

Zimbabwe

Internal Appraisal 2014

1. Brief Description of Process

This Internal Appraisal for the Republic of Zimbabwe was conducted for Gavi by independent technical expert **Deborah McSmith**, in cooperation with the Gavi Senior Country Managers (SCM) **Alison Riddle** and **Stefano Lazzari**, and is based on reports, documentation and clarification provided to Gavi by the national authorities and institutions in the country for the year 2013.

Zimbabwe is reporting on Penta3 and PCV13 coverage in 2013 (Rotavirus vaccine was introduced in 2014) and is requesting these vaccines for 2015, with no changes in presentation. The country is also reporting on the first tranche of an HSS grant for 2013 to 2017, which was sent to the country in 2013 but not used until January 2014 (see Section 7).

2. Achievements and Constraints

The APR reports that one of the reasons for not achieving vaccination targets is that the 2013 targets were set using population projections from the 2002 census, yet coverage for 2013 was calculated using the new figures from the 2012 population census. Therefore 2014-2016 Baseline and Annual Targets in the APR for births and surviving infants were adjusted to reflect 2012 rather than 2002 census data.

A decline in vaccination coverage in 2013 (91%) compared with 2012 (102%) is observed. This is due in part to the increase in number of surviving children but, according to the APR, is also caused by a knowledge gap among health workers, inadequate human and financial resources, competing priorities, low staff morale due to poor working conditions, and to the late disbursement of Health Transition Funds (HTF) by UNICEF.

No rotavirus vaccination was performed in 2013 as the Rotavirus launch was delayed to May 2014 due to a delay in the completion of the Central Vaccine Stores.

Vaccine wastage was within allowable limits across vaccines.

The country reports that it has no gender and equity related immunization problems and that data related to wealth quintiles is not available. 2013 NHIS data shows a slight inequity in DPT3 coverage - 94% for boys and 98% for girls. The country's main equity barrier identified is for women and children from religious objector communities; immunization services are offered to these groups at convenient times and places.

The HSS grant for 2013 to 2017 includes geographic and socio-economic equity indicators; the second indicator relies on wealth quintile data but the APR provides no description of how this data will be collected.

3. Governance

Although the ICC only met twice in 2013, the EPI Program and its key partners held regular quarterly meetings by to help coordinate service delivery. The ICC does review EPI progress reports. Attendance at the May 2014 meeting to endorse the APR 2013 included Ministry of Health and Child Care (MOHCC), WHO and UNICEF, USAID/MCHIP, University of Zimbabwe Community Health Science, Medicine Control Authority of Zimbabwe, and Rotary International. Five CSOs are listed as ICC members – Zimbabwe Red Cross Society, Community Working Group on Health, Zimbabwe Association of Church Related Hospitals, Southern Africa AIDS

Trust and Women AIDS Support Network - however none was present at the May 2014 endorsement meeting. The country should make a concerted effort to ensure that CSO members participate actively and are not serving as token members.

4. Programme Management

Zimbabwe has a cMYP for 2012-2016 and rollout of new vaccines (PCV13, RV) is in alignment with this plan. An EVM conducted in September 2012 identified systemic weaknesses in maintenance of buildings, cold chain equipment and vehicles, stock management systems and procedures, and distribution between each level in the supply chain. EVM key recommendations were to develop CC equipment preventive maintenance plans and vaccine management (SOPs), update vaccine management training, with particular emphasis on stock management and vaccine management SOPs, and use freeze indicators with freeze sensitive vaccines packed with frozen ice packs. The improvement plan shows many tasks completed across 2012 and 2013. No changes have been made in the plan, and next EVM is planned for Sept 2015.

Following the introduction of PCV13 in 2012, a PIE was conducted in January 2013. Recommendations from the PIE were addressed as follows:

- A delay in the production of data collection tools during the introduction was rectified and all levels have adequate data collection tools.
- IEC materials were produced and distributed to all levels.
- The country increased CC capacity at all levels with assistance from partners, contingency plans are in place and the country reported no stock outs in 2013, a significant improvement from 2012 when many stock out problems with various vaccines were identified during the PCV13 pilot.
- Intensive training was carried out to ensure the effective delivery of new vaccines and the recording of associated data.

Following recommendations from the EVMA also conducted in 2012, all provincial Vaccine Storekeepers were trained on the Stock Management Tool (SMT) developed by WHO in 2013. Additional training of storekeepers at district level is planned for 2014 under the HSS grant. In anticipation of the RV introduction originally planned for 2013, EPI Managers at national and sub national levels were trained.

For its EPI program, Zimbabwe has in place an injection safety policy/plan, national dedicated vaccine pharmacovigilance capacity, a national AEFI expert review committee, an institutional development plan for vaccine safety, and a risk communication strategy to address vaccine crises. The country shares its vaccine safety data with other countries, conducts sentinel surveillance for RV and pneumococcal disease and shares data from the sentinel sites with stakeholders.

5. Programme Delivery

The RV introduction planned for 2013 was delayed by the late completion of cold store facilities and the subsequent inability to carry sufficient volumes of vaccine. This was reportedly resolved with new cold rooms at central and provincial levels, and the vaccine was introduced in May 2014. Zimbabwe has done a good job of introducing PCV13 into the existing EPI system in 2012 and has planned well to do the same with RV in 2014.

The country launched an HPV demo project in September 2014 in two districts, to be followed by a roll out in 2016. The demo project targets 10-year-old girls, uses the 3-dose schedule, and relies on CSOs for social mobilization.

A noted accomplishment by the EPI Program in 2013 was a special outreach campaign during African Vaccination Week to one of Zimbabwe's hard-to-reach Khoi San communities, with full community participation and an invitation for the outreach team to return.

Key challenges identified for program delivery in 2013 include human resource shortages at central and sub national levels, a huge funding gap with minimal government funding, defaulting on 2013 co-financing obligations to Gavi, and low staff motivation.

Priority actions identified for 2014 and 2015 include the RV introduction, the HPV demo project, strengthening of outreach services, completion of Central Vaccine Stores, installation of cold rooms at Central and Provincial Vaccine Stores, application for Gavi support to introduce MSD, IPV and Measles Rubella Campaign in 2015, a routine EPI coverage survey, and an injection safety assessment.

The country applied for MSD, MR and IPV vaccines in September 2014.

Given Zimbabwe's ongoing significant struggles with insufficient government financial and human resources for immunization, the country's overall vaccine coverage performance since 2009 and continued introduction of new vaccines is commendable. All of this is at risk, however, if the country continues to experience shortages in operational funds and default on its co-financing obligations

6. Data Quality

The APR notes that the official country estimates are partly based on the results of the EPI coverage survey conducted in 2010. The slight discrepancies between the official estimates and the administrative coverage are a result of the difference between the population figures from the 2012 Population Census and the population on the ground in 2013.

Zimbabwe is putting in place mechanisms to ensure that numbers of children reached at every outreach point are documented. All districts are in the process of updating data on the number of children who are supposed to be reached at such points. Defaulter tracking will be strengthened in all health facilities to ensure every child is reached with vaccinations.

A RED training followed by a national Data Quality Self-Assessment was carried out in August 2013. Five provinces were assessed on program performance, with special emphasis on surveillance, and corrective actions were taken. Quarterly review meetings and supportive supervision activities were held. The country introduced a new web based District Health Information System Tool and all Provincial and District Health Executive members were trained on the use of the tool.

Zimbabwe reports that the National Health Information System has improved its efficiency in data collection and transmission to national level thanks to the provision of cell phones procured through the Global Fund coupled with increasing network coverage.

Though a Multiple Indicator Cluster Survey that was conducted in May 2014, the ICC determined that the MICS served different purposes and still plans to conduct an EPI coverage survey in 2014 in order to validate administrative data.

The country also conducted a Midline Process Evaluation and Mid Term Review for the Results Based Financing Program in 2012, focusing on mother and child health in eighteen rural districts of the country.

7. Global Polio Eradication Initiative, if relevant

Zimbabwe plans to develop an integrated plan for a Measles Rubella campaign and introduction of IPV. IPV will be introduced as a single dose in accordance with the polio end game strategy. Zimbabwe applied for IPV, MR, and MSD in September 2014. The applications will be reviewed by the November 2014 IRC.

8. Health System Strengthening

Due to delays in the clarification process, Zimbabwe received the first tranche of HSS funding (US\$ 959,347) only in August 2013. In the APR, Zimbabwe claims that lack of information on the disbursement and clarity about the destination of fund further delayed the start of the program to January 2014. However, the EPI manager was actually informed by GAVI of the availability of funds on September 4th and the HSS workplan detailed clearly the expected use of the first year allocation for different activities.

The HSS grant has 3 objectives:

1. To strengthen CC Capacity, Stock Management and Distribution System at all levels;
2. To strengthen EPI Data management at all levels in the context of the existing National Health Information and Surveillance System (NHIS);
3. To strengthen EPI outreach services in hard to reach communities countrywide in the context of integrated health services.

Broadly, activities in the HSS grant focus on procurement of energy supply, fuel, several vehicles plus maintenance and insurance, and a number of trainings under Objectives 1 and 2. Activities are well integrated with the RI program and training activities are scheduled in logical sequence. Monitoring processes for the HSS grant are described in detail for district, provincial and national levels.

The country has adopted Results Based Financing as a primary health care financing mechanism in 42 districts. Subsidies are paid according to performance of each health facility for the 21 indicators identified by government, including Gavi HSS indicators. The funds are managed by health centre staff and Health Centre Committees. Periodic assessments on funds utilization and performance are done by supervisors from district, provincial and national levels. The Midline Process Evaluation and Mid Term Review of the program have shown positive impact including increased immunization demand and coverage.

The country is reporting separately on the utilization of funds under its new HSS grant in its Annual Progress Report January to June 2014. In this 6-month period, a total of US\$ 257,986.40 was spent, leaving a balance of US\$ 701,360.60 out of which US\$ 640,000 has been reallocated to the procurement of 8 vaccine distribution trucks for provinces. The remaining US\$ 61,360.60 is planned for training district officers in preparation for the introduction of the Stock Management Tool (following the already completed trainings at provincial level).

While 7 activities were implemented under HSS Objective 1, no activities were implemented under Objective 2 (postponed to Q4 of 2014) and only supportive supervision was carried out under Objective 3. The country reports that it was unable to complete planned activities due to HR constraints. The MOHCC has tasked the Director of Finance and Administration to dedicate an officer(s) for grant management.

Activities that were completed include:

- Training for Health Facility Managers, integrated with RV introduction training and with part of the budget coming from the VIG;
- Training of national level trainers as resource persons for training of district officers. This training reinforced the initial training when the Stock Management Tool was introduced at provincial level in 2013, which resulted in improvements in vaccine stock management at provincial level.
- Training provincial CC technicians in gas, electricity and solar powered refrigerators, with training timed to coincide with introduction of solar refrigerators procured by HTF. Country also intends to train provincial CC technicians in basic cold room maintenance and service.

The HSS APR includes a workplan defining remaining activities to be implemented in the 4th quarter of Year 1 (2014) and requests the disbursement of a second tranche of US\$1 893 368 for

the same period. However, the second tranche of the first year approved budget is only US\$ 959 347. In order to receive this second tranche, the country has to submit a revised budget and workplan for remaining 2014 funds for the amount of US\$ 959 347 and the quarterly financial reports as required by the aide-memoire.

9. Use of non-HSS Cash Grants from GAVI

Zimbabwe is not reporting on ISS fund utilization or CSO support for 2013.

The country received a Rotavirus VIG for US\$ 323,000 in 2013, which was not used since the launch was delayed to May 2014. The country also had a carryover balance of US\$ 20,361 from the 2012 PCV13 VIG and describes an intention to use this combined balance in 2014 for training health workers on RV introduction including IEC materials, supportive supervision, social mobilization, and an RV PIE.

10. Financial Management

A Financial Management Assessment (FMA) was conducted in 2012, and an aide memoire was signed in 25 February 2013.

For the HSS grant, the Director of Planning within MOHCC is responsible for monitoring and reporting progress to the Country Coordinating Mechanism HSS committee on an annual basis. In addition, internal audits are to be conducted and reports covering Gavi cash grants as well as the minutes of the meeting of the CCM-HSS discussing the audit findings are to be submitted to the office of the Comptroller and Auditor General and to Gavi.

During the first year of the HSS grant, the country is required by the aide-memoire to submit to GAVI quarterly interim unaudited financial reports and an annual progress report including annual financial statements. Since the first HSS disbursement in August 2013, no quarterly final report as required by the aide-memoire has been received and the annual progress report does not include the required financial statement on the use of GAVI HSSs funding during the fiscal year.

Zimbabwe uses the country's Procurement Act, which guides the purchases of goods and services for all government departments/organizations. The tendering process is as explained in the Aide Memoire.

The country will provide the financial report and external audit report for RV introduction in the 2014 APR.

11. NVS Targets

The country reports it is on track to achieving national immunization objectives. The 2014-1026 targets were adjusted to reflect the most current census data and targets seem feasible so long as donors continue to provide NVS support.

Within HSS funding, the country lists high expectations for level of improvement for coverage of vaccines for DTP3 coverage, Geographic equity of DTP3 coverage, and measles coverage. This is based on plans to strengthen outreach to hard to reach areas through vehicle purchase, use of CBOs to strengthen demand, and strategies to strengthen the CC capacity, stock management and distribution systems at all levels and improve data management.

12. EPI Financing and Sustainability

The country has not made any contribution to the payment of their traditional vaccines in 2011, 2012 and 2013. In 2013, UNICEF and the Health Transition Fund (with support from the Japanese Government) funded traditional vaccines while Gavi funded their portion of new and underused vaccines (the country was expected to co-finance the rest but defaulted.)

The country's share in the total expenditures for immunization is showing a downward trend, from 69% in 2011, to 60% in 2012, and 28% according to the 2013 APR. The HTF administered

through UNICEF is expected to fund the bulk of the immunization budget for the duration of the cMYP (2012-2016). The cMYP anticipates a widening funding gap after 2016.

Support from Gavi for NVS and injection supplies is not reported in the national health sector budget.

The co-financing requirement for Zimbabwe for 2013 was \$624,500. The payment of an additional \$17,000 for Rota was deferred to 2014, given the postponement of the introduction. As of 30 September 2014, the country remains in default for its co-finance contribution for 2013 despite repeated follow-up by the Gavi Secretariat in-person and in writing. A Gavi mission planned for mid-October will seek to better understand the reasons behind the default.

However, the government has successfully constructed bigger vaccine stores to accommodate additional volumes of vaccines and has mobilized funding through the HTF and USAID/MCHIP for additional CC equipment and support for routine EPI activities. Under Public Private Partnerships, the country has secured support from local private organizations; for example, Econet Wireless is buying refrigerators through an Energize The Chain project.

Following the disruption of outreach activities due to late disbursement of Health Transition Funds (HTF) by UNICEF in 2013, a letter was written to all Provincial Medical Directors sensitizing them to acquit funds in time and suggesting that program managers can return funds if they unable to use them within 6 months and request them again when they ready to use them.

The ICC comments in the APR that operating conditions were extremely challenging in 2013, with a short staffed EPI team because of the government's civil servants hiring freeze, low pay levels and low morale for current staff, and shortage of transportation resources for outreach activities. While the government expresses commitment to paying their agreed share of costs, funds are not available to do so.

The country requests technical assistance to develop a financial resource mobilization strategy to sustain the immunization program in order to reverse the declining immunization trends, to get more than the traditional partners on board, and more investments from tradition partners. Zimbabwe has no likelihood of sustainability unless or until the government begins to make funding for health/immunization a priority.

13. Renewal Recommendations

Topic	Recommendation
NVS	If the country continues to be in default of 2013 co-finance contribution, the High Level Review Panel will have to decide whether to renew support for Penta3, PCV13, and Rotavirus without a change in presentation.
HSS	Release of second tranche in 2014 of US\$ 959 357 pending submission of outstanding quarterly financial reports and a revised budget and workplan for their implementation.

14. Other Recommended Actions

Topic	Action Point	Responsible	Timeline
Co-financing	Country to meet its 2013 reporting and co-financing requirements before further HSS disbursements, vaccine approvals, and NVS renewal	Country	

Traditional vaccines	Country to identify ways to secure funds for future contributions towards the financing of traditional vaccines.	Country	
HSS	Provide explanation for how wealth quintile data will be collected for the HSS grant M&E Framework, since this data is not currently collected.	Country	
HSS	Country to explain how the funds administration problem is resolved prior to receipt of second tranche of HSS funds.	Country	