Joint Appraisal Report

Country	Zimbabwe
Reporting period	September 2015
cMYP period	2015 - 2019
Fiscal period	January – December 2014
Graduation date	N/A

1. EXECUTIVE SUMMARY

1.1. GAVIGrant Portfolio Overview

Zimbabwe has experienced a declining national economy that has affected most public sectors. The health sector has not been spared, and there has been significantly reduced government expenditure on health. A country that was once able to procure all of its own childhood vaccines and fund all of its operational expenses of the Expanded Programme on Immunization from its own resources is now confronted by serious financial difficulties.UNICEF took over procurement of traditional vaccines and supplies from 2003up until this date. This was augmented by the GAVI support that came into effect the same year.

GAVI has supported the country in New Vaccine Introduction, Immunization Services, Injection Safety and Health Systems Strengthening support. The country has received funding support for new vaccines that included DTP-HepB-Hib introduced in 2008, PCV13 in 2012, Rotavirus vaccine in 2014 and HPV Vaccine demo project in 2014. GAVI also provided funds for Health Systems Strengthening in 2013 and this is programmed to continue until 2017. All of these investments and partnerships have contributed to a reduction or elimination of vaccine preventable diseases. In particular, the GAVI support has contributed significantly to the reduction of diseases such pneumonia, Hepatitis B and rotavirus as evidenced by data from PBM and Rota sentinel surveillance sites.

1.2. Summary of Grant Performance, Challenges and Key Recommendations

Grant Performance

- **Achievements**

Immunisation Coverage: In 2014, the program managed to sustain high immunisation coverage of above 90% for all antigens as evidenced by a Pentavalent 3 coverage of 91%, although this was a slight decline from 2013. This was mainly caused by delays in disbursement of outreach funds. Despite this, there has been a steady improvement in immunisation coverage particularly over the last 4 years, with DPT3 coverage being maintained above 90% between 2011 and 2014 (WHO UNICEF Estimates). WHO estimates for PCV in 2014 were 91% for PCV 3 and 48% for RV (second dose). (WHO UNICEF Estimates). Prior to 2010, DPT3 coverage ranged between 65% and 75% for a period of 10 years, so these recent coverage improvements point to a sustainable turn around in EPI performance in Zimbabwe. Targets have also been updated in 2013 based on 2012 census figures, replacing the former population estimates based on the previous census in 2002. The last coverage survey was in 2013, where 87% was reported for DPT3 (contrasting with a 95% official estimate for DPT3) and 73% for PCV (MICS 2013). The sustained high coverage has resulted in reduction of VPDs. The last measles outbreak was in 2010, when 9696 cases reported. There were zero confirmed measles cases reported in 2014, but with reporting of 1130 confirmed cases of rubella to WHO in the same year (WHO Immunisation Monitoring Data Base 2015).

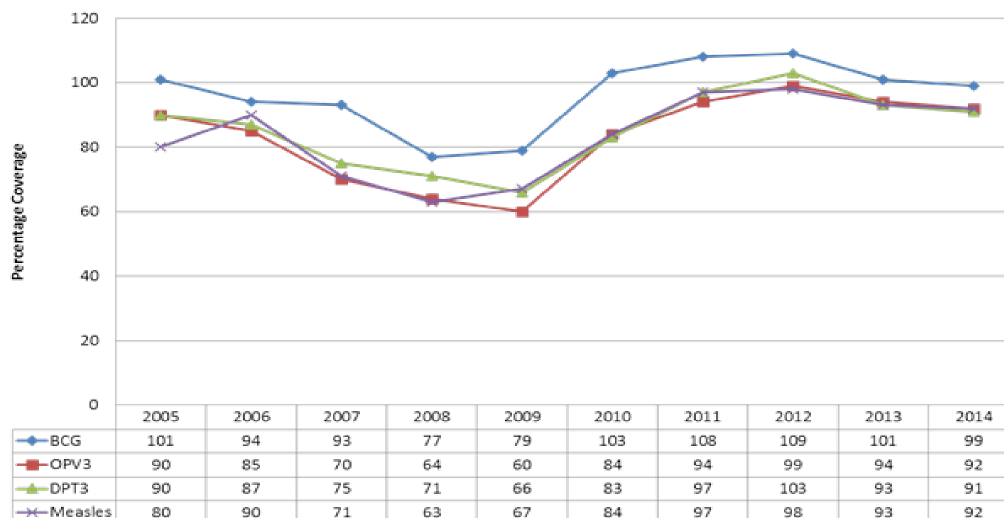
New Vaccine Introductions: PCV 13 vaccine was introduced in 2012 with coverage expanding to 91% in 2014 (WHO UNICEF Estimates). Rotavirus vaccine was introduced part way through the year during 2014 with 48% coverage achieved by the end of the year (APR 2014). A Measles Rubella campaign is

planned for 2015 and IPV introduction in the same year. An HPV vaccine demonstration project is underway with the first dose of the first round having been conducted in September 2015.

Immunisation Continuing Training: Training of 1,600 health facility managers in EVM to improve vaccine management skills at service delivery level was conducted in 2014. There was also training of 11 EPI Officers and 11 Provincial Vaccine Storekeepers in computerized vaccine stock management. The computerized vaccine stock management is now in place at provincial level.Training of 24 provincial cold chain technicians in refrigeration repairs and maintenance with emphasis on solar direct drive systems was also implemented.

Cold Chain &Vaccine Management: The construction of the Central Vaccine Stores fully funded by the Government of Zimbabwe was one of the conditions for the release of the Rotavirus vaccine. There was installation of 10 new cold rooms at the Central Vaccine Stores and 11 cold rooms, one at each of the 8 provinces and 3 major cities fully funded by Health Transition Fund (HTF a multi donor pooled fund). 104 solar direct drive refrigerators for 2 provinces have been procured with installation in progress. (ICC 2015)

Immunisation Coverage



- **Challenges**

Immunisation Financing for Outreach and procurement: There was a delay in procurement of vehicles for vaccine delivery due to exorbitant local prices as compared to UN prices. This affected utilization of GAVI HSS funds with an implementation level of only 28% in 2014. A major challenge is the inadequate transport and fuel for outreach work. Funding for procurement of outreach vehicles under GAVI HSS did not come as per the original budget framework and hence low performing districts did not improve on their EPI coverage. In addition, outreach funds budgeted under the Health Transition Fund administered by UNICEF did not come as planned. This was caused by HTF donors' failure to disburse funds as expected. Only one disbursement covering one quarter was disbursed to districts for outreach work hence vaccination coverage was lower in 2014 compared to 2013 (91% DPT3 compared to 95% in 2013 – WHO UNICEF Estimates).

Human Resources Management: As outlined in the general and health system context, human resources management has been a significant challenge for many years. There is inadequate supportive supervision to lower levels. Despite the ongoing training programs, there are knowledge gaps in some health workers. This is at times a result of staff turnover. In addition to shortage of staff at the service delivery level, there is also inadequate staffing levels in the central EPI Unit, particularly for vaccine management. There is neither Stores Officer nor Stores Assistant at the Central Vaccine Stores hence the bulk of the work is being done by the Logistician.This compromises the quality of work. Additional shortages include lack of a program assistant, absence of two Cold Chain Technicians in posts at central level and absence of Monitoring and Evaluation Officers posts in the Unit. Currently the government has

a full 'establishment' of health workers as per the original criteria, but because of the increase in disease burden and the introduction of new vaccines, the staff in existing posts are currently overburdened and there is need to revise the old establishment in order to add more staff.The Health Services Board is currently conducting a workload indicator staffing needs assessment in bid to rationalize staffing levels.
Key Recommended Actions To Achieve Sustained Coverage And Equity
1. Procure vehicles to support outreach work in 18 high risk districts and that of other equipment under the current disbursed HSS and ISS funds. This will be done through WHO. The MOU for this activity is now awaiting PS signature for the funds to be transferred to WHO. 2. Develop a sustainable model for outreach financing and supportive supervision. The country needs to review the current outreach points, stream line the number of points and come out with strategically positioned high volume outreach points which will save more people. This is in line with objectives for achieving equity and quality in health. The government needs to sustain equitable distribution of EPI services 'to hard to reach' populations. All subsidies for the EPI programme under RBF need to be reviewed upwards in order to support outreach services and supportive supervision. 3. Continuous training of new staff in EPI issues is a must, especially on the job training. There is a need to retain experienced staff so that all new staff receive induction and orientation in EPI activities. There is also a need to develop integrated supportive supervision checklists to have programme specific objectives which also focuses on the EPI programme 4. Additional staff recruitment should be prioritized to improve service delivery and vaccine management – requirements are: a National Surveillance Officer,11 Provincial Surveillance Officers, a Stores Officer, a Stores Assistant and 2 Cold Chain Technicians, with support from partners for salaries, where necessary.

1.3 Requests to GAVI's High Level Review Panel

Grant Renewals

New and underused vaccine support

- Support is requested for extension of Pentavalent vaccine support as per table 1.2 from the APR (extension of support based on new cMYP) (from 2016), and for extension of support from 2017 for PCV13, Rotavirus and Measles 2nd Dose.
- Support is also requested for 2016 for Rotavirus (2 dose schedule), PCV 13 and Measles second dose support for 2016.
- A HPV demonstration project will be completed in 2015, after which a proposal will be submitted to GAVI for nationwide introduction. The IPV proposal has already been approved and the vaccine will be introduced in 2015

Table 1.1 APR 2014

Type of Support	Current Vaccine	Preferred presentation	Active until
Routine New Vaccines Support	Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	2016
Routine New Vaccines Support	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	2015
Routine New Vaccines Support	Rotavirus, 2-dose schedule	Rotavirus, 2-dose schedule	2016
Routine New Vaccines Support	Measles second dose, 10 dose(s) per vial, LYOPHILISED	Measles second dose, 10 dose(s) per vial, LYOPHILISED	2016
Preventive Campaign Support	MR, 10 dose(s) per vial, LYOPHILISED	Not selected	2015

Table 1.2 APR 2014

Type of Support	Vaccine	Start year	End year
Routine New Vaccines Support	Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	2017	2021
Routine New Vaccines Support	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	2016	2020
Routine New Vaccines Support	Rotavirus, 2-dose schedule	2017	2021
Routine New Vaccines Support	Measles second dose, 10 dose(s) per vial, LYOPHILISED	2017	2020

Health System Strengthening Support

A request is made for financing of the 2016 activity plan, subject to adequate rates of expenditure of HSS funds in the first quarter of 2015

1.3. Brief Description of Joint Appraisal Process

The Joint Appraisal process began with partner mapping to come up with a report writing team, who prepared the report. For details of the partners who composed the report, see Annex A. The report was then presented to stakeholders for discussion before endorsement by the ICC. Documents reviewed included the Annual Progress Report, GAVI Support decision letters, the Multi Year Plan for Immunisation, Health Sector Review and Post Introduction Evaluation (PCV13). The following was the timeline for the process;

- April 26th -30th -Desk Review
- May 11th To 15th -Joint Appraisal Report Writing

- May 27th -Joint Appraisal Review Stakeholders Meeting
- July 27th – July 29th In country visit by GAVI team with consultations with MoH, MoF and Development partners
- August 27th – 29th – Review and Revision of Joint Appraisal Document by Independent Consultant in consultation with EPI Team, partners and GAVI Secretariat.
- August 30th September 10 – Final review and revision of JA after inputs from country EPI Team and partners
- September 11th-ICC Meeting To Endorse Joint Appraisal Review Report
- September 15th -Submission of the Joint Annual Review

2. COUNTRY CONTEXT

2.1. Comment On The Key Contextual Factors That Directly Affect The Performance of GAVIGrants.

- **General Context**

Zimbabwe's health situation and health system context cannot be understood unless referenced to wider political and macro-economic context (Health Sector Review, 2010). Following independence and an initial period of growth of the economy and the PHC system, an economic collapse occurred in the 1990s leading to a dramatic decline in GDP of 37% and an associated sharp decline in life expectancy from 66 to 42 years (Health Sector Review 2010). In 2009, economic growth rates declined to minus 14% (cMYP 2015). The under-5 mortality rate is estimated at 75 per 1,000 live births (MICS 2014), which represents a decline from the rate of 84 per 1 000 live births recorded in the 2012 census. In terms of impact on health systems of the economic crisis, the two main issues have been emmigration of the health workforce and fiscal constraints on the financing of the public sector.In December 2010, the vacancy levels in the public health sector were 87 percent for nursing (cMYP 2015). Rebuilding the health care workforce is therefore a major priority for EPI, as the new primary care nurses who are now needed to staff the rural health centers have limited knowledge and skills in EPI (cMYP 2015). In terms of macro-economics, Zimbabwe returned to an economic growth trajectory from 2011, but economic growth is projected to decrease to 2.8% in 2015 (IMF, 2015). The cMYP costing analysis indicates only very slight increases in health spending per capita (from $58 in 2013 to $68 in 2016) (with 51% of this being private expenditure). Although there is a return to moderate economic growth, the general macro-economic context points towards ongoing fiscal constraints for financing of the EPI program.

- **Health System Context**

The Government of Zimbabwe through the Ministry of Health and Child Care desires to have the highest possible level of health and quality of life for all its citizens, attained through the combined efforts of individuals, communities, organizations and the Government, which will allow them to participate fully in the socio-economic development of the country. Guided by its mandate and in line with the Results Based Management framework, the Ministry of Health and Child Care has therefore defined the following Key Result Areas (KRAs) of Improving the health status of the population, improving the quality of care and health systems strengthening. Health care in Zimbabwe is provided by public facilities, non-profit groups, church organizations, company-operated clinics (such as those of mining companies), and for-profit clinics. Zimbabwe's health delivery services are decentralized, with health care provided at primary, secondary, tertiary, and quaternary levels (HSS Proposal 2012).

- **Immunisation Program Context**

The Expanded Program on Immunisation is a Unit within the Ministry of Health and Child Care (MOHCC). The program operates under the concept of the Primary Health Care which the Government of Zimbabwe adopted in 1980.The EPI Unit falls under the Nursing Directorate, Community Health Services department. The EPI Manager is responsible for management of all immunisation activities.The MOHCC provides policy formulation and guidance on all health issues in the country. The EPI works in collaboration with partners who are coordinated by the Inter Agency Coordinating Committee (ICC).The ICC has two main roles, that is, mobilizing resources and providing an independent oversight to EPI operations. There are several technical committees complementing the ICC one of which is the National

Immunisation Technical Advisory Group (NITAG). NITAG was established in 2011 to provide technical guidance on immunisation policies including introduction of new vaccines and operational research among others.

In terms of **costing and financing**, due to the above mentioned macro-economic constraints, in recent years the program has been heavily financed by development partners, including the financing of traditional vaccines. In 2013 and 2014, Zimbabwe was in arrears for payment of co-financing of new vaccines, but these arrears have now been paid. Operational funding for outreach has been constrained by very limited funding through the Health Transition Fund. APR data (APR 2014) now indicates that the government finances 7.8% of total immunisation costs, GAVI finances 68% and other development partners the remainder. This trend is set to continue with planned introduction of new vaccines including HPV and MR.

In terms of **cold chain systems**, there is a four tiered system, including central vaccine stores, provincial vaccine stores, District vaccine stores and health facilities. The last EVM was in 2012 and the most recent improvement plan is dated 2012. AEFI systems are now established, and there is an increasing number of AEFI being reported due to increased awareness and reporting by health workers. The Medicines Authority of Zimbabwe has established a National Pharmacovigilance Committee to review, classify and respond to drug reactions including vaccines. Demand generation activities are supported through volunteer health workers and partnerships with NGOs/CBOs. **Human resources management and continuing training** are a major component of current EPI operations, in order to meet the challenge of outmigration of health workers and the requirement to place and retain PHC nurses with EPI skills, and vaccine management and surveillance capacity in the Central EPI Unit.

3. GRANT PERFORMANCE, CHALLENGES AND RENEWAL REQUESTS

3.1. New and Underused Vaccine Support

3.1.1. Grant Performance and Challenges

- **Immunisation Coverage**

The base year for 2014 vaccination coverage objectives was the 2012 APR where DTP-HepB-Hib3 coverage was 102%. The country missed the target of 100% DTP-HepB-Hib3 coverage but managed to reach 91% coverage. This decline was not only in percentage terms but also in absolute figures; 428 883 children reached in 2012; 413 241 in 2013 and 398 938 in 2014. However there are still inconsistencies in the denominator provided by the 2012 census. The decline, noted in all antigens, is mainly attributable to inadequate funding of outreach services resulting, in some ‘hard to reach’ populations not receiving vaccinations, knowledge gaps, and inadequate support supervision The available funding under the Health Transition Fund was not disbursed as planned; in fact only funds for one quarter were disbursed. Despite the decline in numbers vaccinated in the last year, the EPI program has still been able to maintain EPI Coverage above 90% since 2011 (see figure below of reported coverage in Zimbabwe 2006 – 2015) (EPI Progress Report 2015)

- **Immunisation Inequities**

The 2014 administrative data shows that the DTP-HepB-Hib3 coverage for girls was 92% compared to 90.4% for boys. This data shows that there are no significant differences between girls and boys accessing immunisation services.The 2015 draft Vaccination Acceptability Assessment Report also confirms that there are no gender disparities in accessing immunisation services among the Apostolic Faith groups. The report also indicates that 67% of children from vaccination hesitancy Apostolic Faith groups are not vaccinated. Religious doctrine is believed to be reason of vaccination hesitancy but it is rather the religious leaders themselves who argue for its importance and use it as a tool to exercise power and influence vaccination behaviors. Apostolic Faith caregivers are fearful of sanctions if they vaccinate their children, and rely instead on prayers. Poor knowledge on vaccines is also a major factor of hesitancy. By and large, the power and influence of Government or the use of some mechanisms or policy to regulate, encourage and/or require immunizations is widely believed among all stakeholders to

provide a framework for reducing hesitancy and enhancing demand for vaccination. Though there is this finding, the new constitution of Zimbabwe is now clear on the protection of children under the declaration of rights.

According to the Zimbabwe Demographic Health Survey 2010-11 children in urban areas are more likely than rural children to have received all basic vaccinations (70 percent compared with 62 percent, respectively). At the provincial level, full vaccination coverage ranges from a high coverage of 83 percent in Bulawayo to a low coverage of 47 percent in Manicaland. Some children in Manicaland were also most likely to have received no vaccinations (27 percent). A mother's level of education relates to immunisation coverage; 69 percent of children whose mothers have at least some secondary education are fully immunized compared with 52 percent of children whose mothers have only primary education. Children in the fourth and fifth wealth quintiles are more likely to be fully vaccinated (74 percent and 73 percent, respectively) than their counterparts in other wealth quintiles (55 to 62 percent).

- **Implementation progress**

New vaccine introduction: Rotavirus Vaccine introduction was initially planned for January 2014 but only commenced on 01 May 2014. This four month delay was caused by late completion of the Central Vaccine Stores building. However the introduction was a success and the country has since conducted a PIE in March 2015 results of which are still being compiled. GAVI is supporting IPV introduction in 2015 and a Rubella Containing Vaccine in the form Measles Rubella will also be introduced through a campaign in Sept/Oct 2015 and continued through the routine immunisation programme. Plans are also underway for a nationwide HPV vaccine introduction in 2016. HPV is currently being piloted in two districts (commenced in Sept. 2014) with objectives being to vaccinate in the primary school environment and utilize CBOs to reach out of school girls and to mobilize communities. As it is very early in the intervention cycle, assessments/evaluations will be required prior to the development of the scale up national proposal later in 2015.

Vaccine Management*:*The IRC recommendation was concerned with the inadequate cold chain capacity at Central level to accommodate the Rotavirus vaccine. This was resolved by the completion of the new Central Vaccine stores and installation of new cold rooms (IPV Proposal, 2015). Cold chain capacity is now adequate for both immediate and intermediate future new vaccine introductions.

Surveillance and AEFI*:*The country has a system in place which keeps track of AEFI. AEFI guidelines are available at each facility to guide health workers on how to manage AEFI. There are committees in place from district to central level which are responsible for carrying out investigations on AEFIs. The country has a case based surveillance system which monitors AFP, NNT, and Measles suspected cases. There are also focal persons at all levels from the health facility who do active search on EPI targeted diseases under surveillance. The Polio Risk Analysis tool is in place to monitor the level of risk by district, province and nationals.The country has got PBM, CRS and Rotavirus Vaccine impact assessment and intussusception monitoring sentinel sites at three central hospitals in Harare.

- **Key Lessons Learned to Inform Future Routine Vaccine Introductions or Campaigns**

The main recommendations for the PCV post introduction evaluation were as follows:

1. District and Service delivery level to have written and shared implementation plans
2. All logistics to be in place before introduction
3. Increase duration of training to at least 3 days to adequately cover all topics
4. Improve distribution of training materials including guidelines at subnational level
5. All data collection tools to be made available to all health facilities prior to training
6. Nurses to be trained in Effective Vaccine Management
7. Secure adequate funding for all pre-introduction activities
8. Major events should not be combined at the same time as one of them will be compromised, for example PCV13 introduction and NIDs.

These recommendations were taken into consideration during the introduction of Rotavirus vaccine and as a result the country had minimal problems during the introduction.

- **Compliance with Data Quality and Survey Requirements:**

The country introduced the web based DHIS2 tool to improve on the completeness and timeliness of data as well as real time data analysis. In addition annual desk reviews of administrative data are done to identify low performing districts. The eighteen priority districts which are being supported under GAVI HSS were identified using this approach.The country plans to conduct a Post MR/OPV Campaign and EPI Coverage Survey fourth quarter 2015 with funding from GAVI and local partners. It is hoped that this survey will also address the socioeconomic, gender and other barriers to access and utilization of health services in addition to validating administrative data.A Data Quality Self-Assessment was carried out in 2013 and the country scored a quality index of 79% falling short by one percent to achieve the minimum standard expected of 80% of a well-functioning system. It also showed that data was not being analyzed and utilized at point of generation and subnational levels. Districts are being encouraged to conduct DQS regularly in order to identify quality gaps and develop interventions for data quality improvement. Meanwhile the Ministry is planning to train Data Managers and EPI Focal persons in data and information management using GAVI HSS funds.

Key Implementation Bottlenecks and Corrective Actions,

- **Vaccine and Cold Chain Management Issues:**

There were no vaccine stock outs at Central and sub-national level. However, there were infrequent vaccine stock outs at some service delivery level facilities which were attributed to poor stock management and unavailability of transport. At least one health facility nurse from each facility was trained in vaccine management, using the GAVI HSS funds. The cold chain assessment in 2010 identified many capacity and maintenance gaps in the system, which has since been addressed through development of a long term replacement and maintenance plan. The addition of cold rooms centrally and 8 provinces and 3 major cities have provided assurances for introductions of newer vaccines in 2015 including IPV and MR (IPV proposal 2015).As outlined elsewhere, the main current bottleneck is the inadequacy of vaccine management staff numbers in the Central EPI Unit and other locations, which will require filling and unfreezing of posts. Maintenance of cold chain equipment at central level is contracted out while at provincial and district levels there are designated technicians (IPV proposal). Many of these vaccine management staff is also being trained through the current HSS grant (see HSS section).

- **Human Resources Management and Service Delivery/Outreach Bottlenecks**

There is neither a Stores Officer nor a Stores Assistant at the Central Vaccine Stores, hence bulk of the work is being done by the Logistician. This compromises the quality of work. At the management level, there is neither a Program Assistant nor Secretary to follow up on outstanding issues, records management and attending to incoming and pending urgent issues, especially when the EPI team is engaged in 'out of office' activities, to ensure continuity. There are no Cold Chain Technicians in post and no Monitoring and Evaluation and Surveillance Officers posts in the Unit. At the service delivery level, there is still a shortage of nurses and skilled EPI staff. Corrective actions will include creating new posts, unfreezing existing posts, implementing continuing training programs (through HSS Strategy), and developing a justification to MoH/MoF for placement of staff. As outlined elsewhere in this Joint Appraisal, lack of regular and timely outreach funding is impacting on immunisation coverage. Corrective actions will include advocacy to the Health Transition Fund for outreach funding as well as improved utilization of HSS funds.

- **Demand Generation and Communication:**

Traditionally the EPI program has been working with Health Promotion Officers, Nurses, Environmental Health Technicians and Community Health Workers to do social mobilization. In view of the need to reach more communities, GAVI has provided funding for engaging Community Based Organizations to improve community dialogue on health issues including immunisation. Disbursement of funding for social mobilization is delayed. As a result, provincial teams have been tasked to source funding at local level to bridge the gap in the production and distribution of IEC material. Promotional material is produced centrally in English, Shona and Ndebele, yet there are other minority languages which need promotional material. The production and distribution of minority language IEC materials has been

decentralized to provinces to address this problem.There are few Village Health Workers compared to requirements. There is continuous engagement to train more to meet the requirements, and a program of community dialogue through partnerships with NGOs/CBOs is proposed for the next 3 years of the HSS program.

- **Challenges in meeting co-financing requirements**

The country has managed to clear the 2014 co-financing requirements. The obligation for 2015 is USD748 000. Therefore it asked for savings of USD224,201 to be applied to the 2015 obligation leaving a balance of USD 451,298. The country is in the process of getting funding from treasury with the expectation that this requirement will be cleared by December 2015. It will be important that the country ensures that an appropriate budget is available for co-financing for the coming years, to prevent a default situation in the future.

- **Financial performance and challenges**

The country used the Rotavirus vaccine introduction grant as budgeted though the amount fell short to meet all activities planned for the new vaccine introduction. However, the country managed to circumvent the shortfall by integrating introduction activities with other meetings. The country has not experienced any challenges in the management of the VIGs and HSS grants so far, aside from the existing issues of procurement of transport vehicles (through HSS) and outreach funding through the Health Transition Fund.The $20,000 balance from 2014 for VIG is planned to be used for IEC materials for routine EPI. The country took advantage of the Rotavirus vaccine introduction grant to combine it with GAVI HSS funding for vaccine management in training health workers at service delivery facility level. Remaining issues to be addressed in relation to financial management include conducting of external audits in 2015 for both HSS and NVS for 2014 (see recommendations).

3.1.2 NVS renewal request / Future plans and priorities

- **Reasonableness of targets for next implementation year**

Population figures reflected in previous APRs up to 2014 were projected from the 2002 census. Now the 2014 APR projections are based on the 2012 census and the figures are now lower than those based on the 2002 census. This has a direct effect on the number of doses required for 2016 onward. The targets set for 2016 appear reasonable and achievable considering previous performance and planned strategies.

- For pentavalent vaccine there were reported to be 412,515 children vaccinated in 2014 (87%) with a target of 415,575 in 2016 (93%) (APR 2014)
- For PCV13, there were 397,240 vaccinated in 2014 (91%), with a target of 415,572 in 2016 (93%) (APR 2014)
- For Rotavirus, there were 209,609 children vaccinated in in 2014 (48%), with a target of 424512 in 2016 (95%)

Rotavirus vaccine was introduced in May 2014. Taking into consideration that this vaccine was introduced in May, 198,987 children were reached out of the eight months target of 291,456 surviving infants, surpassing the approved target of 70%. In terms of the overall 12 months cohort, coverage achieved was 45% (APR 2014). Targets for rotavirus are significantly above 2014 results. This is due to the fact these were vaccines that were introduced mid-year in 2014. Wastage rates are within acceptable levels.The country has no plans to change any vaccine presentation(s) or types in 2016. The program will require continued support, particularly in terms of funding for outreach activities.The projected coverage objectives seem attainable given the fact that GAVI will avail funding to support eighteen low performing districts in the next two years and with continued support from local partners.

The country plans to apply for GAVI support for a nationwide HPV vaccine roll out in 2016 and there are no plans for change in any vaccine presentations or types.

- **Future Priorities for New Vaccines and EPI**

Currently there is no risk to future implementation, other than to the previously mentioned challenges of human resources placement and financing of operational costs. There is a need for continuous monitoring and improvement of the financial management and human resource management system.

For new vaccines, the main priorities in 2015 will be introduction of MSD in form of MR and conducting of MR campaign in 2015. IPV will also be introduced and will include the switch from tOPV to bOPV in April 2016. Other priorities for 2015 include reducing large numbers of unvaccinated children, strengthening surveillance and sustaining polio free status, attaining targets towards measles elimination, and improving the quality of immunization data (Quarterly Review, 2015).

a. Health Systems Strengthening (HSS) Support

i. Grant Performance and Challenges

The HSS program has three objectives relating to cold chain support, EPI data management and outreach services

- **Achievement of Results**

The country managed to achieve 91% vaccination coverage for DTP3, surpassing the target set in the M&E framework by a one percentage point. However, there is a risk in maintaining this high coverage taking into consideration that the HTF has of late not been financially supporting outreach work. The EPI will require an advocacy strategy so thatthe HTF will mobilize adequate funds so that EPI outreach can be adequately supported.

- **Implementation progress**

The country has not been able to implement activities under the GAVI HSS as planned because of unforeseen challenges. The bulk of the budget under the first HSS tranche was to go towards procurement of vehicles for vaccine delivery. The country had wanted to procure these using Government procurement process but this proved difficult after having realized local prices were too high for required numbers. The procurement has since been handed over to WHO. Despite these constraints, important progress has been made as documented in the APR 2014, which includes the following:

Objective 1 Cold Chain: In the area of training close to 100% of planned activities have been implemented for training in vaccine management for health facility managers, and national and provincial level trainers. These training activities were integrated with the rotavirus vaccine introduction. (APR 2014).
Objective 2 EPI Data Management: No activities were planned in 2014
Objective 3 Outreach: 81% of supportive supervision activity was carried out in 18 priority districts.

A total of $5,823, 352 was approved in 2012. Two disbursals have been approved ($1,918,714 in 2012 and 2,147,211 in 2015). There is a budget of $ 2,437,907 proposed for 2015, consisting of implementation of activities across the three objectives, including the procurement budget for transport vehicles. A budget plan/request of $939,663 is requested for 2016.

- **Degree of participation of key stakeholders**

Key stakeholders involved in the HSS grant implementation included WHO, UNICEF, USAID/MCHIP and members of the CCM drawn from various organization including CSOs. The GAVI HSS has a component to fund capacity building of CSOs to enhance community dialogue in eighteen low performing districts. Money for CSOs was requested in 2014 APR for use in 2015/16.

- **Bottlenecks and Corrective Actions**

The major bottleneck was *procurement of vehicles* due to inhibitive costs in the local market and this ended up affecting timely utilization of the funds. This has since been addressed through engagement of WHO to take up the procurement process.The original grant budget plan for the first year was not received as planned, and this, in combination with delays in procurement, has resulted in delayed implementation.

An additional ongoing bottleneck is *shortage of staff at both management and service delivery level,* a point particularly stressed by the ICC in its comments on the APR (APR 2014). Corrective actions that will be required include strengthening human resources management, in particular improved staff allocations at central level and unfreezing existing posts and creating new posts with support from partners (APR 2014).
The final major bottleneck is *gaps in outreach and lack of outreach funding*. A recommendation in this JA (and in the cMYP) is to (a) revitalize the RED strategy, (b) develop guidelines on outreach services (c) strengthen supportive supervision to high risk districts (HSS Strategy) (d) procure transport vehicles to support outreach activities (HSS proposal 2012) and (e) demand creating activities through training NGOs/CBOs in community dialogue and training VHWs in tracking of drop outs (HSS Proposal 2012). As most health outreach funds are received through the health

transition fund (HTF), additional advocacy efforts will be required from governments and partners to secure funding for outreach service operations. Also, the ICC minutes 2015 (approving the APR 2014) stressed the importance of utilization of HSS funds in the second year for outreach (ICC Minutes May 2015).

- **Compliance With Data Quality and Survey Requirements**

The Ministry is complying to some extent with data quality requirements with routine administrative data being submitted to national level on monthly basis. The last MICS survey that was carried out in 2013 indicated an 8% gap between survey coverage (87%) and reported coverage for DPT3 (95%). Post Campaign and Routine EPI coverage surveys are proposed for 2015 (EPI Quarterly Report, 2015). The country conducted Post Introduction Evaluations (PIEs) of new vaccines, developed improvement plans based on findings. Most of the recommendations have been addressed. The last Cold Chain Assessment was done in 2010 and the next one is due fourth quarter 2015.A rotavirus post introduction evaluation is being conducted in 2015. An Effective Vaccine Management Assessment (EVMA) is planned for fourth quarter 2015 and this is expected to inform on major qualitative aspects of vaccine management in the country. The last EVMA was conducted in September 2012 and most components of the improvement plan have been implemented.

- **Overall Programmatic Capacity of Entity Managing HSS Grants**

As outlined above, the country is challenged by staff shortages, interrupted service funding for outreach and problems with procurement. But despite these challenges, and as illustrated by coverage rates above 90%, the country seems to have adequate capacity to manage the grant. In the current and future program years, this will need to be substantiated by higher level of utilization of HSS funds. Required external financial audits for 2014 also need to be processed.

- **Financial Performance and Challenges*:***

The country achieved 28% implementation level in terms of funds budgeted for 2014 mainly used for training of health workers, supervision and procurement of fuel. The bulk of the remaining funds ($640,000) were allocated for procurement of vaccine delivery trucks. The Government wanted to procure the vehicles on their own but later on decided to have the vehicles procured by WHO after having realized they would not be able to procure the required numbers if locally procured. This delayed the procurement process and the procurement did not take place in 2014.

Key challenges regarding the financial management of HSS grant include delayed cash releases from Treasury for the period January to June 2015. However the problem has now been resolved and the outstanding funds have now been received.The country is not receiving performance payments under the GAVI Performance Based Funding (PBF) approach.

- **Overall Financial Capacity of Entity Managing HSS Grants**

The Ministry of Health and Child Care has the Financial Management Capacity to manage the HSS grant. The staff available has the requisite skills and with the support from the Permanent Secretary's office, we believe that the Ministry is able to manage this grant.

i. Strategic Focus of HSS Grant

The strategic objectives of the HSS grant are to strengthen cold chain management, data management and outreach services in the country. These areas are the major enablers to improving routine immunisation coverage in the country.The proposal is also focused on 18 priority districts of the country.

ii. Request for a new tranche, no-cost extension, re-allocation or reprogramming of HSS funding / Future HSS application plans

A total of $5,823, 352 was approved in 2012. Two disbursals have been approved ($1,918,714 in 2012 and 2,147,211 in 2015 as per Decision letter from GAVI on 22nd January 2015). A budget plan/request of $939,663 is requested for 2016. Confirm with GAVI

b. Graduation Plan Implementation

Although a graduation plan is not applicable for Zimbabwe, and given the ongoing concerns regarding financial sustainability (including financing of traditional vaccines and securing outreach funding) early financial sustainability planning should be proposed to prepare the ground for graduation status at a later date.

c. Financial Management of All Cash Grants

- There are no financial capacity constraints which may be a threat to the financial management of this grant.
- Cash utilization is heavily dependent upon the program manager's financial resources requests. The department has been committed to ensure that cash is utilized as soon as required by the program whenever required. However, challenges may be encountered upon requesting funds from the account holder who is the Ministry of Finance.

Modifications to Financial Management Arrangements.

- There may be a need to modify the financial management arrangement in order to give the Ministry the responsibility to manage the Grant accounts in order to avoid unnecessary delays and bottlenecks currently being encountered with Ministry of Finance.

Major issues arising from Cash Programme Audits or Monitoring Reviews

- No issues can be reported as the grant is yet to be audited.

Degree of compliance with Financial Management Requirements

- To date the Ministry has been complying with all the requirements of GAVI's Partnership Framework Agreement. However there is still room for improvement especially if the modifications are made to the financial management arrangements.

d. Recommended actions

Actions	Responsibility	Timeline	Potential financial resources needed and source(s) of funding
Strengthening of EPI management capacity through development of technical proposal to unfreeze and fill essential EPI Management posts (cMYP 2015 Pg 24)	MOHCC& in country partners	2015-2016	None
Development of technical proposal/or advocacy strategy to secure finance for immunisation operations and outreach funding (through HTF and HSS)	MOHCC & in country partners	2015-2016	None
Development of more detailed financial sustainability plan / advocacy strategy for immunisation financing (including advocacy through Parliamentary Portfolio Committee) (cMYP 2015 Pg 24)	MOHCC & in country partners	2015-2016	None
Expedite Procurement of vehicles to support outreach services	WHO and MOHCC	August 2015	None
External Audit of GAVI HSS funds	MOHCC	November 2015	?
Utilization of balance of VIG	MOHCC	1st Quarter 2016	None

- **TECHNICAL ASSISTANCE**

4.1 Current Areas of Activities and Agency Responsibilities

The Ministry of Health and Child Care received two types of funding from GAVI which are new vaccine support and health systems strengthening. All vaccines and supplies both traditional and new are being procured through UNICEF. At local level, WHO offered technical support during the training of health workers on effective vaccine management and cold chain maintenance for subnational staff.

The Ministry also received technical support from WHO,UNICEF, USAID/MCHIP during the new vaccine application to GAVI for introduction of Rota, Measles Second dose in the form of Measles Rubella, Measles Campaign and Inactivated Polio Vaccine. The same partners participated in the training of health workers for introduction of these vaccines. They also participated in the launch of the new vaccines including supervision.

4.2 Future needs

1. **Cold Chain and Logistics**
The Ministry is planning to conduct a Cold Chain Assessment to find out the state of equipment in the field and to come up with a 5 year cold chain equipment replacement plan (2016 – 20200). The replacement plan will require funding to be mobilized through the ICC. An Effective Vaccine Management is due in 2015 with technical support from WHO. The country will need both technical and financial assistance in implementing recommendations of the assessment.
2. **Comprehensive EPI and Surveillance Review**
The country is overdue for a Comprehensive EPI Review to assess the effectiveness of the existing administrative systems of EPI in view of current developments in the immunisation programs. The last one was conducted in 2008. The country would need to take advantage of the review to combine it with a surveillance review. These will require both financial and technical support from partners.
3. **EPI Outreach**
Outreach work did not receive adequate funding from the Health Transition Fundin 2014 because of late disbursement and delayed accounting of funds. The GAVI HSS support for procurement of 31 vehicles to support outreach work will go a long way in ensuring that hard to reach populations are reached with vaccinations. The Ministry will need to mobilize enough resources to meet daily subsistence allowances for health workers attending to outreach work and as well as fuel for outreach vehicles. Partners support is required in this area to develop a technical proposal/rationale for securing of outreach financing.
4. **Human Resources and Outreach Financing**
The Ministry of Health and Child Care will continue advocating for unfreezing of EPI posts at central level more so in view the new Central Vaccine Stores that requires additional personnel. Partners could be approached to assist either in lobbying for the unfreezing of posts or funding some of the posts, or for developing technical proposals to the Ministry of Health to secure sustainable financing of essential human resources for EPI operations.
5. **Additional Areas for Technical Support needed :**
    - EPI Disease Surveillance
    - tOPV to bOPV switch
    - Immunization Supplies Management
    - Development of cMYP
    - Write up of JAR report
    - New vaccine introduction
    - Post marketing Surveillance
    - EPI Laboratory Supportive
    - Comprehensive EPI review
    - Monitoring and Evaluation
    - Data Quality Self-Assessment
    - HPV vaccine application and roll out

- **ENDORSEMENT BY ICC, HSCC OR EQUIVALENT& ADDITIONAL COMMENTS**

The ICC met and reviewed the contents of the draft joint appraisal report. The report was agreed and adopted after a few minor amendments, following members comments. The ICC commends the EPI team on the coverage levels achieved despite the outstanding problem areas and bottlenecks referred to in the report.

In order to ensure that overall coverage continues at the current level, and that ‘hard to reach’ communities are adequately supported, ICC urges that all parties involved make every effort to ensure that outstanding need referred to in the report are met.

In particular:
Outreach
That transport for outreach is improved, including ensuring that adequate numbers of fully serviced and fuelled vehicles are available in each District.
That required training is carried out for all staff carrying out outreach work.
Personnel
The increasing numbers of vaccine types being carried and consequently the number of doses of vaccines both stored and given have significantly increased the pressure on vaccine storage facilities and the personnel managing them, as well as upon healthcare staff who man the clinics and vaccination centres. This in turn impacts upon the overall management of the EPI programme and on the ability to carry out fully effective programmes and campaigns. It is clearly vital that vaccines stocks are effectively controlled and managed, and that cold chain equipment is properly maintained and serviced.
Adequate numbers of well trained personnel are clearly essential.
The ICC is aware that a personnel assessment is being carried out, but the JAR highlights the positions that need to be filled urgently, and the ICC recommends that this be done as soon as possible.

Reporting compliance – the ICC recommends that outstanding audits, compliance checks and reviews be carried out as soon as possible. The results of these exercises provide positive feedback to our donors and partners on the effectiveness of the programme operations and use of resources and funding.

AD MacDonald
ICC Chair

Signatures of ICC Members Endorsing this Report

NAME	***DESIGNATION***	***ORGANISATION***	***SIGNATURE***
Don MacDonald	*ICC Chairperson*	*Rotary International*	
Maxwell Hove	*Principal Director-Curative Services*	*Ministry of Health and Child Care*	
NamoGonah	*NCC Chairperson*	*Ministry of Health and Child Care*	
David Okello	*Country Representative*	*World Health Organisation*	
Reza Hossaini	*Country Representative*	*UNICEF*	
Rose Kambarami	*Country Director*	*USAID/MCHIP*	
AlexioMangwiro	*Country Director*	*CHAI*	
	Country Director	*Zimbabwe RED Cross*	
Gugulethu Mahlangu	*Director General*	*Medicines Control Authority of Zimbabwe*	

Brief description of how the joint appraisal was endorsed by the relevant national coordination mechanism: The JAR had been circulated to all ICC members to allow them to review the contents. The ICC then met to review the report and to make any agreed changes arising from members comments. The ICC then formally adopted the report.
Issues raised during debrief of joint appraisal findings to national coordination mechanism: The ICC comments on its concerns are included above. No major issues were identified by ICC members that had not already been included in the report.
Any additional comments from • Ministry of Health: • Partners: • GAVI Senior Country Manager:

- **ANNEXES**

[Please include the following Annexes when submitting the report, and any others as necessary]

- **Annex A. Key data** (this will be provided by the Gavi Secretariat)

- **Annex B. Status of implementation of the key actions from the last joint appraisal and any additional High Level Review Panel (HLRP) recommendations**

Key actions from the last appraisal or additional HLRP recommendations	Current status of implementation
Not applicable. This is the first Joint Appraisal for Zimbabwe	

- **Annex C. Description of joint appraisal process** (e.g. team composition, how information was gathered, how discussions were held)

- **Annex D. HSS grant overview**

General information on the HSS grant							
1.1 HSS grant approval date			2012 -2017				
1.2 Date of reprogramming approved by IRC, if any			Not applicable				
1.3 Total grant amount (US$)			$6,799,509.14 (includes PBF) $5,823,352.00 (Excludes PBF)				
1.4 Grant duration			2012-2015				
1.5 Implementation year			January -December				
(US$ in million)	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
1.6 Grant approved as per Decision Letter		6,799,512 (includes PBF)					

<table>
<tr><td>1.7 Disbursement of tranches</td><td></td><td>959,357</td><td></td><td></td><td>959,357</td><td></td><td></td></tr>
<tr><td>1.8 Annual expenditure</td><td></td><td></td><td></td><td>264611</td><td></td><td></td><td></td></tr>
<tr><td colspan="3">1.9 Delays in implementation (yes/no), with reasons - Yes</td><td colspan="5">There were delays in implementation in 2014 due to complications with the procurement process</td></tr>
<tr><td colspan="3">1.10 Previous HSS grants (duration and amount approved)</td><td colspan="5">-</td></tr>
<tr><td colspan="8">1.11 List HSS grant objectives
1. To strengthen the Cold Chain Capacity, Stock Management and Distribution System at all levels countrywide
2. To strengthen EPI Data Management at all levels in the context of the existing National Health Information and Surveillance (NHIS) system
3. To strengthen EPI outreach services in hard to reach communities countrywide in the context of integrated health service delivery</td></tr>
<tr><td colspan="8">1.12 Amount and scope of reprogramming (if relevant)
The delay in implementation in 2013 and 2014 due to problems with the procurement system will mean that funds will need to be moved into subsequent program years. The last decision letter on HSS indicated that years 4 & 5 for HSS would now be merged so that the HSS program can now fit into a 4 year program (ending in 2017). There is however no plan for reprogramming of HSS objectives or strategies. Two disbursals have been approved ($1,918,714 in 2012 and 2,147,211 in 2015 as per Decision letter from GAVI on 22nd January 2015)</td></tr>
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- **Annex E. Best practices (OPTIONAL)**