Joint Appraisal Report 2017

Country	Zambia
Full Joint Appraisal or Joint Appraisal update	Joint appraisal update
Date and location of Joint Appraisal meeting	29-31 August 2017, Lusaka, Zambia.
Participants / affiliation	See Annex
Reporting period	August 2016 – August 2017
Fiscal period	January – December
Comprehensive Multi Year Plan (cMYP) duration	2017 - 2021

1. SUMMARY OF RENEWAL AND EXTENSION REQUESTS

1.1. New and Underused Vaccines Support (NVS) renewal request(s)

Type of support (routine or campaign)	Vaccine	End year of support	Year of requested support	Target (population to be vaccinated)	Indicative amount to be paid by country	Indicative amount to be paid by Gavi
Routine	Pentavalent	2021	2018	819,950	US$2,141,000	US$336,500
Routine	PCV	2021	2018	819,950	US$7,352,500	US$1,164,000
Routine	Rota	2021	2018	819,950	US$3,082,000	US$530,500
Routine	MR	2018	2018	819,950	US$112,091	No Information
Routine	IPV	2018	2018	819,950	No information	No information

1.2. New and Underused Vaccines Support (NVS) extension request(s)

Type of Support	Vaccine	Starting year	Ending year

1.3. Health System Strengthening (HSS) renewal request

Total amount of HSS grant	US$9,059,475
Duration of HSS grant (from…to…)	2018 – 2020
Year / period for which the HSS renewal (next tranche) is requested	N/A
Amount of HSS renewal request (next tranche)	N/A

1.4. Cold Chain Equipment Optimisation Platform (CCEOP) renewal request

Not Applicable

1.5. Indicative interest to introduce new vaccines or request Health System Strengthening support from Gavi in the future

Indicative interest to introduce new vaccines or request HSS support from Gavi	Programme	Expected application year	Expected introduction year
	National HPV Vaccination	2017	2019

2. CHANGES IN COUNTRY CONTEXT SINCE LAST JOINT APPRAISAL

LEADERSHIP, GOVERNANCE AND PROGRAMME MANAGEMENT

Following the 2016 general election, the Ministry of Health underwent significant structural and leadership changes in an effort to deliver universal health coverage by strengthening the primary health care approach which supports promotive, preventive, curative, rehabilitative and palliative services. Immunisation has been identified as a bedrock to achieving goals under the preventive health pillar.

The Expanded Programme on Immunisation (EPI) falls under the Directorate of Public Health within the MOH. The EPI team is comprised of National EPI manager (a newly constituted position), two EPI officers, 1 national cold chain officer and 2 national Logisticians, one of which is seconded by CIDRZ as an embedded position. Assisting and providing support, both financial and technical, to the EPI team is the EPI sub-committee. The sub-committee meets monthly and is comprised of Government and relevant partners. The EPI sub-committee has a range of sub-groups organised around thematic areas that meet periodically.

The Zambia ICC is chaired by the Minister of Health or designated representative and comprises key partners working in the health sector. The ICC has a quarterly meeting schedule, however these are not always met. Extra-ordinary ICC meetings can be called for interventions requiring immediate attention. Heads of Agency are the official representation on the ICC, however delegates are often sent to meetings which undermines the decision making power of the ICC forum. In an effort to strengthen the governance and oversight capabilities of the ICC, there are recommendations to prioritise ICC strengthening in 2018 through an asessment which will include a comprehensive review of both the TORs and memebership of the group. The ICC secretariat will also work to develop an endorsed annual work schedule for the forum.

The Zambia Immunisation Technical Advisory Group (ZITAG), was established in 2016 and all members have been trained. The operationalisation of the ZITAG is evidenced by development of the SOPs guiding the group and also the agreed annual work plan for 2017. So far, four meetings have been conducted and key recommendations presented to the programme to guide decision making.

IMMMUNISATION FINANCING

The EPI operational budget has remained stagnant for the preceding three years. However the Govenrment has demonstrated a renewed commitment to the immunisation programme as evidenced in the 50% increase in budget allocation for 2018 (from about ZMW 44m to ZMW 69m and ZMW800,000 to ZMW 1.6m for Procurement of Vaccines and Programme Management pending parliament approval -. Over the last year there has also been an improvement in the release of funds at all levels. At the District and Provincial level 11 out of the 12 expected grants from the Ministry of Finance were disbursed while at central level a bulk release equivalent to 4 out of the expected 12 grants were disbursed. Other partner funding through multilateral and bilateral coorperation could not be isolated at the time of the report.

Zambia developed a new cMYP (2017-2021) which projects the estimated programme costs at US$ 558,170,928 with a funding gap of US$ 397,909,620 over the five year period, to meet this gap the EPI team (with technical and financial assistance) intends to develop a Resource Mobilisation Plan.

3. PERFORMANCE OF THE IMMUNISATION SYSTEM IN THE REPORTING PERIOD

3.1. Coverage and equity of immunisation

COVERAGE

Table 1. 2016 Antigen target vs actual coverage (JRF, 2016)

Antigen	*2016 Target*	*2016 Coverage*
DTP3	95%	99%
PCV3	90%	98%
OPV3	95%	95%
RV2	88%	99%
MCV2	60%	59%

Drop-out rates (JRF 2016) were as follows: Penta 1-3: 0%; PCV1-3: 1%; RV1-2: 0%; MCV1-2: 40%. As indicated above, the drop-out rates for MCV2 remain very high. To address this, there were social mobilisation activities that took place on MCV2 and other antigens during the year. The EPI manual has also been updated to address vaccination beyond the first year of life.

Table 2. 2016 Provincial coverage of selected antigens (HMIS, 2016)

Province	DPT 3	OPV 3	PCV 3	RV 1	Measles	RV 2
Central	110%	104%	104%	112%	110%	106%
Copperbelt	81%	79%	80%	83%	81%	92%
Eastern	93%	90%	91%	96%	103%	92%
Lusaka	90%	88%	90%	96%	93%	98%
Luapula	104%	103%	105%	114%	112%	154%
Muchinga	86%	75%	83%	94%	89%	21%
Northern	98%	93%	98%	101%	92%	84%
North Western	99%	97%	102%	102%	100%	97%
Southern	96%	92%	95%	101%	99%	90%
Western	90%	81%	88%	96%	82%	103%

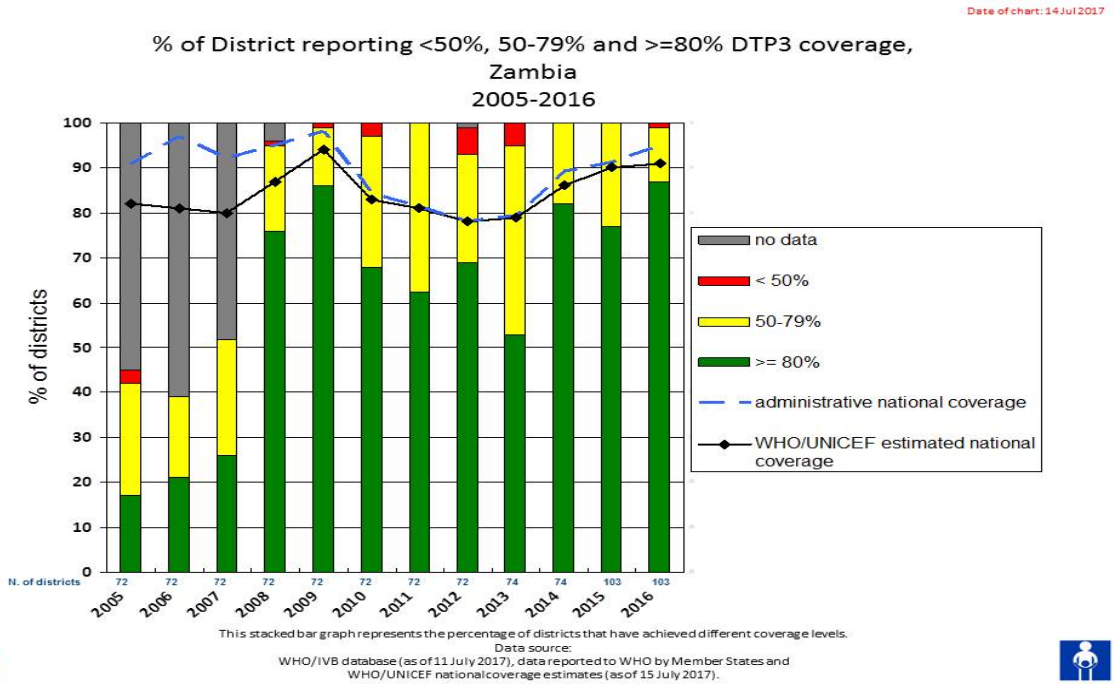
The table above demonstrated the data challenges which remain a persistent problem. Both the numerator (entered by health care workers), as well as the denominator (used for forecasting) and weak Civil Registration and Vital Statistics (CVRS) systems make it difficult for the country to truly assess progress. Whilst national coverage rates for DTP3 were at 95% or RV2 at 94%, great variances of the data existed at the subnational level. Data for decision-making is also an issue, as data generally is just reported and very little analysis of the data is done. The data challenges related to both the nuermator and denominator are impacting the programme's ability to adequately assess progress and coverage at both national and sub-national level. There are on-going discussions with the Central Statistics Office and the Ministry of Health on the need for updated population estimates.

EQUITY

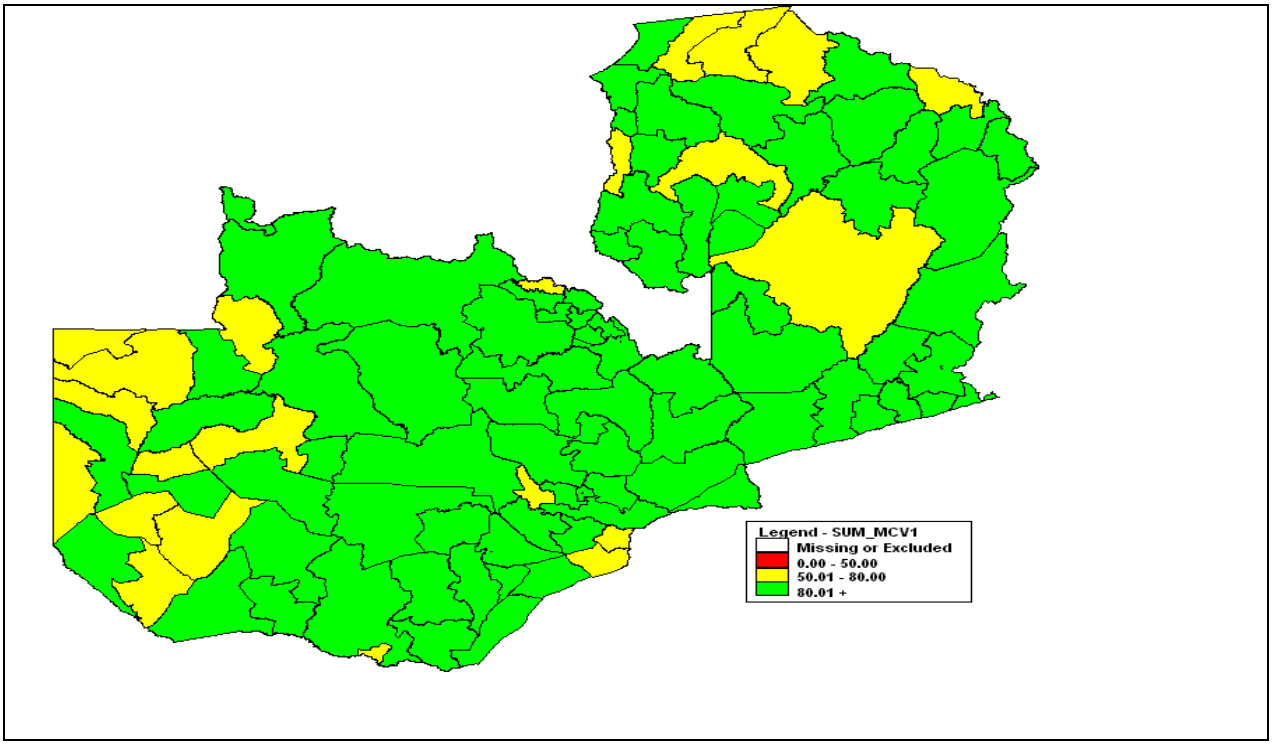
The Zambia equity situation remains as reported in the ZDHS 2013-2014 which showed that overall, 68 percent of children age 12-23 months were fully immunised by the time of the survey. With regard to specific vaccines, 95 percent of children had received the BCG immunisation, and 85 percent had been immunised against measles. Coverage of the first dose of the DTP and polio vaccines was relatively high (96 percent each); however, only 86 percent and 78 percent of these children, respectively, went on to receive the third doses of these vaccines, contributing to respective dropout rates of 11 percent and 19 percent between the first and third doses. The findings show that 2 percent of children age 12-23 months did not receive any vaccine at all.

Fully immunised coverage differences by child sex are small [68.9 percent for males vs 67.7 percent for females]. However differences by other factors are high e.g. urban children vs rural is 76% compared with 65%; 52 percent among children of mothers with no education compared to 81 percent among children of mothers with more than a secondary education;

The graph below shows performance trends by district and it can be noted that an increased number of districts reported coverage below 50% compared to the year 2015.



The performance for the coverage of the first dose of measles showed that none of the districts performed below the 50% mark although twenty out of one hundred and four districts still reported coverages below 80% as per map below.



3.2. Key drivers of low coverage/ equity

HUMAN RESOURCES FOR HEALTH

Human Resources for Health remains a constant challenge in ensuring equitable vaccine access. The burden at the Health Facility is significant, with limited staff, which is exacerbated in more rural and hard to reach areas. In response to this, the government in 2016 recruited 7,400 frontline health workers against the projected 32,000 with plans to recruit an additional 1,000 in 2017. While there were on-going efforts to ensure adequate numbers of health care staff, this needs to be complimented by ensuring that staff are also appropriately capacitated for their roles. Capacity building efforts are being supported through MoH, the Gavi HSS grant and other key partners in the country.

SUPPLY CHAIN

The 2015 EVMA highlighted significant improvements across the immunisation supply chain in Zambia. One of the key areas that needed further strengthening was vaccine management, as such the country has been rolling-out Logistimo (web-based vaccine management tool). Logistimo is operational at the national vaccine store, all provincial vaccine stores, 104 Districts out of 109 and 35 (all Lusaka District) Health Facilities out of over 2,000 countrywide. Twenty-three selected Health Facilities in two Districts were piloting the continuous temperature monitoring system. In the first three quarters of 2017, stock availability improved in all Provinces from an average of 59% in Quarter 1 to above 90% in Quarter 3 mainly due to the enhanced visibility and functionality offered by the Logistimo platform.

However, supervisory visits and the Gavi audit report highlight on-going challenges in relation to vaccine management. Challenges include un-updated records, unexplained stock adjustments, irregular stock counts, inconsistences in temperature and VVM monitoring and absence of essential information on vaccine records. It was also reported that Standard Operating Procedures were not always followed. Based on the feedback highlighted above, the EPI team and the partners will be undertaking an evaluation of Logistimo to develop a business case for further roll-out. This evaluation will also include key lessons learned to date that need to inform on-going management and utilisation of the Logistimo tool to ensure a correction of the inconsistencies that have been noted.

An evaluation and modelling of the immunisation supply chain took place to assess the functioning and determine the level of resources and time it takes to move resources from the national level down to the point of care. The report has highlighed that there are options to change the current system that would reduce costs, increase data visibility and decrease the time that Health Facility staff spend out of their facilities. An EPI-Optimisation Strategy has been developed that seeks to pilot, evaluate and scale-up key findings from the EVMA, DQS and other current EPI initiatives.

COLD CHAIN

Lusaka and North-Western Provincial Vaccine cold rooms have been installed and are functional. Hence, all 10 Provinces have functional walk-in coldrooms. The updated inventory for the period under review indicates that 85% of the (2,500) facilities have vaccine refrigerators. Of those assessed during the supply chain modelling exercise (2,232) 95% had functional refrigerators.

In May 2018, the EPI plans to apply for the Cold Chain Equipment Optimisation Platform (CCEOP) to bridge the remainining and growing gap of facilities with fridges older than 10 years that need to be decommissioned, frigdes that are frequently breaking down, gas and kerosene fridges and the gap created by new healt facilities which have been completed faster than the MoH has been able to procure fridges. The CCEOP is also expected to be the platform that will facilitate expansion of the use of RTMs.

DEMAND GENERATION

Social mobilisation activities have had a positive impact on demand creation. Communication for immunisation is mainly conducted during Child Health Week, Supplemental Immunisation Activities (SIAs) and vaccine introductions. It has been recoginsed that there is a need for more sustained and consistent social mobilisation in support of immunisation. In response to the challenge, the government has partnered with Civil Society Organisations (CSOs) to assist in on-going social mobilisation activities. An EPI Communication Strategy has recently been developed to streamline and strengthen immunisation communication activities to enhance demand for immunisation services. Routinisation of communication for immunisation as well as demand creation interventions are integral parts of strengthening routine immunisation. The Lusaka HPV Vaccination Demo exercise in selected facilities had a successful demand creation interventions which included among other things, media orientation, and drama group activities at community level.

GENDER-RELATED BARRIERS

The gender barriers include:

- **Power and Decision making** – Decision-making is vested in men, this can include decisions for taking a child for immunisation services. For fear of marital discord and domestic violence, a woman may not go against her partners decision. In addition, health education targets women resulting in low male involvement, yet men are decision-makers and often providers of financial resources in homes. The facilities have been encouraging more male involvement. Selected facilities visited over the next 12 months would be expected to report such changes in terms of numbers. Other RMCAHN programme are also tracking this indicator.
- **Knowledge and beliefs** – Many times a mother's lack of knowledge results in the propagation of myths and misconceptions about immunisation. The EPI Communication Strategy currently in print is expected to be an effective tool for delivery of appropriate immunisation information.
- **Education, Information and Communication -** Due to high levels of illiteracy, communication may not be clear and many are shy to seek clarification in group counselling and health education during immunisation sessions. The newly created MoH directorate responsible for health promotion has been engaging stakeholders to ensure a sustained level of social mobilisation for the available media as opposed to intensified activities around events such as campaigns.

The barriers identified above are anecdotal and would require further investigations to gain more understanding.

3.3. Data

COMPLIANCE

The Zambia EPI conducted an annual desk review as part of the recommendations made following capacity building efforts facilitated through partners. A proposal to develop a national data quality improvement plan has been tabled for endorsement through the Directorate of Planning and Policy. The DQIP will include the annual desk reviews, interrogate completeness, timeliness, internal and external consistencies, trend analysis and triangulate various data sources. The draft plan will include undertaking periodic in-depth assessments of routine coverage data, which would encompass immunisation coverage surveys. A desk review and field assessment are covered in the plan. Preparations for a field assessment are underway for implementation early next year. In addition, the country has built capacity in two external experts to support the implementation of data quality improvement interventions. At the Health Facility level, there have been efforts to introduce electronic registries to improve data completeness and determination of population denominators in selected Districts in one Province. The Standard Operating Procedures, policies, guidelines, strategic plans, and legal frameworks on data quality also need to be disseminated.

CHALLENGES

EFFORTS AND INNOVATIONS FOR DATA QUALITY

Efforts to improve data quality include the development of a data quality improvement plan (DQIP) that will articulate and operationalise all data quality improvement efforts for the sector. The finalisation of the Data Quality Strategy will articulate and guide strategies for data quality improvement.

As part of the EPI-optimisation strategy, the EPI aims to address some of its data quality and use issues and make recommendations for how to scale. In addition, there is a DQS to be conducted in the coming year which will also help identify gaps in data quality.

SURVEILLANCE DATA

AFP surveillance core indicators:

- Non-polio AFP rate was at 3.4 per 100,000 (target ≥2 per 100,000)
- Stool adequacy rate was at 88% (target ≥80%)

Measles surveillance indicators:

- Non-measles febrile rash illness rate was at 1.7 per 100,000 (target: ≥2/100,000).
- % Districts with at least 1 case with blood specimen/ year was at 48.5% (target 80%).
- 1 percent (330) were due to measles positive cases while 3 percent were due to rubella.

Paediatric Bacterial Meningitis have been sustained with following indicators:

- Percentage of suspected meningitis cases with HI identified by culture, latex or PCR was at 0% (target 5%).
- Percentage of suspected meningitis cases with pneumococcus identified by culture, latex or PCR was at 6% (target 20%).

Positive for Rota was at 30.6% (target ≥30%)

Adverse Events Following Immunisation (AEFI) – No AEFIs were reported in the reporting period.

Surveillance for adverse events following immunisations have remained a challenge there was no funding for capacity building for AEFI surveillance at all levels.

3.4. Role and engagement of different stakeholders in the immunisation system

NATIONAL COORDINATION FORUM

The ICC provides strategic oversight and accountability for the EPI. The EPI sub-committee reports to the Child Health technical working group and provides status updates, supports resource mobilisation and helps build consensus. Within the EPI sub-committee there are specific thematic sub-groups providing a platform for more detailed and technical discussions and planing (M&E, Social Mobilisation, Service Delivery, and Supply Chain and logistics).

The ZITAG provide independent recommendations on key programme decisions.

CIVIL SOCIETY

CSO Engagement: The Zambia Civil Society Immunisation Platform (ZCSIP) continued to support the Ministry of Health with demand creation activities and advocacy at the community level in 22 Districts. During the period under review the ZCSIP was involved in the development of the EPI Communication Strategy and participated in the development of a national HPV Proposal and in the DQS workshop. ZCSIP continued to be part of the EPI TWG meeting at National and District level and supported the implementation of a mop-up HPV vaccination dose 1 in Lusaka District.

In addition, journalists from the 22 Districts were trained in communication for immunisation.

OTHER PARTNERS

In Zambia there is a core group of EPI partners working to support Government and the implementation of EPI across the country. This group consists of WHO, UNICEF, CHAZ, PATH, JSI, CIDRZ, CMMB, SIDA, DfID, GSK, Red Cross, JICA, CDC, World Vision, USAID, The Church of Jesus Christ Latter Day Saints, CRS, World Bank, EU, Lions, Rotary and others. This group of partners supports Government all aspects of EPI from service delivery, surveillance, campaigns, M&E, outreach and social mobilisation to varying degrees and regularity.

PRIVATE SECTOR

Engagement with the private sector was mainly through service provision including the HPV Vaccination demonstration activities in Lusaka District and during the MR campaign countrywide. As immunisation is a public good and has positive societal benefits, further engagement with the private sector took place this past year, with MoH and CIDRZ as they engaged with Llamasoft, a private software/services company, to model and explore options to optimise the country's immunisation supply chain. This work provides a platform for further exploration of private sector engagement and with the development of the EPI-OPT strategy, the country can leverage for increased private sector involvement to fill in and finance other areas of expertise and resources to optimise EPI and even explore opportunities to outsource, and to aid with data or demand generation.

CROSS-SECTORAL COLLABORATION

Cross sectoral collaboration played a key role in the implementation of various activities during the period. EPI collaborated with the Ministry of Education in the development of the HPV proposal, as well as in the implementation of the Lusaka district HPV demo vaccination exercise and providing premises for conducting outreach activities. The MR campaign of 2016 was also such an activity that drew input from all partners. Other collaborating ministries included the Ministry of Chiefs and Traditional Affairs, the Ministry of Religious Affairs for community sensitisation and the Ministry of Works and Supply for transport in support of the measles campaign and child health weeks. The Ministry of Home Affairs through the Department of National Registration, Passport and Citizenship has partnered with the programme to develop a system (Civil Registry and Vital Statistics) that would potentially help to address denominator issues.

The programme will continue to nurture relationships with these and other cross sectoral partners to support ongoing and future activities. The Ministry of Health collaborated with the Central Statistical Office and other line Ministries in adapting the DHS protocols. The Ministry collaborated with line Ministries on the Joint External Evaluation (JEE) of International Health Regulation (IHR) country core-capacities.

4. PERFORMANCE OF GAVI GRANTS IN THE REPORTING PERIOD

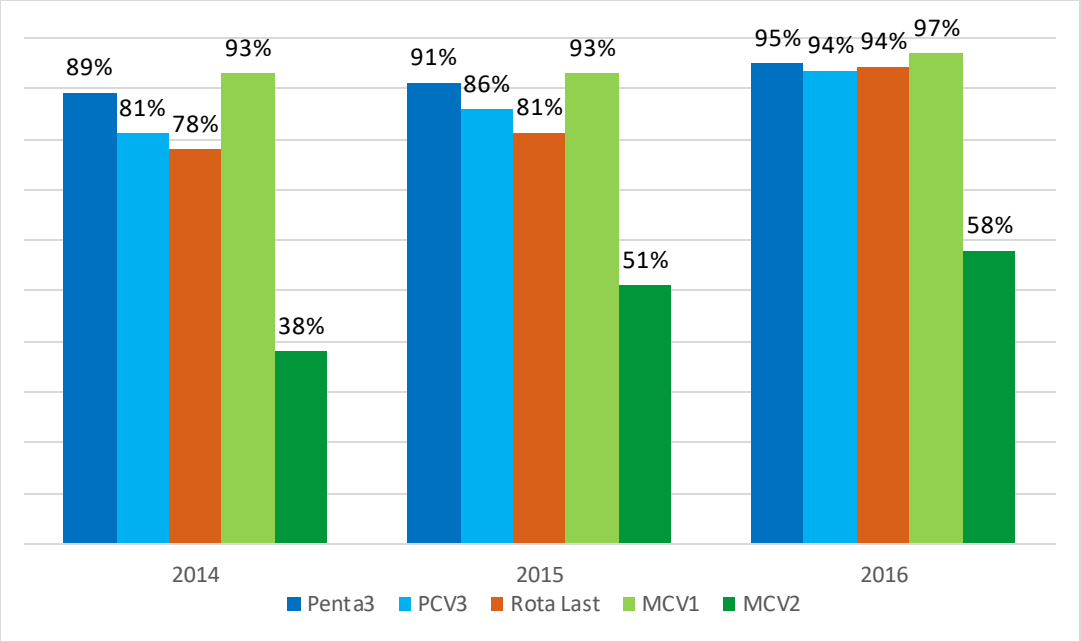
4.1. Programmatic performance

Table 4. 2016 Antigen target vs actual coverage for New Vaccines (JRF, 2016)

Antigen	*2016 GPF Target*	*2016 Coverage*
DTP3	93%	99%
PCV3	90%	98%
RV2	95%	99%
MCV2	45%	59%

While all targets were met, there remain bottlenecks and risks in meeting coverage targets. While the official/community head count denominators overshadow the interpretation of theses coverages, the increase in absolute numbers can not be doubted.

Penta3, Rota, PCV3, MCV1 & MCV2 (Administrative coverage data): 2014-16



The table above highlights that the difference in coverage across Penta, PCV and Rota has been consistently stabilising over the last three years. There remains a percentage point difference between Penta and PCV and there is a need for some more detailed analysis to understand the discrenacy in these figures as the vaccines are administered on the same schedule. Despite on-going efforts to support Second Year of Life Platform, the coverage for MCV2 remains low and EPI TWG and relevant partners will continue to explore interventions to strengthen coverage.

NVS

Measles Rubella Introduction – The vaccine was introduced in September 2016 through an SIA followed by routinisation in 2017. A Post SIA Coverage survey was conducted which indicated coverage of 96%. A number of activities as stipulated in the introduction plan were implemented.

A Post Introduction Evaluation for MR was planned for early 2018.

HSS
The Gavi HSS grant was approved in November 2015, with a budget of $9,096,176 over 3 years. There have been delays to initiating this grant, in the first year, working out financial and management arrangements for the grant, which were resolved at the end of 2016. There were further delays due to the transition in the Ministry of Health and the finalisation of the Gavi audit that took place in July 2017. Ministry is working to address these issues and it is anticipated that the grant will start in early 2018.

Improving immunisation coverage and equity are the central themes of the Zambia HSS grant. Given the relatively limited size of the grant, interventions have been targeted to focus on national level programme management strengthening and service delivery and LMC strengthening in 7 target districts, in the North of the country. These districts were selected based on lower performance in terms of immunisation coverage. The grant will focus on strengthening the development of micro-plans in the district and also address key bottlenecks in relation to support for transport to conduct regular outreach which has been identified as a key bottleneck to more equitable and higher coverage rates of immunisation in the districts.

4.2. Financial management performance (for all cash grants, such as HSS, vaccine introduction grants, campaign operational cost grants, transition grants, etc.)

The Country received a grant in the sum of USD4,501,573.00 to support operational costs related to the Measles Rubella campaign out of which USD3,900,300.00 was utilised during the period under review, representing an 86.6% burn rate. Limited time between availability of funds and implementation led to other partners with faster procurement processes to finance some of the activities. Some of the funds remaining are meant for the Post Introduction Evaluation (PIE). Funding remittances to Provincial and District Health Offices were disbursed without challenges. The external audit had not been finalised at the time of reporting partly due to late submission of financial reports from the Provinces and Districts which had to be manually consolidated before draft financial statements were submitted to Auditor General's office for review and certification.

4.3. Sustainability and (if applicable) transition planning

Financing of the immunisation programme
The government continues to engage local partners such as WHO and UNICEF and others to support immunisation activities. Funding for the immunisation sector are largely from Gavi and the Government. There are a range of multilateral agencies such as JICA, DFID, SIDA, CDC, CIDRZ, PATH, USAID, CHAZ, World Bank and supporting child health interventions which also benefit the immunisation programme. The funding gap in the near future implies that the programme has to seek innovative means to raise resources. Financial sustainability will be a a key focus particularly efforts targeted at maintaining the recent imcrease in government funding to the programme additional resources from local and external partners will also be sought.

Polio Transition - The country has had support from sources such as the Global Polio Eradication Initiative where polio, measles and rubella surveillance have been supported. The country has not yet developed a polio support transition plan but has prioritised this for next year. The Zambia National Public Health Institute has taken a lead to ensure that a plan is developed to sustain investments made so far. Initial preparations for Polio transition include the uptake of some polio activities into the MOH/ZNPHI plans for continued support.

4.4. Technical Assistance (TA)

PARTNER ENGAGEMENT FRAMEWORK UPDATES

PEF Update: WHO through the PEF funds targeted support in the areas of data, leadership and governance and the immunisation supply chain. A data quality review meeting was conducted, while the Data Quality self-assessment shall be conducted in early 2018. WHO through Gavi PEF funds supported a consensus building workshop for Key Performance Indicators (KPIs) with participation from all Provincial EPI logisticians thai will guide the monitoring of performance of vaccine management through Logistimo. In addition, PEF funds, through WHO were used to support Leadership and Governance activities through ZITAG meetings. Activities still pending for the 2017 PEF are the Data quality self assessment and one ZITAG meeting scheduled for the fourth Quarter of 2017.

WHO played a key leading role in the provision of Technical Assistance for the development of the HPV vaccine National application as well as providing external technical assistance for the costing of the proposed strategy. WHO will continue to provide Technical Assistance next year in activities for the preparation of introduction of the HPV vaccine in the event of approval . Through other Gavi funds, WHO supported surveillance for vaccine preventable diseases, specifically rotavirus, paediatric bacterial meningitis and intussusception surveillance. VIG funds to support MR introduction into routine were chanelled through WHO and as such WHO played a key role in supporting the MoH with the introduction.

During 2016, the PEF support to UNICEF was targeted in two programmatic areas, namely supply chain strengthening and demand creation. The total programmable budget for 2016 (USD193, 944) approved by the Gavi PEF MT was fully utilised by the end of Q2 in 2017. Activities covered the implementation of recommendations from EVMA, support for improved stock management and preparation for the introduction of new vaccines (MR and IPV), support for use of logistics data for action and support for behaviour change communication on RMNCH-N. Specific activities included workshops for the cMYP development and HPV vaccine introduction application, training of all 103 District staff and 33 Health Facilities staff in vaccine management and use of the stock management web-based tool [Logistimo]. Additionally, the funds supported some activities for social mobilisation and communication for routine immunisation and 2nd year of life child health interventions and staff costs.

At the time of the JA in August 2017, UNICEF Zambia had received USD $157,425 for implementation of 2017 PEF TCA activities (including staff salaries, travel, consultants & workshops/trainings) out of the approved USD $193,900. The funds were committed for ongoing activities for equity analysis for investigation of the drivers of coverage variance across different variables such as wealth quintiles, geographical locations, etc. and investigation of the drivers of the immunisation drop-out rates for various antigens. And in addition, a workshop for development of Cold Chain Equipment Maintenance was planned for December 2017.

5. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

Prioritised actions from previous Joint Appraisal	Current status
1.Immunisation Supply Chain and cold chain • Develop consolidated report of all partner activities related to vaccine management and the immunisation supply chain. • Evaluate vaccine management and immunisation supply chain performance; identify opportunities to improve the effectiveness and efficiency for vaccine management, monitoring and supervision, to strengthen accountability over the cold chain system, and to synergise routine information systems that provide timely and reliable data on availability, quality and costs to allow to measure progress towards system optimisation. • Develop consolidated plan for vaccine management and immunisation supply chain strengthening. EVM Improvement Plan • Review the implementation status of the 2015 EVM and develop a prioritised action plan with milestones and timelines and roles and responsibilities. • Vaccine management strengthening – Stock Management Systems (Stock Records and Logistimo), Temperature Monitoring, Basics of Vaccine Management, Monitoring and Supportive Supervision. • Finalised National CCE Maintenance Plan including dissemination.	Draft (EPI-OPT) Complete Draft (EPI-OPT) Partially done Ongoing In progress but not complete
2. ZITAG • Operationalised ZITAG by Q1 2017; held 3 meeting during the year. • Study tour to visit country with a well-functioning NITAG.	Complete Complete - attended SAGE meeting in Geneva
3. Data Quality • Strengthen engagement with MoH M&E team to support mentoring, monitoring and supervision, with agreed workplan developed. • Regular (quarterly) data quality review meetings.	M&E to develop work plan Two data quality review meeting conducted (one HMIS data and one on Logistimo data)
4. New Vaccines • Develop HPV National Application. • Investigate the drivers of the inconsistencies in the drop-out rates across vaccines (Penta3, PCV3, Rota) • Complete costing of 2YL Plan; implementation of the 2YL activities.	Application submittedx Not Done Costing completed, implementation on-going

5. Immunisation Financing:	
• Resource mobilisation framework to be developed.	Not done
• Establish bi-annual briefing sessions with parliamentary committee on health.	No done
• Organise roundtable session with key private sector organisations.	Not done
• Identify high level champions to support political advocacy on immunisation financing.	Not done
6. Comprehensive Multi Year Plan:	
• Develop Resource mobilisation tool derived from the cMYP.	Not done
• Formal dissemination of the cMYP.	Not done
7. Coverage and Equity:	
• Equity analysis conducted to provide further insight into the drivers of coverage variance across wealth quintiles and geographical locations.	Not done
• Action Plan developed to address key drivers of immunisation inequity.	Not done
Additional significant IRC / HLRP recommendations (if applicable)	**Current status**

1. ACTION PLAN: SUMMARY OF FINDINGS, ACTIONS AND TECHNICAL ASSISTANCE NEEDS IDENTIFIED AND AGREED DURING THE JOINT APPRAISAL

Overview of key activities planned for the next year:

Key finding 1	Insufficient domestic resource allocation to support the expanding portfolio of the immunisation programme (vaccines and operational costs) and the need for more comprehensive resource tracking for immunisation.
Agreed country actions	• Development of investment case for vaccines to effective resource mobilisation; • Annual level resource tracking of funding committed and disbursed to the immunisation programme.
Associated timeline	End of 2nd Quarter, 2018
Technical assistance needs	Require a consultant and support for consensus meeting(s)
Key finding 2	Insufficient data available on key drivers for low coverage and equity in certain districts which undermines the ability of the programme to target interventions for these areas.
Agreed country actions	Development and implementation of recommendations from the in-depth equity analysis;
Associated timeline	End of 4th Quarter, 2018
Technical assistance needs	TA to support implementation of recommendations derived from the equity analysis.
Key finding 3	Need to strengthen the supply chain (including CCE) for enhanced delivery of vaccines and improved vaccine management.
Agreed country actions	• Evaluation of the implementation of roll-out of Logistimo. • Evaluation of the piloted Remote Temperature Monitoring devices and planning for further roll-out. • Development and submission of CCEOP application. • Resource mobilisation and begin phased-in implementation of EPI-Optimisation strategy to improves vaccine management practices, streamline the immunisation supply chain and roll-out Logistimo to the Health Facility level in Southern Province.
Associated timeline	End of 4th Quarter, 2018
Technical assistance needs	Consultant for CCEOP application needed
Key finding 4	Discrepancies in CSO and head-count data undermining the ability of the programme to adequately assess coverage and a lack of a data quality improvement plan to enhance coordination for efficient data management.
Agreed country actions	• Resource mobilisation and implementation of EPI-Optimisation Strategy that addresses administrative and supply chain data in Southern and Western Provinces. • Bring evidence to CSO to validate the triangulation of data to verify population estimates and other data sources and follow up with CSO. • Development of a costed DQIP. • Support finalisation, printing and dissemination of the AEFI Manual and reporting tools.

	• Support orientation of Health Workers in AEFI guidelines and reporting.
Associated timeline	End of 3rd quarter, 2018
Technical assistance needs	Financial resources and TA
Key finding 5	Governance and oversight through the ICC needs to be strengthened to enhance strategic guidance for the programme.
Agreed country actions	**ICC Strengthening** • Benchmarking the ICC TORs and membership against the Gavi recommendation –Development of an annual work-plan for the ICC **EPI Team Strengthening:** • Conduct self-assessment of EPI programme and strategy to address key bottlenecks • Support ZITAG work schedule Implementation.
Associated timeline	End of 2nd Quarter, 2018
Technical assistance needs	Financial resources

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

To be tabled at the ICC meeting of Q1 in 2018

ANNEX 1

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ANNEX 2

Compliance with Gavi reporting requirements

	Yes	No	Not applicable
Grant Performance Framework (GPF) reporting against all due indicators			
Financial Reports			
Periodic financial reports			
Annual financial statement			
Annual financial audit report			
End of year stock level report			
Campaign reports			
Immunisation financing and expenditure information			
Data quality and survey reporting			
Annual desk review			
Data quality improvement plan (DQIP)			
If yes to DQIP, reporting on progress against it			
In-depth data assessment (conducted in the last five years)			
Nationally representative coverage survey (conducted in the last five years)			
Annual progress update on the Effective Vaccine Management (EVM) improvement plan			
Post Introduction Evaluation (PIE)			
Measles-rubella 5 year plan			
Operational plan for the immunisation programme			
HSS end of grant evaluation report			
HPV specific reports			
Transition Plan			

In case any of the required reporting documents is not available at the time of the Joint Appraisal, provide information when the missing document/information will be provided.