	Expected introduction year
	Rotavirus vaccine introduction	*Approved 2016*	*Introduction 2ND t quarter 2017*
	Meningitis A Campaign in selected 38 high risk districts	Approved 2016	N/A

**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

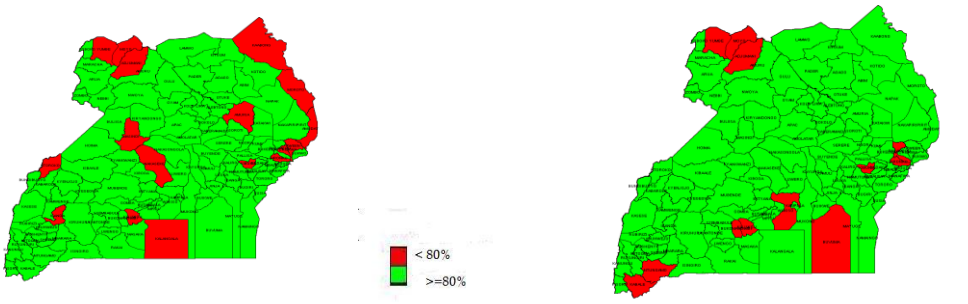
[If relevant, comment only on any changes since the previous joint appraisal to key contextual factors that directly affect the performance of Gavi grants – see guidance document for more details]

Governance: In 2015, Uganda had an estimated total population of 35,993,950 and expected to increase to 36,860,700[1] in 2016. The population growth rate is 3.00% and infant mortality rate of 53/1000 Live Births[2]. The number of districts has increased from 112 (2015) to 116 effective July 2016. In an effort to improve routine immunization services, Uganda now has an immunization act March 2016 that provides a framework for establishment and management of the immunization fund, guides enforcement and implementation as per the set EPI policy and standards. During 2015, NITAG was fully functionalised to provide an independent advisory technical and policy guidance to the immunisation program.

Coverage and Equity: In 2015, an improvement in performance was observed, overall 12 out of 112 districts had DPT coverage below 80% compared to 16 out of 112 districts in 2014 **(**Figure 1Figure 1**).** Dropout rate at the sub national level still remains high. More than 40% districts reported a dropout rate >10%[3]. The GAVI FCE Household survey 2015 conducted in 19 districts provided an analysis of the key determinants of vaccination among children aged 1 to 5 years in Uganda. Among 3,751 children who had received pentavalent 1,928(25%) did not complete their 3 dose schedule. Multivariable models showed that: religion, tribe, place of child delivery, maternal education, wealth quintile, travel time and transportation costs were predictive of whether a child completed their vaccination schedule or not[4]. To mitigate the disparity in 2015, using the Gavi HSS grant, all districts were supported to scale up RED/REC micro-planning, advocacy and community social mobilizations, expanded cold chain capacity and improvements in program management to ensure effective immunization service delivery. Uganda has planned to conduct an equity assessment in 2016 that will further sharpen the micro planning to reach the underserved communities.

Figure 1: Pentavalent Coverage 2014 and 2015

2014 2015



Programme Management and Financing: UNEPI team is constituted of 9 technical officers; of whom 7 are GoU supported (1 Program Manager, 2 Senior Medical Officers, 1 Assistant Engineer, 2 Cold Chain Officers and 1 Senior Nursing Officer. Additional 2 cold Chain technicians are supported under Gavi HSS1 grant. Management and coordination of the Gavi HSS1 grant and VIG is through MoH Gavi secretariat staff namely 1 project coordinator and 1 project administrator. Two officers from Health education Department support social mobilization and communication activities of the Program. Four (4) new staffing additions in 2015 included 2 Medical Officers (MO) supported by CHAI; 1 M&E Officer and 1 CCT supported by Gavi HSS1 grant.

Uganda Comprehensive EPI, Surveillance, Immunization Financing Review and Post Introduction Evaluation of Pneumococcal vaccine was conducted in Feb 2015 and findings were used to update the cMYP and development of HSS proposal. The cMYP was aligned with 2015/16 - 2019/2020 Health Sector Development Plan (HSDP) and WHO regional immunization strategic plan 2014 - 2020.

In 2015, USD 23,954,052 (including HSS funds approved but not yet disbursed by Gavi to the Country) was available from Gavi of which USD 12,863,109 was spent /committed in 2015. While USD 1,159,360 was used for introduction of HPV, USD 11,703,749 was used to implement ISS and HSS activities; leaving a balance of USD 11,090,943 for expenditure in 2016 on IPV introduction and HSS

[1] Projected UBOS population 2016
[2] UBOS Census 2014
[3] JRF 2015
[4] Summary report on determinants of vaccination among children aged 1 to 5 years in Uganda

activities Annex C: Review Cash grants from Gavi HSS1 grant (Annex C). Currently external audit for 2015 is on-going.

Service delivery: Using Gavi grants, there was upscale in service delivery as witnessed by the 88 districts that received the funds being strengthened and supported to implement 121,189 (84%) of their planned outreaches. The 88 districts were supported to develop micro-plans, conduct outreaches and distribute vaccines and related supplies to scale up efforts to reach every community[5]. Twenty four districts that did not receive Gavi funds support due to poor accountability and change of account numbers performed sub optimal with only 1,024 (7%) of their planned outreaches conducted.

New Vaccine Introduction: In November 2015, UNEPI rolled out HPV vaccination into routine immunisation program in all 112 districts targeting girls of primary 4 in school and age 10 years in the community (2.2% of the total population). MoH-UNEPI applied for Gavi Rotavirus Vaccine (RV1) introduction grant and MenA vaccination campaign grant in 38 high risk districts. MenA campaign is planned for November 2016 while RV1 introduction will be in the second quarter of 2017 after MoH has responded to Gavi Program Capacity Assessment (PCA).

Vaccine Supply & Logistics: Effective Vaccine management (EVM) improvement plan was monitored through monthly vaccine management meetings. Of the 5000 Fridge Tags procured under Gavi HSS1 support, 500 were installed in all the district vaccine stores and health facilities alongside the installation of the SDD fridges. Installation of the remaining 45,000 is currently on going to cover all health facilities across the country. Refurbishment of the National Medical Stores in preparation for the installation of the 11 WICR and 1 WIFR that increased cold chain capacity for storage of HPV vaccine was done. Expansion of CC capacity and rehabilitation of the CC system at both the National and District level was done. At National Medical Stores, 12 cold rooms and 1 freezer room were installed. 355 Solar Direct Drive (SDD) fridges, 674 electric fridges and 1000 vaccine carries were procured, distributed and installed in all districts. Efficient maintenance of the cold chain system was conducted in 35/112 districts. Spare parts, maintenance tool kits, 90 generators, 674 voltage stabilizers and 500 gas cylinders to bridge the existing gaps identified were procured.

Transport*:* Seventy one motor vehicles, 600 motorcycles, 10 motor boats and 1,500 bicycles were procured and distributed. Of these, 65 motor vehicles and 598 motorcycles were distributed to the districts to support vaccine and immunisation activities. Four refrigerated vaccine delivery trucks were procured to improve delivery of vaccines and logistics to the districts.

Communication & community linkages: MoH and Health Development Partners raised the awareness of 560 religious leaders on RMNCAH issues, this provided them better understanding on the continuum of care using the life cycle approach and further strengthening the partnership in mobilizing communities and changing key behaviours related to RMNCAH and immunization. IEC materials, both print and electronic media, were developed and distributed to all the districts for HPV and IPV introduction and Measles campaign. The 2015/16- 2019/20 Community Health Extension Workers (CHEWs) Strategy) was developed as part of the national health system to equitably strengthen service delivery at the community/ household levels. At the request of MoH, a Harvard Opinion poll was conducted to assess communities' knowledge, attitudes and practices on immunisation. The findings from this opinion poll will be used to develop a new EPI communication strategy and review key messaging for the various target audiences.

Surveillance and Monitoring: Training and mentorships of Data Improvement Teams was done in 11/14 (79%) regions covering 86 (77%) districts. The updated HMIS data collection tools were printed and distribution is ongoing. Three new vaccine sentinel sites have continued to document impact of new vaccine introduction.

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

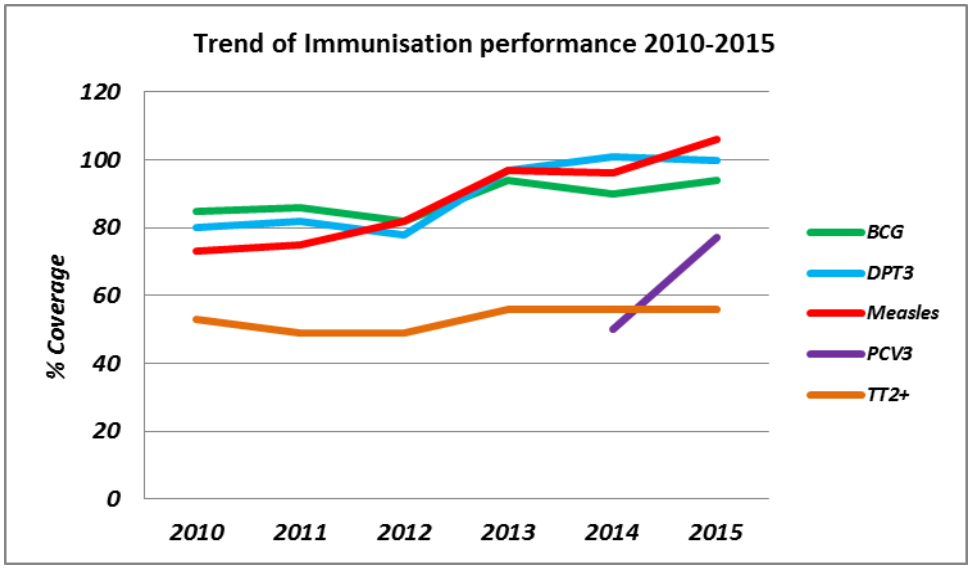
3.1.1. Grant performance, lessons and challenges

[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]

[5] HMIS data, 2015

The GoU immunization program currently provides a total of 13 antigens in the immunization schedule. UNEPI. Immunization performance over the last 15 years (Figure 2**Error! Reference source not found.**) has showed tremendous improvement[6] .

Figure 2: Immunization coverage performance 2010-2015



Pentavalent (Penta) vaccine (DPT-HepB-Hib)

Penta vaccine was introduced in the immunization program in June 2002. Penta3 is one of the national indicators for HSDP 2015/16 - 2019/20 performance monitoring. Penta3 national coverage for 2015 was 100%[7] for the past 2 years. The proportion of districts with coverage of Penta3 greater than 80% increased from 86% (96/112) in 2014 to 89% (100/112) in 2015. In 2015 alone, 7,864,000 total number of Penta vaccine doses were procured [8]against 6,010,000 committed.[9]

Challenge:

Data quality gaps especially inaccurate denominators. 55/112 (49.1%) districts in 2015 reported coverage rates above 100%[8].

Plan:

- To complete the first phase of the DIT process by implementing in the remaining two regions (Kampala A and Kampala B)
- To conduct an end term evaluation of the DIT intervention to inform the next phase of implementation of DIT.
- To conduct an immunization coverage survey in all districts

Pneumococcal Conjugate Vaccine (PCV)10

PCV10 was introduced in the EPI program in April 2013 in a phased approach; by June 2014 the entire country was administering PCV10. National coverage PCV3 for 2015 was 87% (DHIS2) this is an improvement compared to 50% (2014). There was improvement within district PCV3 performance in 2015, a total of 35/112 (31%) districts coverage was below 80% compared to 108/112 (96%) districts in 2014. Only 1 (1%) district was below 50% coverage in 2015 compared to 53/112 (47%) districts in 2014[10, 11] . The proportion of districts reporting PCV10 stock outs reduced from 33% in 2014 to 12% in 2015. PCV stock outs at district and HF was attributed to the inadequate amount of PCV10 vaccine that Uganda received during the year as explained below.

Challenges:

The coverage gap between Penta3 and PCV3 has narrowed from 52 (2014)[13] to 13 (2015)[14] percent difference. However, this difference still exists due to the following reasons:

[6] UDHS2 administrative data
[7] DHIS2 administrative data
[8]NMS stock reports
[9] Gavi decision letter 2014
[10] JRF 2014
[11] JRF 2015

- The total number of PCV doses committed by Gavi was 4,861,600 and amount received was 4,843,200 doses.
- Vaccines were below the minimum stock level of 1.5 months of stock for an average of 3 months per annum between 2014 and 2015[12] resulting in stock outs at district and health facility levels.

Planned activities:

- Continued engagement with Gavi on the quantities required. For 2017, the PCV quantities required is 5,080,000 as per the submitted vaccine renewal request. MoH will also continue to strengthen vaccine management at all levels through introduction of a LMIS and regular review of stocks by the vaccine management committee.

Human Papilloma Virus (HPV) Vaccine :

HPV vaccine was introduced into the routine immunization in November 2015 targeting 10 year old girls through School based (Primary 4) and Community strategy. HPV introduction date was postponed from the planned introduction in April to November 2015 due to inadequate cold chain capacity.

HPV1 national coverage has increased from 23% in 2015 to 50% in Jan-April 2016. The low 2015 coverage was attributed to school closure soon after HPV introduction. A mixed delivery strategy with integration of HPV administration with integrated Child Health Days was used to enhance the HPV uptake. Given the current coverage trends, the country is confident that the 80% target will be achieved by October 2016. HPV PIE is planned for October/November 2016, but will likely be rescheduled to 2017 due to competing priorities.

Challenges:

- Combined trainings of HPV with measles campaign led to inadequate focus on HPV knowledge among health workers (HPV target population, vaccine estimates and delivery strategies)
- Delayed availability of data collection tools

New Vaccines approved for introduction in 2016:

Rotavirus Vaccine

In 2015, UNEPI applied for Gavi Rotavirus vaccine introduction grant which was approved in 2016 and planned introduction in 1st quarter 2017.

Men A vaccine mass campaign

Uganda applied for Gavi support to conduct meningitis A campaign in 38 high risk districts. Approval was received in June 2016, and the campaign is planned for November 2016.

IPV/tOPV-bOPV

In 2015, Uganda started preparations for the Polio end game activities including IPV introduction, Switch from toPV to bOPV and Polio campaigns.

Lessons learnt from NVI:

- Cascade training should be carried out after availability of funds and tools, including vaccine vial dummies
- UNEPI should conduct forecasting using Antigen 1 coverage/backlog cohort to avoid shortages
- Lack of clarity and uncertainty of processes between application, introduction and sustainability timelines by all partners
- Long delays between training and introduction leads to knowledge gaps.
- NVI (PCV and HPV) both had a lag time of 6 months before realization of improved coverage. Therefore strategic planning and interventions are required to bridge this laxity in improvement of coverage
- Whereas integration is a good practice, the Integration of training for the measles campaign and HPV new vaccine introduction affected the quality of the trainings and the introduction[13]. Therefore, meticulous planning is necessary to obtain positive results.
- The introduction of HPV & IPV were both opportunities to strengthen communication on routine immunization
- Challenge in funding for routine immunization operational activities. The vast majority of the funding for Social Mobilisation & Communication interventions is for campaigns.
- Recognition of the importance of mobilising religious leaders to support both campaigns and routine immunization
- VHTs play a crucial role in community mobilisation for both campaigns and routine immunization

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

[12] Uptake report of PCV and HPV vaccines May 2016 (CHAI-UNEPI analysis report)

[13] Gavi FCE 2015 report

expected future applications (include in table 1 above), emerging new priorities for the national immunisation programme]

Reasonableness of targets for next implementation year

UBOS is responsible for population statistics for guiding national planning including provision of annual population projection figures (UBOS abstracts 2015). MoH uses these figures in immunization planning including in the development and update of cMYP for the program. The MoH targeted population 2016 for the Gavi supported vaccines using the cMYP costing tool 2016-2020 targets are:

- DTP-HepB-Hib target population(surviving infants): 1,644,143
- Pneumococcal (PCV10) target population(surviving infants): 1,644,143
- HPV quadrivalent target population: 814,025
- IPV target population(surviving infants): 1,644,143
- Rotavirus target population (surviving infants): 1,644,143

Table 2: Projected wastage rates

The UNEPI uses the projected wastage rates to estimate the vaccine requirements

VACCINE	WASTAGE RATE	WASTAGE FACTOR
BCG	70%	3.33
OPV	15%	1.18
IPV	10%	1.11
PCV	5%	1.05
DPT-HepB-Hib	10%	1.11
MCV	40%	1.67
HPV	5%	1.05
TT	15%	1.18

Table 3: Projected growth by year in coverage performance given recent trend[14]

Number	Base year	Baseline and targets				
	2014	2016	2017	2018	2019	2020
OPV 3 coverage	**82%**	85%	90%	90%	92%	94%
PCV 3 Coverage	**50%**	85%	90%	90%	92%	94%
DPT 3 coverage	**78%**	85%	90%	90%	92%	94%
MCV1 coverage	**82%**	86%	88%	90%	90%	92%
HPV 2 Coverage	**38%**	80%	85%	85%	87%	88%

The set targets will be achieved through improvements in Training and mentorship in RED/REC, problem solving supportive supervision, contribution of NVI (capacity building, cold chain strengthening and communication), PIRI in districts with high number of unimmunized children, expansion and maintenance of efficient cold chain system at all levels of the health system, improved last mile delivery through provision of transport equipment. However the targets will be reviewed after the findings from the planned EPI coverage survey.

Plans for change in any vaccine presentation(s) or type(s) 4

- Also interested in switching to 4 dose PCV vial for optimization of cost and storage space

Issues to be addressed to ensure a successful product presentation/type switch

- To acquire information on vaccine availability and on job training on the PCV 4 dose vial

Any expected future applications to Gavi for new vaccine introductions or campaigns (in the next two years – include in Table 1 of the template)

According to the current cMYP, several NVI have been planned in the next 5 years. Due to concerns about capacity to co-finance, the NITAG has been requested by MoH to provide evidence based decision making to help prioritize the introduction of new vaccines. However over the next 2 years Uganda had planned the following NVI:

Measles Rubella introduction:

The country plans to introduce MCV2 into routine immunization in 2017. Due to the burden of Rubella infection among the population, UNEPI plans to conduct a measles rubella campaign and introduce MR in the routine immunization program in 2018 (cMYP 2016-2020).

[14] cMYP 2016-2020

Yellow Fever

Yellow fever outbreaks occurred in 2016 and outbreak responses were conducted in 3 districts. The country plans to develop and implement a national yellow fever vaccination policy for Uganda basing on the risk assessment findings by 2017. In view of this, MoH will implement YF policy in 2017 and YF vaccine introduction into RI in 2018

Hepatitis B birth dose:

- UNEPI introduced hepatitis B in routine immunization in 2002 as part of DPT-HepB-Hib and plans to Introduce hepatitis B Birth Dose through prioritization and guidance process of the NITAG
- Vaccination of people in high risk district is ongoing and fully supported by GoU
- MoH will finalize Hepatitis B vaccine strategy and policy in 2016
- MoH to establish Hep B sentinel surveillance

Risks to future Implementation and mitigation actions

- GoU failure to meet the ever increasing co-financing costs on time. Among the mitigation actions include:
  - NITAG to provide guidance on prioritization of future new vaccine introduction over the cMYP 5 year lifespan.
  - Operationalization of the immunization fund under the Immunization Act 2015
  - Development of the immunization financial sustainability and Investment plan after determining the cost for fully immunizing a Ugandan child including all planned NVIs over the next five years
  - Conduct a cost benefit analysis to inform NVI
  - Galvanize in-country philanthropy towards immunization fund
- Inadequate program capacity to take on more new vaccines (human resources, data management, surveillance). UNEPI will mitigate the identified risks through:
  - Good planning and implementation for the immunization fund to address these gaps.
  - Targeted technical support for inclusion of international and local partners to support RI
- The program will update the CCE inventory and plan for expansion and rehabilitation factoring in all planned new vaccine introductions.

Emerging new priorities for the national immunisation programme based on the latest cMYP and annual work plans

- All districts implementing REC activities by end of 2017
- To achieve at least 80% coverage for all routine childhood antigens (using DPT-HepB -Hib3 as a measure) in 80 % of districts by 2020
- Reduce immunization coverage inequity within districts
- To conduct OPL training and equip at least 10,000 health workers over 2 years on routine immunization and disease surveillance by all immunization stakeholders
- To conduct bi-annual problem solving focused technical support supervision visits to all low performing districts by 2020
- Build capacity of operational level to utilize coverage data for micro-planning and informed implementation of EPI activities
- Operationalise Cold Chain maintenance plan
- Improvement of vaccine management (forecast, temperature control, stock visibility , consumption rate, study on wastage rates)
- Need to put emphasis on strengthening community linkages with service delivery for promoting routine immunization
- Develop and implement a national yellow fever vaccination policy for Uganda basing on the risk assessment findings by 2017

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 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]

Program managements and Financing

- *EPI Support Supervision at district level:* There exists inadequate PHC funding for districts to conduct regular quarterly supportive supervision[15]. The HSS1 grant was used to supplement the PHC funds to the districts to improve supportive supervision as eluded in section 2 (service delivery). Out of 2 planned supervisions using Gavi funds, 1 was conducted by 86 districts. A total of 26 districts did not receive funds due to poor accountability or bouncing of funds due to changes in account details.
- At national level, 2 supportive supervisions using Gavi funds were conducted in a total of 88 districts. Key findings included: all districts visited had received disbursed Gavi funds; need for increased funding for high population districts like Kabale; need for Health Worker training on OPL; need for reorientation of accountants on Gavi funds guidelines; limited data collection tools; irregular performance reviews; and inadequate funding for implementation of developed microplans.
- *Micro-planning for immunization:* EPI review documented a lack of micro plans in districts (only 20% of HFs had EPI REC micro-plans, with only 12 % having catchment area maps). Health Development Partners (HDPs) supported MoH through funding to districts to develop micro plans in a total of 112 districts and update REC Micro plans for EPI.
- *Human Resource gaps:* There are 1.22 HWs per 1000 persons which is below the WHO recommendation of 2.88 per 1000 persons. These gaps are at national and district level which affects EPI service delivery[16]. At national level, Gavi funds were used to support the remunerations of one M&E officer, two cold chain technicians, project coordinator, project administrator, accountant and 7 drivers.
- 360 health workers were trained on cold chain and logistics management
- Internal audits conducted and reports used to improve program management
- External audit for 2012/2013 conducted in 2015, external audit for 2014 conducted in 2015. External audit of 2015 was ongoing.

Immunization Service delivery

- *Static and Outreach support:* EPI review reported inadequate and limited resources to conduct outreaches. All health facilities with fridges are supposed to conduct static and outreach immunization sessions to reach the target population, hard to reach and underserved communities. HDPs and Gavi HSS grant supported the districts to supplement the inadequate PHC funds to the districts to improve regularity of outreaches. Through the outreach support, the proportion of districts achieving DPT3 coverage above 80% increased from 86% in 2014 to 89% in 2015 (figure 2).
- *Transport:* Of the 112 districts, 109 (97%) district did not have reliable transport for support supervision, logistics distribution and outreaches. In order to address this gap, the Gavi HSS1 grant was used to procure transport for the central and district level as reported in section 3.2.1. After the procurements and distribution of transport to districts, 48 districts (42%), still lack reliable transport and this has been included in GAVI HSS2.

Vaccines and Logistics

- *Cold and dry storage capacity:* At the national level, storage capacity of +2^{o}C to +8^{o}C increased by 178,100 litres after the installation of 12 cold rooms and is adequate for the planned introduction of new vaccines. All the fridges and carriers have been distributed and installed in districts (section 3.2.2). This created an additional capacity of 38,650 litres. Twelve percent (12%) of district vaccine stores and 35% of health facilities will have storage gap by 2020, which will be addressed in the CCEOP and GAVI HSSII grants. The CVS was refurbished to create additional dry storage space.
- *Maintenance of cold chain:* CCI, EVMA and EPI review showed inadequacies in cold chain maintenance and lack of spare parts in the districts. MOH with support from HDPs and Gavi conducted preventive maintenance in 35 districts that were found in need. The 2014 CCI assessment indicated the majority of cold chain equipment was relying on stem thermometers which are no longer recommended to monitor vaccine storage temperatures. Through the HSSI grant, 5,000 Fridge Tags were procured, 500 were installed and remaining 45,000 fridge tag is currently ongoing to all health facilities across the country. This intervention is expected to improve visibility and response to temperature violations so as to deliver potent vaccines to beneficiaries. Maintenance tools and spare parts were procured.

Surveillance and Monitoring

- *Data collection tools at district and health facility level:* Inadequate monitoring tools, lack of data analysis and use of data for action have been reported in program assessments. There also exists discrepancies among the primary data sources namely child register, tally sheet and monthly summary which affects the quality of data.
- A total of 437 health workers from 7 districts were trained in HMIS/DHIS2, additionally Data Quality Assessments were conducted in 55 districts and 154 health facilities.

  Data Improvement Teams (DIT) strategy that is partly supported by Gavi continued to be implemented. In 2015 a total 332

[15] Uganda Comprehensive EPI review 2014

[16] Human Resources for Health Commitments (2014/15 - 2018/19)

DITs were trained in a total of 9 regions. *Vaccine Preventable Disease surveillance:* VPD surveillance is operating through the IDSR framework. Training in IDSR was conducted in 89% of the districts. The three sentinel surveillance sites for new vaccines continue to provide data to document the impact of Pentavalent, PCV and provide data for decision making for Rotavirus. There was no hib confirmed case in 2015. The challenge facing VPD Surveillance is limited case based surveillance implementation due to irregularity of cash flows and dependence on polio eradication funds from WHO. This is being addressed by continued engagement of MOH to take it up as part of the polio legacy planning.

Advocacy, Communication and Social Mobilization (ACSM)

Key activities implemented include:

- A total of 560 religious leaders attended a high level advocacy meeting, presided over by the President of Uganda, to raise awareness on immunisation and RMNCAH in general including continuum of care through strengthening partnership in mobilizing communities and changing key behaviors related to immunisation and RMNCAH.
- Through implementation of the RED/REC strategy (linking services to communities component), the social mapping tool was used to identify key community structures and individuals for mobilisation.
- Special focus was given to accessing of hard to reach communities and mapping of mobile populations in Karamoja (North-East Uganda). The mapping helped in improving micro planning to reach these communities. Gavi funds were also used to support mobilization for outreach activities at village level.
- Revitalization of Health Unit Management Committees was also a key strategy undertaken to improve the linkages between communities and health facilities.
- At the request by MOH, the Harvard opinion poll was initiated in 2015 to assess knowledge, attitude and practices on immunization. The findings will be used to update the EPI communication strategy.
- Radio campaigns were aired nationally to mobilize communities for Integrated Child Health Days services, Polio & Measles campaigns and the introduction of HPV & IPV. In addition districts were supported with funds to use district based radio stations to conduct radio talk shows and air announcements to mobilize their populations for immunisation services. Districts were also supported to conduct orientation meetings with stakeholders which included religious/cultural/political leaders, CSOs and NGOs. Thirty five districts (31%) were supported to develop micro plans that included districts specific communication activities. IEC materials were developed, translated and distributed to all districts for both campaigns and routine immunisation
- Strengthening community linkages: Following the VHT assessment, a stakeholders' meeting was held which led to the development of the Community Health Extension Workers (CHEWs) strategy that is being finalized.

Strengthening the capacity of the private health sector to deliver EPI services

- There is a growing proportion of clientele that receive services from the private sector yet the linkage between the private and public sectors remains weak. There exists inadequacies in the coordination as far as planning and reporting from the private health sector is concerned.
- A total of 1,519 private health facilities were mapped in Kampala of which Eighty five (85) received fridges to increase access to immunization services. 179 health workers from private clinics were trained on EPI/IDSR. A follow up supportive supervision was conducted in a total of 100 private health facilities. Key findings include irregular power supply leading to interruption of cold chain functionality

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]

Challenges faced

The major challenges faced were mainly due to financial issue affecting major program components:

- The program has not regularly documented the annual expenditure of operations of EPI which is a vital requirement for mobilization of resources
- Co-financing defaulting of GoU due to operational and administrative issues with in MoFED and MOH
- Procurement for constructions has been constrained due to protracted discussions between Gavi and MoH
- Competing public health priorities further worsened by inadequate human resources and the lengthy processes and demands of Gavi requirements which led to delays in implementation of priority activities including approval of the revised work plan and budget for No Cost Extension

- Slow financial processes due to lack of a Gavi dedicated accountant since December 2015
- GAVI financial reporting has not yet been well aligned with the MoFED IFMs

Way forward

- Establish financial tracking and monitoring system for EPI funds
- The immunization Act (2016) mandated the setting up of immunization fund in order to assure better and predictable funding for vaccines procurement as well as operational activities. This has opened the opportunity of setting up robust resource mobilization mechanism that targets government (through appropriate organs like the parliament) the communities as well as development partner organizations
- Expedite the recruitment process for a financial manager for the Gavi funds
- Initiate discussion between MoFED, MoH and HDP to front loading of funds for immunization co-financing
-

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]

No Cost Extension: the GoU applied for a no cost extension from July 2015 to June 2016 that was approved in November 2015. Due to delayed procurement of construction works, an Exceptional No Cost Extension (ENCE) has been sought from Gavi from July 2016 to June 2017 that was granted.

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 for Uganda

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]

- Of the total approved **$ 26,775,424** Gavi grant portfolio , **$ 17,569,262** had been utilized/committed by 30th June 2016
- This leaves a balance of **$ 9,075,171** of which **$ 6,451,332** expired on 30th June 2016 and **$ 2,623,839** committed for civil works
- **Efficient utilization of HPV VIG** specifically for training has been leveraged to cover more trainees than earlier planned.
- Tracking and reporting immunization expenditure has been haphazard e.g. for **2014/15** there was **no expenditure reported** in the JRF. In order to meet program management needs as well as GVAP reporting requirements, a **framework to track program expenditure (national + sub-national)** will be developed and implemented
- One of the challenges affecting timely implementation and lengthy retirement times for advances has been due to lack of financial guidelines.

The details of the financial cash flows are shown in UNEPI led the process by holding a meeting that identified four key staff members to pre-fill the JAR template and organize for the workshop for JAR. The draft report was discussed in a 1 day meeting attended by key EPI stakeholders including WHO, UNICEF and CHAI. Reference was made to various available documents that included EVMA 2014, EPI review 2015, Joint Appraisal Report 2015, APR 2014 and activity reports. The refined report was shared with Gavi Geneva, WHO regional office, ESA/IST, UNICEF regional office and in country partners in preparation for the workshop. A four day workshop that drew participation from Gavi Geneva, WHO HQ, UNICEF regional Office, WHO AFRO, ESA/IST, MoH and all EPI in country stakeholders. The workshop included a one-day field visit to two districts. The workshop fine-tuned the report, later followed by several in-country meetings

between MOH and partners to finalize, the report was later presented to HPAC on 17 August 2016 for approval which was granted. After approval byby HPAC, the MoH and Partners incorporated comments. The MoH submitted the report to Gavi Geneva and shared with international stakeholders that participated in the JAR exercise on 5th September 2016.

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

Technical Assistance requirements: **AS HIGHLIGHTED IN SECTION 2**

.

1. **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
Give updates to HPAC on EPI performance on quarterly basis	Implemented on quarterly basis
Mobilize funding for NITAG activities	Fully implemented. The funds have been obtained from PEF 2016 and included in Gavi HSSII for future activities
Integrate transportation of EPI surveillance samples into the existing hub sample transportation system	Ongoing through pilots in selected districts in 2016 using the global health security fund and STOP 48.
Advocate for increased allocation and meet the co-financing obligation for new and underused vaccines	GoU increased the co-financing obligation allocation from 7.4bn in 15/16 to 8.2bn in 16/17
Advocate for frontloading for co-financing to the first quarter of the financial year.	Advocacy in progress.
Conduct quarterly supervision visits for trained DITs	Not done

2. **PRIORITISED COUNTRY NEEDS**[17]

[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	Does this require technical

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

	completing the actions	**assistance?*** *(yes/no)* If yes, indicate type of assistance needed
Vaccines and Logistics **Strategic activity: Strengthening Immunization supply chain capacity to manage the expanded EPI scope of vaccines** - Operationalize and implement HSS II and CCEOP grants - Initiating the procurement and disposal process for cold chain equipment - Implement exceptional NCE activities - Conduct bi-annual CCIs - Cold chain repair and maintenance - Conduct a national waste management assessment - EVM self-assessment - EVM implementation plan and monitoring Review and print job aids on key EVM and cold chain maintenance tasks and distribute them to all health facilities and DVSs (include printing) - Establish 14 logistics regional team in efficient vaccine management - Train 14 teams (of three people) to be Regional TOTs in efficient management of vaccines/EPI commodities and other essential medical supplies with emphasis on quantification, forecasting, Vaccine Tracking and Vaccine Temperature Monitoring. - Monitor implementation of TSC guidelines - Design and develop an LMIS system	**January – December 2017**	- Yes. Local TA from HDPs – UNICEF, WHO, CHAI, PATH to coordinate and support the implementation of the EVM IP and monitoring - Yes. Need external TA for EVMA for 3 months
Coverage and Equity **Strategic Activity: To strengthen the capacity of district and health facility teams to reach every child with immunization services** - Scale up the implementation of 2016 RED/REC approach within districts with focus on equity and coverage through micro-planning - Carry out Operational level health worker training and mentorship using focused problem solving support supervision - Implement recommendations of 2016 Equity Assessment - Implement recommendations of the Training Needs Assessment - Support districts to reach the underserved and hard to reach communities through micro-mapping	**January – December 2017**	Yes. Need Technical Assistance from Local Partners 2 UNICEF National Staff and 4 consultants to support districts for 6 months
New Vaccine Support **Strategic Activity:** Support and strengthen new vaccine application and introduction processes - Rota vaccine Introduction - Application for MR, MSD and Yellow Fever - Support NITAG activities - PIEs for HPV, IPV and Rota	**January – December 2017**	-Yes. Local TA for NVI application -Yes. Need external TA for NVI and PIE – WHO and UNICEF 2 weeks Yes. Need TA to support C4D activities for Rotavirus introduction – UNICEF 3 months
Financial Sustainability: **Strategic Activity:** • Support the setting up of the Immunization Fund and its implementation as provided in Immunization Act (2016)	**January – December 2017**	-Yes. Need external TA -Hire a financial consultant for resource mobilization framework WHO

• Support development and implementation of resources mobilization framework to ensure financial sustainability • Establish and operationalize mechanism for tracking and reporting immunization financing and expenditure		
Data and Surveillance **Strategic activity: Support and strengthen data and surveillance Systems for improvement of quality and data use for action** - Conduct in-depth assessment of EPI information management system and data quality - Develop and Implement the national multi-year data quality improvement plan - Strengthen regional IDSR hub	**January – December 2017**	• Local TA and Hire consultant to coordinate assessment
HSS Grant **Strategic Activity: Support and strengthen the capacity to implement Gavi HSSII** - Incorporate EPI content into curriculum for pre service training and implementation OPL training	**January – December 2017**	• Local TA
Communication **Strategic Activity: Social mobilization campaign on routine immunization** **-** Conduct orientations with religious leaders in low coverage districts on RI and their roles - IPC training for health workers in low coverage districts - Review and finalisation of communication materials on RI - Updating of National and sub-national level EPI communication plans based on findings from recent Harvard Polling Study Findings Strategic Activity 2: National and district level dissemination of the Immunisation Act - Develop, translate and disseminate communication friendly version of the Immunisation Act - District level orientation meetings (focused on roles & responsibilities of the key actors)	**January – December 2017** **January – December 2017**	• Yes, UNICEF - local (2) TA required to support Health Promotion & Education Division at MOH
Strategic Activity: National and Districts level dissemination of immunization act • Develop, translate and disseminate communication friendly versions of immunization act • Districts level orientation meetings focused on the roles of the immunization actors	**January – December 2017**	**Local TA** – UNICEF 4 months

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

3. 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	UNEPI led the process by holding a meeting that identified Five (5) key staff members to pre-fill the JAR template and organize for the workshop for JAR. The draft report was discussed in a 1 day meeting attended by key EPI stakeholders including WHO, UNICEF and CHAI. Reference was made to various available documents that included EVMA 2014, EPI review 2015, Joint Appraisal Report 2015, APR 2014 and activity reports. The refined report was shared with Gavi Geneva, WHO regional office, ESA/IST, UNICEF regional office and in country partners in preparation for the workshop. A four day workshop that drew participation from Gavi Geneva, WHO HQ, UNICEF regional Office, WHO AFRO, ESA/IST, MoH and all EPI in country stakeholders. The workshop included a one-day field visit to two districts. The workshop fine-tuned the report that was later finalized by MOH and in country partners which was later presented to HPAC for approval. Once it was approved by HPAC after incorporation of comments it was submitted to Gavi Geneva and shared with international stakeholders that participated in the JAR exercise.
Issues raised during debrief of joint appraisal findings to national coordination mechanism	Why Moyo, Adjumani and other districts continue to perform poorly: we need to examine the population figures in those districts. UNEPI informed HPAC that EPI coverage survey to be conducted in August-September 2016 will inform EPI to get the true picture of coverage. MoH resource center is working with Uganda Bureau of Statistics (UBOS) to align some of the population figures. •DPT3 coverage at national level is 100%, while some districts still report low immunization coverage. We need to address the equity issues in all districts to access opportunities for full vaccination •The nomenclature of DPT should change since we are giving five vaccines in one: we need to use DPT-HepB-Hib nomenclature •Low coverage of TT2+ (PAB), UNEPI needs to ensure ways to improve the coverage •Vaccine co-financing: Delays of co-financing and whether there is a plan to have government funds for 2017 timely disbursed to Gavi •When the country expects introduce Rotavirus vaccine

4. 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)**

UNEPI led the process by holding a meeting that identified four key staff members to pre-fill the JAR template and organize for the workshop for JAR. The draft report was discussed in a 1 day meeting attended by key EPI stakeholders including WHO, UNICEF and CHAI. Reference was made to various available documents that included EVMA 2014, EPI review 2015, Joint Appraisal Report 2015, APR 2014 and activity reports. The refined report was shared with Gavi Geneva, WHO regional office, ESA/IST, UNICEF regional office and in country partners in preparation for the workshop. A four day workshop that drew participation from Gavi Geneva, WHO HQ, UNICEF regional Office, WHO AFRO, ESA/IST, MoH and all EPI in country stakeholders. The workshop

included a one-day field visit to two districts. The workshop fine-tuned the report, later followed by several in-country meetings between MOH and partners to finalize, the report was later presented to HPAC on 17 August 2016 for approval which was granted. After approval byby HPAC, the MoH and Partners incorporated comments. The MoH submitted the report to Gavi Geneva and shared with international stakeholders that participated in the JAR exercise on 5th September 2016.

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

Technical Assistance requirements: **AS HIGHLIGHTED IN SECTION 2**

Annex C: **Review Cash grants from Gavi HSS1 grant**

Review Cash grants from Gavi HSS, ISS, VIG grant					
GRANT DISBURSEMENT	**Amount Approved (USD)**	**Amount Received (USD)**	**Received Date**	**Spent/ committed**	**Balances**
HSS	**19,242,000**	**4,372,695 GoU-MoH**	**4th Sep 2013**	**1,748,856**	***2,623,839**
		8,286,982 UNICEF	**6th Nov 2014**	**8,286,982**	
ISS I	**818,424**	**818,424**	**1st Jul 2010**	**818,424**	
ISS II	**2,649,520**	**2,649,520**	**4th Sep 2013**	**2,649,520**	
VIG					
PCV	**1,372,000**	**1,372,000**	**21st Sep 2012**	**1,372,000**	
HPV	**1,336,980**	**1,336,980**	**16th Feb 2014**	**1,336,980**	
IPV	**1,356,500**	**1,356,500**	**3rd Mar 2015**	**1,356,500**	
Gavi (Not Disbursed to counntry)					**6,451,332**
Total	**26,775,424**	**20,193,101**		**17,569,262**	**9,075,171**

Figure 3: 2015 Central Vaccine Store status