Joint Appraisal report 2018

Country	Zambia
Full JA or JA update	☑ **full JA** ☐ JA update
Date and location of Joint Appraisal meeting	20-22 August 2018, Lusaka, Zambia
Participants / affiliation[1]	See Annex 1
Reporting period	August 2017 – August 2018
Fiscal period[2]	January – December
Comprehensive Multi Year Plan (cMYP) duration	2017 – 2021
Gavi transition / co-financing group	Preparatory Transition

1. RENEWAL AND EXTENSION REQUESTS

Renewal requests were submitted on the country portal

Vaccine (NVS) renewal request (by 15 May)	Yes ☑	No ☐	N/A ☐
HSS renewal request	Yes ☐	No ☑	N/A ☐
CCEOP renewal request	Yes ☐	No ☑	N/A ☐

Population / **Birth cohort** / Vaccine	**Pentavalent**	**PCV**	**Rota**	**IPV**
Population in the target age cohort	843,728	843,728	843,728	843,728
Target population to be vaccinated (first dose)	693,173	693,173	693,173	658,514
Target population to be vaccinated (last dose)	658,514	658,514	658,514	
Implied coverage rate	96%	96%	96%	89%
Last available WUENIC coverage rate	94%	94%	96%	0
Last available admin coverage rate	94%	94%	96%	0
Wastage rate	5%	10%	5%	10%
Buffer	25%	25%	25%	25%
Stock reported	423,070	183,840	1,129,300	0

Zambia has continued receiving new vaccine renewal support from Gavi. Currently there are four vaccines under this support specifically Penta, PCV, Rota and IPV. Measles Second dose support has not been received since 2014. Regarding vaccine availability in 2017, the country has not recorded any stock outs at all levels in this period. Vaccines were adequate for the targeted population. Quantification of vaccines is conducted yearly and informed by available stocks, and target coverage and target population (CSO population projections).

Indicative interest to introduce new vaccines or request Health System Strengthening support from Gavi in the future[3]

Indicative interest to introduce new vaccines or request HSS support from Gavi	**Programme**	**Expected application year**	**Expected introduction year**
	HPV introduction	2018 - completed	2019
	HSS		2019

[1] If taking too much space, the list of participants may also be provided as an annex.
[2] If the country reporting period deviates from the fiscal period, please provide a short explanation.
[3] Providing this information does not constitute any obligation for either the country or Gavi, it merely serves for information purposes.

2. RECENT CHANGES IN COUNTRY CONTEXT AND POTENTIAL RISKS FOR NEXT YEAR

Changes which occurred that directly affected the performance of the immunisation programme and Gavi grants included flooding in the rainy season, diseases outbreaks such as cholera in Lusaka district and Measles in Mansa and Lusaka districts; threats of importation of circulating vaccine derived poliovirus (cVDPD) from neighbouring country, influx of refugees from neighbouring countries of which 19% are underfives, mobile populations coming into the country placing demand on the health system, instability of the national currency due to drop in copper prices coupled with increase in the fuel price and other factors that drive the economy.

The past year was incredibly busy for the Zambian EPI: the following programme were commenced: HSS implementation and the project to strengthen immunisation through sero-surveillance; the HPV proposal for national rollout was approved, Zambia conducted the following: oral cholera vaccination campaign and relevant evaluations wich are ongoing; the Measles Rubella (MR) Post Introduction Evaluation the introduction of Inactivated Polio Vaccine (IPV); the country switched formulations of PCV, completion of the EPI-Optimisation plan and the Full Country Evaluation for 2017.

The country has had support from sources such as the Global Polio Eradication Initiative where polio, measles and rubella surveillance have been supported in the context of Integrated Disease Surveillance. Though the country is yet to develop a polio support transition plan, as part of this process, a Polio Asset Mapping has been conducted to map the investments for transitioning.

Please list a maximum of five most important risks (i.e. with a high likelihood to happen and / or a high potential impact if it did happen).

- Anticipated elections in neighbouring countries may exacerbate the already high population movements between resulting in an increased demand for the program and a risk of outbreaks;
- Natural disasters such as floods may pose a risk for outbreaks of water borne diseases;
- Uncoordinated introduction of multiple innovations not interoperable with the existing DHIS2 as well as on-going implementation of parallel reporting systems (paper-based and electronic system) at service delivery level;
- Creation of new districts which will require investment of resources in the health system (both human and equipment) and strong management structures;
- Dependencies on external financial support for activities such as SIAs and new vaccine introductions.

3. PERFORMANCE OF THE IMMUNISATION PROGRAMME

3.1. Coverage and equity of immunisation

COVERAGE

Overall coverage of under-1 full immunisation achieved well above target (99%), however there are still a significant proportion of districts with low coverage for fully immunised (35%). The coverage for MCV2 showed an increase from the previous reporting period but continued to perform below target and 16 districts were noted to have MCV2 coverage below 50%. Data quality challenges continued in the period under review with a number of districts reporting coverage over 100% and negative drop out rates.

Table 1. Antigen target vs actual coverage (JRF, 2016-2017)

Antigen	*2017 Target*	*2017 Coverage*	2016 Coverage
DTP3	95%	94%	95%
PCV3	90%	94%	94%
OPV3	95%	92%	91%
RV2	88%	96%	94%
MCV2	60%	64%	58%

Drop-out rates (JRF 2017) were as follows: Penta 1-3: 1.03%; PCV1-3: 6%; RV1-3.03: 0%; MCV1-2: 33.3%. A comparison of national coverage rates for select antigens by year from 2013 to 2017 shows a continued increased in coverage rates.

Figure 1: Trends of National Antigen Coverage by Year, 2013-17 (JRF)

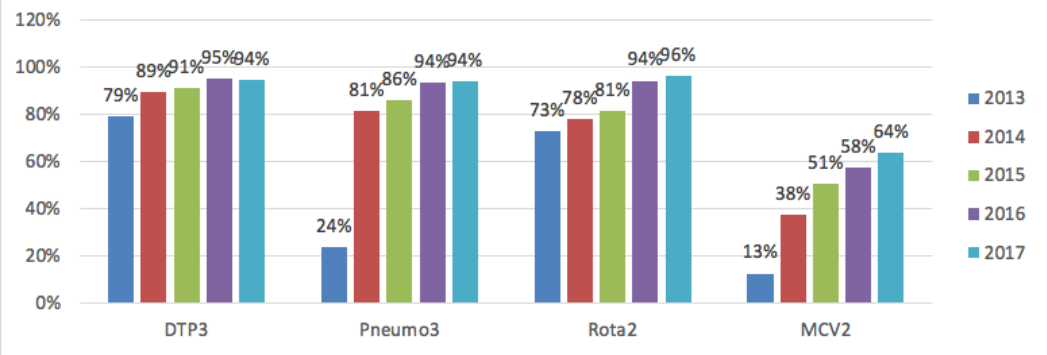
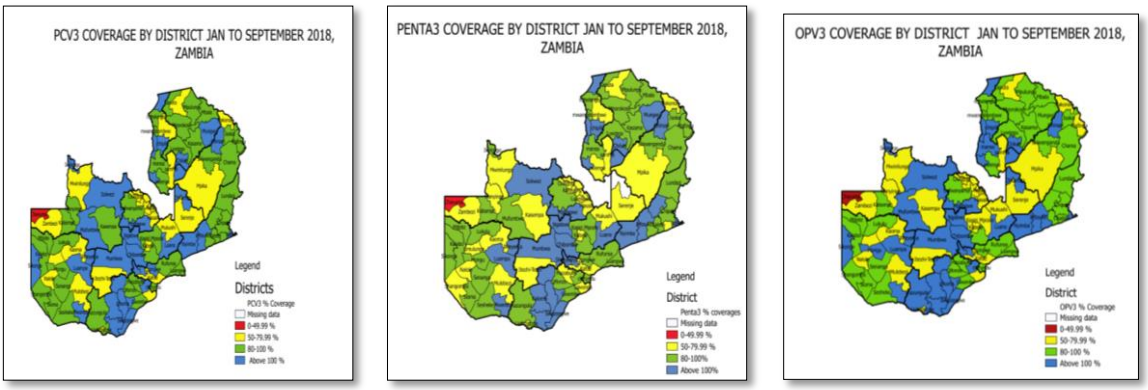


Figure 2: District coverage for Antigens provided at 14 Weeks – January- September, 2018



The heat maps above illustrate immunisation coverage by district for the third doses of the selected antigens (PCV3, Penta 3 and OPV3). The discrepancy in coverages across the districts highlight the data quality challenges that are being experienced; key factors contributing to the challenges include: denominator anomalies, data handling at point of generation and limited use of data for decision making. As a remedial measure, discussions between the Central Statistical Office and the Ministry of Health have led to a revised analysis of the projected populations, this was applied to data in 2018, however the revised projections did not resolve the denominator issue. The use of these new denominators therefore was suspended. It is hoped that the drive to increase health care workers in the country will lead to a more manageable work load and ultimately improve data collection at the points of generation.

EQUITY

Strong health and immunisation systems are vital to deliver vaccines to all the children; despite a noticeable increase in vaccine coverage, inequalities in coverage still remain high with pockets of under-immunised children often found in hard to reach areas. Many live in urban slums or in remote rural areas or may be unregistered with health facilities and beyond the reach of health care workers.

The Zambia Coverage and Equity Study Report (CESR) of 2018 indicated that wealth and education of mothers were the main drivers of immunisation inequity. There were also some regional disparities, but to a lesser degree. The regression analysis showed that wealth status had a strong and robust effect on the probability of being immunised, with the top two wealth quintiles roughly twice as likely to be immunised relative to those in the bottom two quintiles. Similarly, children of mothers with secondary or higher education attainment are more likely to be immunised relative to children of uneducated mothers.

It was seen that the low performing districts were generally either more rural or predominantly peri-urban districts. This confirmed earlier findings from the Demographic and Health Survey (DHS) that there are significant variations in immunisation coverage across the provinces in Zambia. For example, in 2001, while the coverage was fairly high in Copperbelt (79.4%) and Southern Provinces (77.8%), it was somewhat low in Luapula (61.7%) and Northern provinces (60.5%). Similar observations could be made for the 2014 results.

Secondly, the assessment reaffirms that the concentration index is positive for both years (2001 and 2013), suggesting that there are pro-rich inequities in immunisation in Zambia. It also highlighted the value of the concentration index (0.055 in 2001 and 0.054 in 2013) and suggests that pro-rich inequities in immunisation are persistent. However, it was also noted that the concentration index changed very little over the study period and there was a strong suggestion that the pro-rich inequities increased for BCG and measles, but dropped slightly for DPT and OPV. The results from the study analysis strongly suggest that wealth and education of the mother (both proxies for socio-economic status) are the main contributors to the states of pro-rich inequities of immunisation). Analysing only the wealth status, the study found a strong and robust socio-economic effect on the probability of being immunised. The suggestion was that those in the top 2 quintiles (the rich) are roughly twice as likely to be immunised relative to those at the bottom of the socio-economic ladder. Similarly, it was concluded that there was a relationship between immunisation and wealth holds in that, children from mothers with secondary or higher attainment are roughly 1.5 times more likely to be immunised, relative to children from uneducated mothers. Other factors analysed in the study related to equity included an absence of a link between health infrastructure and full immunisation. It was revealed that there is strong negative link between distance and immunisation. In districts where a higher percentage of women highlighted distance as a barrier, the rate of full immunisation coverage is much lower.

Additionally, a strong link was shown between immunisation coverage and outreach activities. There is a noted variance for vaccine coverage in antigens that are supposed to be given at the same time, indicating varying availability of the vaccines at sub-district levels. Based on the findings 20 consistently low performing districts were identified and have been tasked with developing targeted Action Plans to address low coverage and inequity. To date, funding has been mobilised for 1 of these district plans and 4 districts (Luwingu, Samfya, Mwense, Mpika) are part of the overall HSS grant, which additional efforts to strengthen and implement these plans are underway. The Minitsry has responded further by including a dedicated budget line from treasury for outreach activities. In addition, as part of the transformation agenda for health which aims to bring health services as close to the community as possible, there is a plan to build an additional 650 health posts.

3.2. Key drivers of sustainable coverage and equity

HEALTH WORK FORCE

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 was exacerbated in more rural and harder to reach areas. In response to this, the government has over the recent past recruited in excess of 15,000 frontline health workers against the projected 30,000 over the life span of the national health strategic plan 2017 to 2021. This on-going effort to ensure adequate numbers of health care staff will be complemented by ensuring that staff are also appropriately capacitated for their roles.

The sector reform has highlighted that significant staff movement is a potential barrier to achieving critical milestones and meeting key requirements and expectations for the EPI. Achieving our goal of sustainably improving coverage and equity requires strong leadership, management and coordination of the immunisation programme. Strengthening service delivery teams (EPI teams inclusive) at the national and subnational level was at the core of the reform with the aim of improving their structures, capabilities, processes and practices to improve functionality. Expediting the process of reform would enhance national and subnational capacity for sustained coverage and equity. Increase in numbers has improved staff

availability at service delivery of immunisation services but planned supervision and continued mentorship of these staff will capacitate them appropriately. Due to the expansion of the immunisation programme (number of vaccines, new health facilities and increasing population) there is a need to expand staffing across all levels: National, Provincial and district. Many frontline health care workers at service delivery level will require RED/C training, consistent supervision and mentorship while district level management teams need middle level management training.

SUPPLY AND COLD CHAIN

The National Expanded Programme on Immunisation (NEPI) has had good collaboration with several supply chain partners over the past 15 years. In the next 12 months, plans are to leverage lessons learnt from the innovations, people and institutions, including:

- Remote Temperature Monitoring (RTM);
- Logistimo;
- Provincial and District Cold Chain officers for maintenance;
- Dose Per Container Partnership (DPCP);
- Immunisation supply chain system (re)design; and
- Key recommendations from the CCEOP application development process.

Further, Zambia recently submitted the CCEOP application which is expected to ensure the backbone of the programme, cold chain, is well taken care of in terms of availability, reliability and quality. The CCEOP development process had also highlighted areas that needed constant follow such as implementation of EVMA recommendations and inventory updating.

SERVICE DELIVERY & DEMAND GENERATION

In the past year, the country has initiated a number of activities to strengthen routine immunisation service delivery. These include printing and dissemination of EPI guidelines (EPI manual, RED/C guideline, Cold chain manuals); training of national trainers in RED/C, orientation of frontline health care workers in selected districts, supportive and mentorship visit in selected districts, procurement of transport, provision of funding for outreach activities at district level, implementation of biannual child health weeks.

Advocacy, communication and social mobilisation activities have been in part supported through the Health Promotion Unit of the newly created Department of Health Promotion, Environment and Social Determinants (DHPESD). The MoH with partners has continuously conducted social mobilisation activities such as national and local airing on electronic media discussions and spots/jingles on immunisation and engagement of key stakeholders (parliamentarians, chiefs and religious leaders) on immunisation.

The Zambia Civil Society Immunisation Platform (ZCSIP) has also played a critical role in communications for immunisation (C4I). Civil Society Organisations (CSO) have been contracted to contribute to government efforts in improving and sustaining immunisation coverage at district level. CSOs are conducting community education through drama performances, door-to-door outreach and defaulter tracing activities conducted by community health workers, community stakeholder engagement (Religious and Community leaders, and dialogue meetings).

CSOs have used community radio stations and churches to create awareness and demand for immunisation services. In addition, they have been instrumental in mobilising communities in readiness for child health week. The CSO have supported advocacy efforts in resource mobilisation for the immunisation program.

GENDER-RELATED BARRIERS

The findings from the 2013-14 Zambia Demographic and Health Survey (ZDHS) are still relevant as has been re-affirmed as reported in the CESR 2018. There is little discrepancy between coverage of boys and girls but involvement of men in taking children to vaccination points is still low. In order to address barriers to immunisation that have been highlighted by caregivers, health facilities have been conducting outreach services at trading places (including but not limited to fishing camps, market places). These initiatives have been specifically designed to increase access to services.

LEADERSHIP, MANAGEMENT & COORDINATION

The Ministry of Health in recent years has seen many new faces in leadership at all levels of health care. The staff changes means that there is a recurrent need for training and orientation, funding and support is not always readily available for these activities. The recruitment of 15,000 frontline health workers poses a similar challenge from a training perspective – while the increased levels of staff are much needed, the effectiveness of the new staff is reliant on adequate training and supervision.

At national level, the ICC has been expanded to include major stakeholders that were not previously represented. The functionality of the ICC is however not yet at optimal levels as not all the new stakeholders have been appropriately orientated on the roles and responsibilities of the ICC.

3.3. Data

Status of health and immunisation information system

The Data Quality Improvement Planning (DQIP) Process carried out involved system review, data desk review and field review. The final step of improvement planning will be carried out within early December 2018. The findings from system review show that the country has one main information system, the DHIS2. This is complemented by several other similar systems namely, SMARTCARE, *Zambia Electronic Immunization Registry (*ZEIR) supported by PATH being implemented in Southern province, mVacc (supported by UNICEF) and Logistimo supported by (WHO). These systems offer some additional information that is not captured through DHIS2.

Efforts are underway to improve integration of different data systems that are in use. For example ZEIR and mVacc are currently being integrated. SMARTCARE and DHIS2 integration is in early stages in order to allow SMARTCARE data to be automatically exported to DHIS2 without the need for manual input. UNICEF and PATH are supporting ZEIR and mVacc integration while CDC is supporting SMARTCARE and DHIS2 integration. Evaluation for Logistimo is planned to commence in December 2018 with support from UNICEF in order to access how well the system is working and plan for further roll out.

Denominator related information

The Data quality improvement desk review, systems assessment and field assessment processes showed that denominator issues are still a challenge for the immunisation system, often leading to reported coverage over 100% in many districts. The EPI programme uses CSO population figures and estimates and this has historically posed challenges with both over and under estimations compared to headcounts. The CSO was engaged by MoH regarding the denominator issues. Remodelling has since been conducted in order to redistribute among the districts early 2018. The new estimates are for 2017, 2018 and 2019 which are being utilized by MoH for purposes of planning and forecasting. The effects of these changes will be tracked as implementation progresses.

Key challenges pertaining to data availability, quality and use

The Data quality improvement desk review, systems assessment and field assessment processes supported by WHO showed that key challenges relating to data were incomplete reporting by districts, timeliness of submission and inconsistencies in monthly reporting. Reporting rates are generally high, but not all districts report fully. In 2017, 51% of facilities had complete reporting and the remainder had incomplete reporting. Of those with incomplete reporting, 43% had over 90% reporting rate and only 6% had between 83% to 89% reporting rate.

Currently staff numbers are still inadequate coupled with gaps in skill-set of the personnel responsible for handling data at various levels was a challenge that affected how well data could be generated and utilised. Within CHU itself there is no one specifically assigned to handle data or with M&E expertise, although the M&E unit has assigned someone to handle immunisation data. However, this person has other responsibilities and thus there is a view that CHU needs a dedicated person to handle its data needs in order to improve data use. Other factors adversely affecting data quality and use include Supportive monitoring and supervision not being done due to various constraints and data desk reviews not being done as planned. There is also weak feedback between levels with regards to data.

Compliance with Gavi's data quality and survey requirements
The EPI programme is working towards being compliant with Gavi's data quality and survey requirements. The ongoing and soon to be completed DQIP process is part of efforts to further improve on data quality for the programme. Through system review, data desk review and field review, the data system was assessed and recommendations and plans to improve on data quality will soon be utilised. Part of the requirement for continuous data quality improvement is to set up a Data Quality Team which will be responsible for oversight on data quality issues as well as bear responsibility for ensuring plans are implemented and there is accountability for the DQIP process. In addition, the national demographic and health survey whose report is anticipated to be ready in June, 2019 will provide updated independent estimates of immunisation coverage.

Main efforts/innovations/good practices focused on evidence-based data improvement interventions and level of scale up
An integrated Child and Mother Follow-up Register was introduced January 2018 in order to provide an event-based longitudinal cohort register which tracks events and services for children from the first post-delivery visit until the 23rd month of birth. The information collected on this register can be grouped into: Registration/Demographic details; birth history; immunisation of infants and booster doses thereafter but before the 2nd birthday. The new register will help enhance tracking of programmatic achievements relating to mother child health, especially at facility level. The U5 register now carters for children 24-59 months. The integrated MCH register is however yet to be fully rolled out and thus many facilities are still using the under-five register for all children from 0-59 months.

The DHIS2 is the main system used to capture immunisation data. The system is rolled out in all the districts and a few health facilities. However there exists other systems such as the Zambia electronic Immunisation System, Mvaccination and Logistimo which also play a critical role in immunisation and these are not integrated into the main DHIS2. Plans and discussions are underway to ensure that some of these systems are integrated into the DHIS2. The IDSR system is integrated within the DHIS2, however, there is another form that is used to report directly surveillance data to the Zambia National Public Health Institute hence making the DHIS2-IDSR module weak. Work began on the establishment of an e-IDSR platform to be on DHIS2 to improve reporting to real time.

Surveillance Data
AFP surveillance core indicators, Non-polio AFP rate was at 2.8 per 100,000 (target > 2 per 100,000) and Stool adequacy rate was at 86% (target > 80%).

3.4. Immunisation financing

The national health financing framework, medium-term, cMYP and annual immunisation operational plans and budgets have been aligned. The National Health Strategy has components for EPI, both vaccine procurement and service delivery which have been incremental overtime and every year the budget is revised and the budget line for vaccine procurement and service delivery is upward adjusted. Generally, sufficient resources in the national health budgets for the immunisation programme and services are allocated. However, the main issue has been delay in disbursement of funds. Despite this, the country has not defaulted in its financing obligation in the past 3 years and all reporting is done.

As a programme, we are able to keep track of all finances that are directly disbursed to the central level. However, challenges still exist in tracking immunisation financing to lower levels. In the past couple of years, national economic difficulties have led to limited funds being released for routine immunisation services. For the noted gaps the country has developed the resource mobilisation framework to complement government efforts.

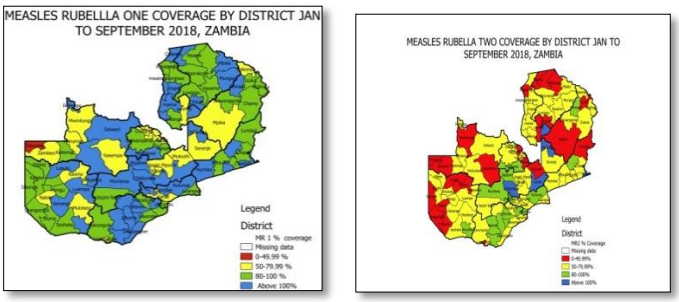
4. PERFORMANCE OF GAVI SUPPORT

4.1. Performance of vaccine support

EPI 2017 coverage rates fell just short of the Grant Performance Framework (GPF) targets for the year—off by 1-3%, and when comparing 2016 to 2017 coverage performance, coverage rates were about the same. Refer to table 1 and figure 1 above in section 3.1. In addition to routine vaccine service delivery, logistics and monitoring, the programme undertook a targeted cholera campaign in Lusaka District. Over 1,300,000 children and adults were vaccinated for the first dose and second doses of OCV.

A comparison of national coverage rates for select antigens by year from 2013 to 2017 shows a continued increased in coverage rates. Situation analysis for measles and rubella, the country reports high coverages for MR1, however the second dose while improving remains suboptimal shown in below.

Figure 3: Zambia MR1 & MR2 Coverage, Jan-Sept, 2018



Regarding measles surveillance the two core indicators have not been met: regarding Measles surveillance indicators, the Non-measles febrile rash illness rate was at 1.78 per 100,000 (target: > 2 per 100,000) and the second indicator which is Percent districts with, at least, 1 case with blood specimen / year was at 51.3% (56/109) (target > 80%) while the 11(4.0%) of 277 suspected measles cases were measles IgM positive cases while 2 (0.7%) percent were rubella IgM positive cases (Target <10%).

Whilst national DTP3 coverage rates remain high, sub-national figures reveal concerns as many districts are reporting coverage rates over 100% (see figure 2 in section 3.1 above). Analysis of DPT3 coverage rates by district over the last three years reveals 32 districts reporting over 100% in 2015, 34 in 2016 and 47 in 2017. Implementation of the EPI-OPT and expansion nationally would ensure the denominator is sorted once and for all, as while mVacc will take note all eligible children (whether guardians are willing to have their children immunised or not), ZEIR will maintain a good registry that would easily be used for decision making; and implementing systems redesign recommendations will ensure optimised usage of cold chain, transport and staff time all too necessary for data triangulation and usage.

Figure 4: 2015-17 District DPT3 Coverage Ranges by Year, 2015-17 (JRF)

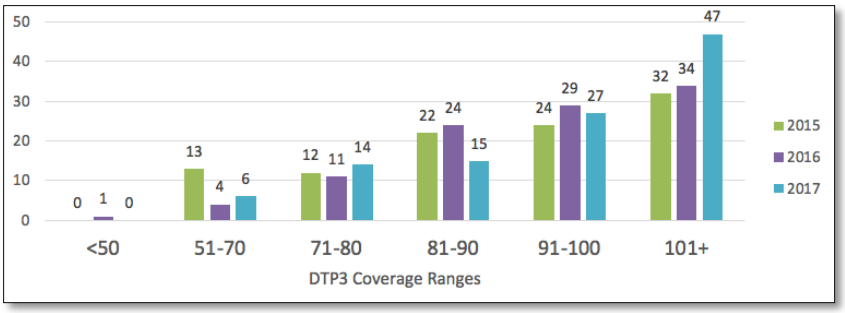
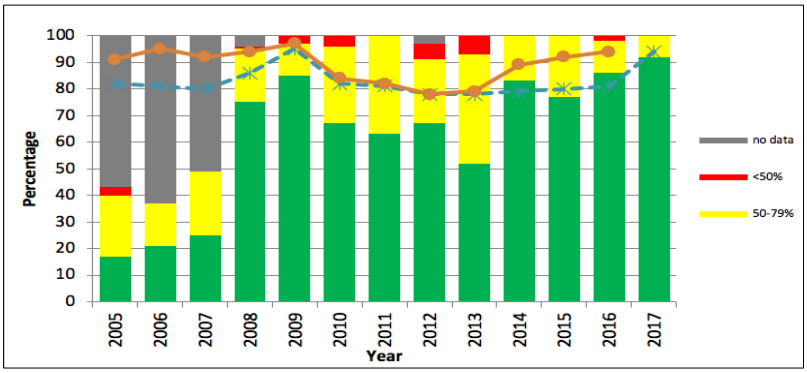


Figure 3: Trends of DTP3 District performance by categorisation 2005-2017 (JRF)



4.2. Performance of Gavi HSS support (if country is receiving Gavi HSS support)

Health Systems Strengthening

The funds for the HSS were received in country in March 2018 by all three involved agencies; the Ministry of Health, CHAZ and UNICEF. Implementation of the oral cholera vaccination delayed the start of HSS activities by over two months. CHAZ were the first to recruit while MOH did two of the three recruitments by mid-July 2018. The trainings were prioritised as arrangements were being made for the baseline to be conducted and the plan was as shared below.

Activities took off with a training plan in place to train trainers and roll out to the target districts. Establishment good governance systems were prioritised as they were seen as key to the success of the programme from the outset. This has also seen recruitment of additional two staff being prioritised at national level. Preliminary activities, which included, engaging or contracting CSOs at district level, procuring bicycles for community health workers and motor cycles for facilities and vehicles for provincial, district and central level offices, procuring of motor cycles for the district CSOs, disbursement of funds in quarter two and procuring of the CHAZ vehicle were also done distribution of these to the districts was partially done due to inadequate fuel for trucks and staff allowances for distribution. The distribution budget estimate appeared to have been drawn from vaccines' distribution, but the frequency of trips was under-estimated.

ICC held on 16th August endorsed the request to Gavi to reprogramme some activities. There is equally a proposal for MoH to conduct the baseline as opposed to using an external consultant. This is expected to not only be a faster way but also enhance ownership of the findings and improved capacity within. Some of the start-up activities are listed in table 3.

Table 3: 2018 Zambia Gavi HSS Training Plan

Training Name	Proposed dates
Conduct ToT on RED/REC strategy	15 - 22/07/2018
Train health workers in RED/REC strategy	12 - 18/08/2018
Develop EPI modules for nursing schools	21 - 25/08/2018
Conduct ToT workshop in C4I for CSOs at national level	29/07-04/08/18
Train drama groups in immunisation at district level	06-19/08/18
Train immunisation champions who can advance immunisation issues	26/08-01/09/18
Conduct ToT on data management and utilisation at district level	26/08-01/09/18
Train frontline health workers on data management and utilisation	09-15/09/18
Develop PBF training manual	26/08 - 01/09/2018

Objective 1	
Objective of the HSS grant (as per the HSS proposals or PSR)	To improve the delivery of immunisation and other child health interventions in Zambia by ensuring that outreach clinics and supportive supervision are operational in target districts
Priority geographies / population groups or constraints to C&E addressed by the objective	This is being implemented in Milenge, Samfya, Lunga, Mwense, Chifunabuli, Mpika, Kanchibiya, Chinsali, Lavushimanda and Luwingu of Luapula, Northern and Muchinga provinces respectively. Constraints being addressed • Lack of supportive supervision at national & district level to the facilities • lack of outreach activities by facilities to the outreach posts. • Inadequate transport for supportive supervision • Inadequate transport to conduct outreach activities
% activities conducted / budget utilisation	• No data. Districts just received the grant to support the outreach activities to the health facilities
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	**Successes** • Districts and facility trained in RED/C strategy to strengthen the supportive supervision and implementation of outreach activities. • Grants disbursed to the districts to support the outreach activities at facility level • Procurement of 4X4 vehicles for supportive supervision • Procurement of motorbikes for conducting outreach activities • Procurement of boats to facilitate water transport for supportive supervision
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **needs for technical assistance**[11]	• Conduct supportive supervision to the districts and facilities • Procurement of zonal vehicles to facilitate distribution and ordering of vaccines to the zoned facilities
Objective 2:	
Objective of the HSS grant (as per the HSS proposals or PSR)	To improve the knowledge and skills of district managers and frontline health workers on delivery and management of immunisation and other child health services.
Priority geographies / population groups or constraints to C&E addressed by the objective	This is being implemented in Milenge, Samfya, Lunga, Mwense, Chifunabuli, Mpika, Kanchibiya, Chinsali, Lavushimanda and Luwingu of Luapula, Northern and Muchinga provinces respectively. **Constraits being addressed** • Increasing knowledge among the districts managers and frontline health wrokers in middle level management, cold chain management, EPI integration in the nursing teaching curriculum, updating the EPI manual. • Providing technical assistance to EPI by employing the M&E specialist, Senior Accountant and HSS coordinator

% activities conducted / budget utilisation	**80 %**
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	**Successes** • District and health facilities staff trained in RED/C • EPI manual updated • Nursing tutors trained in EPI module • Senior Accountant employed **Delayed** • Employing the HSS Coordinator • Training of district managers in middle level management
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **needs for technical assistance**[11]	• Recruiting the HSS coordinator; process of hiring has been initiated
Objective 3:	
Objective of the HSS grant (as per the HSS proposals or PSR)	To develop and implement effective C4I and other child health intervention strategies through the involvement of CSOs
Priority geographies / population groups or constraints to C&E addressed by the objective	This is being implemented in Milenge, Samfya, Lunga, Mwense, Chifunabuli, Mpika, Kanchibiya, Chinsali, Lavushimanda and Luwingu of Luapula, Northern and Muchinga provinces respectively. **Constraints being addressed** • Demand generation for immunization services through social mobilization and communication for immuniation
% activities conducted / budget utilisation	**70%**
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	**Successes** • Drama groups trained in immunization messages • CSO members trained in social mobilization and messaging **Delayed** • Distribution of bicycles for the neighbourhood health committees (NHCs) • Implementation of social mobilization due the delayed distribution of bicycles
Major activities planned for upcoming period	• Distribution of bicycles to the respective districts

(mention significant changes / budget reallocations and associated **needs for technical assistance**[4]	
Objective 4	
Objective of the HSS grant (as per the HSS proposals or PSR)	To improve the collection and utilisation of HMIS data at all levels of the health care system with special focus on district and lower levels
Priority geographies / population groups or constraints to C&E addressed by the objective	This is being implemented in Milenge, Samfya, Lunga, Mwense, Chifunabuli, Mpika, Kanchibiya, Chinsali, Lavushimanda and Luwingu of Luapula, Northern and Muchinga provinces respectively. **Constraint being addressed** • Poor data collection, lack of data utilization and poor data quality
% activities conducted / budget utilisation	17%
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	**Successes** • Trained trainers in data management • Trained frontline health workers in data management • M&E specialist employed **Delayed** • Baseline survey • Training of community health workers in community registers • Printing of under five cards
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **needs for technical assistance**[5]	**Planned for year two of the HSS grant Implementation** • Support monthly district HMIS data review meetings • Conduct support visits by national office to districts and selected health facilities • Conduct mid-term evaluation of the programme • Conduct final evaluation of the programme • Conduct health facility meetings with CHWs to review data from community registers • Train districts to conduct DQS • Support districts to conduct DQS • Conduct national DQS • Print community registers

	• Print facility registers • Print data use campaign posters
Objective 5	
Objective of the HSS grant (as per the HSS proposals or PSR)	To develop and implement a Performance-Based Financing system in the target districts with the aim of improving immunisation and other child health outcomes 0979326747
Priority geographies / population groups or constraints to C&E addressed by the objective	This is being implemented in Milenge, Samfya, Lunga, Mwense, Chifunabuli, Mpika, Kanchibiya, Chinsali, Lavushimanda and Luwingu of Luapula, Northern and Muchinga provinces respectively **Constraints being addressed** • Poor immunization and other child health outcomes
% activities conducted / budget utilisation	50%
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	**Successes** • Developed immunisation PBF programme implementation manual • Trained provincial offices in PBF • Trained district offices in PBF • Trained health facility staff in PBF • Developed PBF training manual **Delayed** • Print PBF training manual • Print PBF implementation manual • Train community leaders in PBF
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **needs for technical assistance**[6]	• Conduct external evaluation of PBF interventions • Pay incentives to districts and facilities that meet targets.

[6] Note: When specifying Technical Assistance (TA) needs, do not include elements of resource requirements. These will be discussed in the context of the Targeted Country Assistance (TCA) planning. The TCA planning will be informed by the needs indicated in the JA. TA needs should however describe - to the extend known to date - the type of TA required (staff, consultants, training, etc.), the provider of TA (core/expanded partner) the quantity/duration required, modality (embedded; sub-national; coaching; etc.), and any timeframes/deadlines. JA teams are reminded to both look back (TA which was not completed/successful in the past) and forward (planned vaccine introductions, campaigns, major upcoming HSS activities, etc.) when specifying TA priorities for the coming year. The TA menu of support is available as reference guide.

4.3. Performance of Gavi CCEOP support (if country is receiving Gavi CCEOP support) - NA

4.4. Financial management performance

MoH received year 1 Gavi HSS activities funds amounting to US$ 1,676,857.00 in second quarter of 2018. The financial reporting for the HSS grant has been submitted to Gavi through the Country Portal.

The Measles Rubella vaccine was introduced in 2017. Activities conducted included the development of guidelines and printing, orientation of health care workers in EPI at all levels, distribution of vaccines, monitoring implementation, advocacy and social mobilisation and orientation of communities for measles rubella. The utilization of funds was 99% and a balance of USD 315 remained. Funds were managed through WHO.

The country received IPV VIG totalling US$526,500.00 to support operational costs related to the IPV introduction. PCV switch was integrated in the same platform and was conducted at once throughout the country with phased supervision. Funding for this activity was managed through World Health organisation. Details reported under WHO TA.

4.5. Transition planning (if applicable, e.g. country is in accelerated transition phase) - NA

4.6. Technical Assistance (TA)

Technical Assistance from partners such as UNICEF, WHO, CIDRZ, UNDP and CHAZ has been instrumental in supplementing government efforts in sustaining the high immunisation coverage. The government had at the last JA provided guidance that streamlined the support from these partners removing the overlaps in support.

Civil Society

The ZCSIP through its facilitating organisation CHAZ continued to support the Ministry of Health with demand creation activities and advocacy at the community level in 22 Districts. This work has continued despite the conclusion of Gavi CSO constituency support through the Catholic Relief Services (CRS) on 30th May 2018. During the period under review the ZCSIP was involved in the OVC Campaign planning, implementation and post campaign in Lusaka district. The signing of the three year agreement with Gavi and Ministry of Health to commence the implementation of the HSS Project in 2018 in seven districts is a critical factor in ensuring that CSOs continue to contribute to immunisation outcomes.

At the beginning of 2018, CHAZ started implementation of the HSS Project activities with MoH and has since contracted six CSOs (Alejo CSP implementing in Mpika District, Kasama Community Christian Care implementing in Chinsali District, Maternal Health Action Zambia implementing Luwingu District, Bwafwano CBO implementing in Mwense, Young Women Christian Association implementing in Samfya and Camfed implementing in Lunga and Milenge Districts. Experience gained during the Gavi CSO constituency support through the Catholic Relief Services (CRS) enabled CSOs qualify as subrecipients under the HSS grant. At the time of the review all CSOs had signed contracts, recruited staff, secured offices, introduced the projetct at community level and started working with district health offices in mapping communities with low immunisation uptake and high defaulter rates.

As part of the HSS project Eighteen CSOs drawn from 11 Districts were trained as trainer of trainers in communication for immunisation. This investment will be critical in ensuring information and skills quality is maintained during the training cascade intended to be rolled out.

About 57 drama group leaders were trained in basic communication for immunisation through drama and script writing. This was also done to ensure information accuracy and complementarity with services. Four hundred and one (401) Religious and Community Leaders were trained in communication for immunisation at community level. These Leaders are now poised to act as change agents and community advocates for immunisation.

In the last quarter of the year, CHAZ plans to train community leaders and community health volunteers in the Reaching Every Child (REC) strategy and community Result Based Financing. IEC materials are being

developed and they will be distributed to all the Seven Districts. With technical support from MoH EPI and CRS Country Office the platform has finalised its 2019 to 2024 strategic Plan. The platform has chosen to adopt a strong focus on Demand Creation, Coordination and Advocacy for increased local financing for sustainable immunisation services as its strategic directions.

Zambia civil society platform (ZCSIP) participated in the international CSOs Immunisation Platforms meeting dubbed ConneXion learning event held in Kenya, Nairobi. ZCSIP conducted project closeout meetings and was visited by the Gavi CSO Constituency OAG team. The Platform participated in the development of the EPI Optimisation Strategy, the CCEOP proposal development and the Equity workshop.

UNICEF

During 2018, UNICEF received a total of USD1,525,600 to support the implementation of the Health Systems Strengthening grant to Government. Since Gavi disbursement of funds in January 2018, the country has utilised 96% of the funds. The support was specific for procurements to support implementation of specific objectives of the HSS itemised below. Specific activities and progress made under the respective objectives are as per table below:

HSS Proposal Objectives	Activity	Implementation status
1. To improve the delivery of immunisation and other MCH interventions by ensuring that outreach clinics are operational.	Purchase short wheel base type of vehicles	In process
	Purchase 4X4 vehicles	Delivery completed, handover being awaited
	Purchase motor cycles	Delivery completed, handover being awaited
	Purchase of 20 tonne truck for distribution of health supplies	In process
	Purchase boats for Samfya and Lunga Districts	Delivery completed, handover being awaited
2. To improve knowledge and skills of health workers on delivery and management of immunisation and other MCH services.	Print EPI modules	In process
	Print MLM modules	In process
	Print EPI Manual	Printed and delivered
	Print Job aids	In process
	Print Cold Chain Maintenance Manual	Delayed
	Print EPI logistics standard operating procedures	Delayed
4. To strengthen the collection and utilisation of HMIS data at all levels with a special focus on district and lower levels.	Purchase computers for CHU-MOH headquarters and districts	In process

During 2018, UNICEF received a total of USD193,860 for TA support of which the programmable funds amounted to USD131,500. The funds were planned for support to implement activities in 2 key PEF functional areas – 1) Country Planning, Management, and Monitoring and 2) Supply Chain and Vaccine Wastage. Specific activities under the functional areas included –a) Development and implementation of action plan to address recommendations from the in-depth equity analysis b) Evaluation of the implementation of roll-out of Logistimo. c) Evaluation of the pilot of Remote Temperature Monitoring devices and planning for further roll-out. d) Development and submission of CCEOP application. The

expected outcomes of the TA are i)The Ministry of Health has capacity to support selected lowest performing districts increase DTP3 coverage to or above 80% ii) Policy guidance/ directive of Logistimo & RTM are endorsed for full roll out of Logistimo & RTM to health facility level and iii) Ministry of Health has updated cold chain supply chain information and resources mobilized to close gaps in the national cold chain supply systems. Since Gavi disbursement of funds in April 2018, the country has utilised 22% of the funds. Progress against set milestones for 2018 are as itemised below:

A) Action plans were developed by the low performing districts for inclusion in the 2019-2021 MTEF plans, following completion of the equity assessment in August 2018. The key recommendation was to do better targeted outreach activities to help in reaching the unreached segment of the population, particularly in the 20 persistently low performing districts. Implementation of the action plans in selected districts will commence in 2019.
B) The CCEOP application was finalised and submitted in September 2018. The country currently awaits formal response from the Independent Review Committee.
C) Evaluation of Logistimo and RTM experienced minor delays. This was due to heavy workload on the National EPI Program during Q3/4 2018 particularly due to finalization and submission of the Gavi CCEOP application, launch of the Gavi HSS and completion of the Joint Appraisal. Engagement of the consultant, however, is well underway with final selection of the preferred candidate having been done in November 2018. Due to logistical complexity of carrying out the activity during the month of December, the activity will be launched in January 2019.

CIDRZ

Additionally, PEF was expanded beyond WHO and UNICEF this year, with a local NGO, the Centre for Infectious Disease Research in Zambia (CIDRZ also coming on board in August 2018 to support national level to strengthening management and governance capacity, strengthen and support capacity building of the immunisation supply and cold chain and to support coordination and functioning of national EPI activities with the aim of improving coverage and equity. The TA coming from CIDRZ will provide seconded staff to the Child Health Unit to Ensure receipt, inspection and timely, accurate reporting of vaccine and safe injection shipments, to Support quantification and forecasting for vaccine requirements for the country and to support the rollout of other vaccines in the country. Additionally, the TA will support quarterly NITAG meetings, the development of the CCEOP application, aid in resource mobilisation and the initiation of EPI-OPT and to provide on-going support for other EPI activities.

UNDP

Approved Budget USD	Expenditure USD	Budget Utilisation %
271,135	**79,390**	**29%**

The following are the major activities implemented in 2018.

1. Configuration of Navision Financial Management Solutions at Ministry of Health (MoH) main data base to meet Gavi budgeting and financial reporting requirements.
2. Five days training for the 7 districts in Results Based Financing (RBF), use of Navision and Gavi financial rules and regulations.
3. The 1st Joint MoH and UNDP financial mentorship currently being conducted.

The following are some of the key successes/outcomes achieved so far,

1. Navision at central level has been configured to incorporate Gavi as a project in the main data base. This means that districts can now log into the main data base and post transactions. HQ at central level is also able to view and monitor transactions at district level thus strengthening oversight and financial controls.

2. Staff at district have been oriented in RBF, Gavi rules and regulations and use of Navision.
3. District offices were able to develop work plans and budgets for 2018 following the training conducted.
4. Districts are now oriented in areas that might impact on project implementation such as ineligible expenses.

5. The 1st mentorship visit has established a firm baseline for the mentorship programme. It has also provided us with an opportunity to identify areas that need urgent attention.

The only activity that has not been implemented this year is the 2nd mentorship visit which has since been moved to next year 2019.

WHO

WHO provides technical assistance mainly at national level to the National Immunisation programme. In the period under review WHO supported capacity building activities towards the skills transfer and improved capacity to data collection, management, analysis and overall data quality improvement, as well as support for the planning and implementation of regular surveys and surveillance activities, as per established guidelines with the following specific activities;

Immunisation Safety to finalise and print AEFI guidelines and orientation of AEFI committee according to new guidelines. To date, the AEFI committee has been oriented and AEFI guidelines are currently being printed. **Data Quality-** the report of the desk review and field assessment have been finalised and the outcomes are to inform the currently ongoing efforts for the development of the Data Quality Improvement plan which is scheduled to be completed by end of the year. Regarding sustainability, WHO supported the Ministry of Health in the **Resource Mobilisation Framework** development process which is to be completed with the finalisation of the Framework pending the final endorsement of the background documents including cMYP by the National Immunisation program. These activities were scheduled for 3rd quarter of 2018 but have been delayed due to key activities that the program committed to including JA process, PIE, Introduction of IPV, development of CCEOP to mention a few. Additional resources were requested for the **strengthening of WASH component of the Cholera Multi Sectoral Plan** which is currently close to finalisation. 87% of funds budgeted under 2018 TCA for the above activities have been committed already for implemented and ongoing activities. The balance of these were budgeted for the Multisectoral plan which has already been implemented through other funding sources within WHO. As such these funds will need to be reprogrammed for other activities.

Regarding **OCV Reactive SIA** – The activity was implemented in response to the Cholera outbreak in Lusaka District and 62% of funds have been utilised for the OCV SIA. Over 1,300,000 children and adults were vaccinated for the first dose and second doses of OCV.

IPV Introduction: IPV vaccine was introduced in the last week of June, 2018. This activity was supported through various new vaccine introduction activities which included adaptation of guidelines, capacity building for staff at all levels, social mobilisation activities, monitoring and distribution activities, program management for new vaccine introduction at national level. 50% funds were disbursed to provinces and districts for related activities while 28% funds are in process of reimbursing MOH funds advanced for the implementation of IPV introduction activities.

NVS Surveillance: Paediatric Bacterial Meningitis (PBM) surveillance has been sustained with the following indicators: Percent suspected meningitis cases with Haemophilus Influenza Type B (HiB) identified by culture, latex or PCR was at 0% (target 5%). Percent suspected meningitis cases with pneumococcus identified by culture, latex or PCR was at 1.2% (2/170) (target 20%). Rotavirus Surveillance - Positive for rotavirus was at 31.7% (137/431) (target > 30%). In 2018, the Adverse Events Following Immunisation (AEFI) surveillance was established with 10 AEFIs reported to date in 2018. Funding for these activities have all been utilised.

HPV Introduction Preparatory activities to be supported by WHO include the review and updating of Guidelines; WHO is in the process of contracting consultant to support this activity. TORs have been identified and consultations with AFRO/HQ are already underway. This activity too has been delayed due to overrunning activities in EPI.

Challenges faced included responses to health emergencies by the EPI team including the Cholera outbreak and intensified surveillance activities in high risk districts and provinces to the threat of importation of circulating vaccine derived polio virus; updating of Polio Outbreak response plan as well as many efforts to meet deadlines for key activities/ time repeated responses that required implementation on the EPI chronogram and outside the planned activities.

5. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

Prioritised actions from previous Joint Appraisal	Current status
1. Immunisation financing Develop resource mobilisation framework	Development scheduled for Q3 and Q4 of 2018.
2. Coverage and equity Implementation of activity plan derived from equity analysis	Coverage and Equity Study Report (CESR) under review, preliminary results are in this report;
3. Supply and cold chain • 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	• CCEOP application was submitted as planned in the Sept 2018 window; • Process to hire a consultant for the evaluations is almost complete and the activity is scheduled for Q4 2018.
4. Data • Implementation of EPI Optimisation Strategy that addresses • administrative and supply chain data in Southern Province. • Operationalisation of the data access policy. • Bring evidence to CSO to validate the triangulation of data to verify population estimates and other data sources and follow up with CSO.	• Resource mobilisation continues for EPI-OPT.
5. Governance and leadership **ICC Strengthening** • Conduct a self-assessment of the ICC and revise the TORs and • membership based on the assessment results • Development of an annual work-plan for the ICC. **EPI Team Strengthening:** • Conduct self-assessment of EPI programme and strategy to address key bottlenecks	• The ICC TORs have been revised and the membership of the group has been expanded. There are still needs to orientate new members which will be ongoing in 2019; • Aspen Health Management is being supported through Gavi under the umbrella of LMC. The embedded management partner is expected to start work in early 2019.

6. ACTION PLAN: SUMMARY OF FINDINGS, ACTIONS AND RESOURCE/SUPPORT NEEDS IDENTIFIED AND AGREED DURING THE JOINT APPRAISAL

Overview of key activities planned for the next year:

Key finding / Action 1	Advocacy for immunisation financing
Current response	Ongoing efforts – cMYP updated and Resource Mobilisation Framework draft developed awaiting endorsement by MOH. Key briefs await finalisation of framework.
Agreed country actions	GRZ/Partners to leverage resources to improve governance, technical capacity, service delivery and data quality with particular emphasis on low performing districts to increase coverage to at least 80%
Expected outputs / results	Increased resource allocation to NEPI, mapping of funding entry and understanding of factors influence and motivation for funding immunization from current and potential funders in 10 poor performing districts
Associated timeline	Throughout the year 2019

Required resources / support	Technical assistance and financial support funded through TCA – WHO and CHAZ
Key finding / Action 2	Improve coverage and equity through targeted approach based on findings from the coverage and equity study
Current response	Equity study conducted
Agreed country actions	• EPI to adapt urban immunisation strategies and provide support to select urban and peri-urban district health management teams for effective implementation and monitoring • Strengthen districts in mentorship and supervision of health facilities to ensure REC micro-plans are reviewed updated and implemented. This should also be included in the annual performance review assessments
Expected outputs / results	• Reduction of unvaccinated/undervaccinated children and reduced inequities in urban slums through adoption and implementation of urban immunisation strategies • Capacity and skills strengthened for REC implementation through mentorship and performance reviews assessment
Associated timeline	Throughout the year 2019
Required resources / support	Technical assistance and financial support funded through TCA: - Urban Immunisation – JSI and UNICEF - Strengthening RED/C implementation through district mentorship - WHO
Key finding / Action 3	Improve supply chain through integrated learning and leveraging
Current response	Implementation of Logistimo, Finalised DPCP pilot in selected districts and recommendations, Finalisation of EPI-OPT Strategy
Agreed country actions	Leverage RTM, Logistimo, systems design recommendations, Provincial and District CC officers for maintenances and Dose per container partnership (DPCP) learnings to improve EPI Rollout of EPI-OPT in pilot province
Expected outputs / results	- Roll out of RTM and Logistimo - EPI-OPT rolled out in pilot province
Associated timeline	Throughout the year 2019
Required resources / support	Technical assistance and financial support funded through TCA: - Roll out of RTM and Logistimo – UNICEF - EPI-OPT rolled out in pilot province – CIDRZ
Key finding / Action 4	Improve immunisation data quality
Current response	Desk review, systems assessment, and field assessment on Data Quality finalised to inform data quality improvement plan development; Roll out of mVacc and ZEIR in selected provinces.
Agreed country actions	• Allocate funds for printing Data Collection Tools • Allocate funds to conduct user orientation trainings on new data collection tools • Leverage ZEIR, mVacc, SmartCare, DHIS2 to improve EPI
Expected outputs / results	• Data Collection Tools printed and disseminated • orientation trainings on new data collection tools conducted • Rollo out of ZEIR and mVacc to improve EPI
Associated timeline	Throughout the year 2019
Required resources / support	Technical assistance and financial support funded through TCA: • Data Collection Tools printed and disseminated - UNICEF • orientation trainings on new data collection tools conducted - UNICEF • Roll out of ZEIR and mVacc to improve EPI – UNICEF

Key finding / Action 5	Planning and preparations to support effective HPV introduction in 2019
Current response	Review of training guidelines and monitoring tools, Draft HPV communication strategy,
Agreed country actions	• Fine tune estimated number of girls to be reached • Strengthen Soc Mob and start at least a month before Vaccination to ensure saturation • Update, implement and monitor HPV communication strategy • Ensure timely planning, coordination and monitoring for HPV introduction
Expected outputs / results	• Effective national roll out of HPV during child health week 2019; • High uptake of HPV vaccine amongst 14 year old routine target cohort.
Associated timeline	2018 through to 2019
Required resources / support	Technical assistance and financial support funded through TCA: • Enumeration of girls with focus on out of school girls; • Strategic Communications Strategy including Social Mobilisation Strategy to support HPV roll-out supported by UNICEF and CHAZ; • Preparation, planning, coordination and monitoring for HPV introduction – CIDRZ & JHIEGO

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

Interagency Coordinating Committee (ICC)

A new Terms of Reference was adopted to the ICC and a broadened scope which includes Reproductive, Maternal, Neonatal, Child, Adolescent Health and Nutrition (ICC for RMNCAH-N). With the redefined TORs, a request was made to partners for active engagement and participation. Participation was requested from SIDA, EU, DfID, World Bank, USAID, Global Fund, Gavi, WHO, UNICEF, UNFPA, WFP and other partners.

The ICC met three out of four quarters in the past fiscal year providing updates on RMNCAH-N issues. Updates pertaining to EPI performance and endorsement or approval for EPI activities included the switch in presentation for PCV, endorsement of the HPV application, introduction of IPV, intention to apply for CCEOP, and feedback from the oral cholera vaccination campaigns and the cVDPV surveillance, preparation and response, along with regular performance updates on EPI performance. Additionally, there were a number of EPI documents or strategies launched during the ICC during the year, including: SOP for Effective Vaccine Management, Zambia Immunisation Information Systems Functional Standards and Assessment Tool, EPI-OPT strategy, EPI manual, EPI communication strategy, EPI pocket booklet and the cold chain maintenance plan.

Zambia Immunisation Technical Advisory Group (ZITAG)

During the 2017-18 fiscal year, all four ZITAG meetings were held providing technical oversight and recommendations to the EPI. During the fiscal year, a Chair and Vice Chairperson were elected and the ZITAG SOP was endorsed. The ZITAG submitted recommendations to the NEPI on the Pneumococcal Conjugate Vaccine and the HPV vaccine application.

The ICC always considers three opinions: from MoH senior management, from the EPI working group and the independent opinion of the ZITAG to endorse a recommendation. The 3-day sitting planned for the Q4 of 2018 would consider appropriate considerations around appropriateness of 14 year olds (versus 9 year olds) for a single age cohort in view of vaccine supply constraints, hepatitis B at birth, appropriateness of the CCEOP application and appropriateness of the typhoid vaccine for Zambia.

ANNEX: Compliance with Gavi reporting requirements

	Yes	No	Not applicable
Grant Performance Framework (GPF) * reporting against all due indicators			X
Financial Reports *			
Periodic financial reports	√		
Annual financial statement			√
Annual financial audit report			√
End of year stock level report (which is normally provided by 15 May as part of the vaccine renewal request) *	√		
Campaign reports *			
Supplementary Immunisation Activity technical report			√
Campaign coverage survey report			√
Immunisation financing and expenditure information			
Data quality and survey reporting			
Annual data quality desk review	√		
Data improvement plan (DIP)		√	
Progress report on data improvement plan implementation	√		
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	√		
CCEOP: updated CCE inventory	√		
Post Introduction Evaluation (PIE)	√		
Measles & rubella situation analysis and 5 year plan		√	
Operational plan for the immunisation programme	√		
HSS end of grant evaluation report			√
HPV specific reports			√
Reporting by partners on TCA and PEF functions	√		

ANNEX 1: 2018 JOINT APPRAISAL ATTENDEES AND CONTRIBUTORS

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