Zimbabwe Joint Appraisal Report 2018

Country	Zimbabwe
Full JA or JA update	☑ **full JA** ☐ JA update
Date and location of Joint Appraisal meeting	21- 23 August 2018 Harare
Participants / affiliation[1]	Annex 1
Reporting period	Jan 2017- June 2018
Fiscal period[2]	January- December
Comprehensive Multi Year Plan (cMYP) duration	2016-2020
Gavi transition / co-financing group	*Initial self-financing*

1. RENEWAL AND EXTENSION REQUESTS

Table 1

Renewal requests were submitted on the country portal

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

Table 2

Observations on vaccine request

Population	13,727,493				
Birth cohort	450,473				
Vaccine	**Pentavalent**	**PCV 13**	**Rotavirus**	**MR**	**HPV**
Population in the target age cohort	450,473	450,473	450,473	450,473	214,895
Target population to be vaccinated (first dose)	437,416	437,416	437,416	414,394	197,703
Target population to be vaccinated (last dose)	423,603	414,439	414,394	391,372	193,406
Implied coverage rate	92%	90%	90%	85%	90%
Last available WUENIC coverage rate	89%	89%	91%	78%	
Last available admin coverage rate	88%	88%	88%	76%	86%
Wastage rate	10%	5%	5%	50%	5%
Buffer	25%	25%	25%	25%	5%
Doses issued to provinces	1,396,340	1,329,900	899,900	1,661,000	20,200
Administered	1,215,033	1,220,377	818,073	742,763	
Balance	181,307	109,523	81,827	918,237	20,200
Percentage Balance	13	8	9	55	100

The country had adequate vaccines and supplies in 2017. A close analysis of the information on the above table shows that there was a variation of 3% between estimated vaccination coverage and actual administrative coverage, with actual coverage lower than projected across all vaccines. The general impression is that vaccine utilisation was satisfactory as it was within the estimated wastage range for each vaccine taking into consideration 3% failure to achieve the estimated coverage objective for 2017.

Table 3

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
	Typhoid	In Progress	2019
	Cholera	To be considered	To be considered
	IPV	Already submitted	2019 First Quarter

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

Key Contextual Factors

The following factors explain changes which have occurred since the previous Joint Appraisal**;**

- Change of government.

  The country had a change of government towards end of year which attracted attention, interest and time of the people as they attended political gatherings and paying less attention to immunizations. This political change brought renewed hope to the social and political environment of the populace. There was also increased political will to health care services as evidenced by recruitment of more staff and participation of the First Lady in the health programmes such as the HPV vaccine roll out where she officiated at the HPV launch.

- Human Resources

  The Ministry employed more than 2,000 nurses in 2017 in order to improve health service delivery. Nevertheless, some cities such as Chitungwiza and Mutare are experiencing shortage of manpower for health care service delivery due to poor working conditions including non-payment and delayed payment of salaries by local authorities. The country applied for ten additional staff for national and provincial levels under the Gavi HSS2 and this is aimed at filling identified gaps in program management. In addition, there is a proposal for Gavi to continue funding salaries for the existing Gavi supported personnel and provide level of effort for existing key EPI staff. Gavi and MoHCC are still in discussion to finalise the staff support.

- Disease outbreaks (cholera, typhoid, malaria and bronchiolitis).

  The country experienced a number of disease outbreaks that could have affected immunisation coverage due to increased workload where priorities and resources were shifted towards management of emergencies. A typhoid outbreak commenced in October 2017 with a total of 3 806 cases reported and 19 deaths and is still ongoing mainly in Harare and Gweru. A cholera outbreak also started in March 2018 in Harare and Chegutu district. Harare also experienced an outbreak in bronchiolitis in children. Seasonal malaria still remains a problem in some districts.

- Internal Migration

  The country has continued to experience high rural to urban migration which has seen most people moving to major cities. As a result, there is sprouting of illegal settlements in major cities where there are no health services and these settlements are usually not formally recognised by their local authorities. Internal migration has created urban slums and highly mobile populations who are difficult to reach with immunisation. There are plans to reach

these special populations through establishment of targeted outreach points at specific market places and illegal settlements.

- Natural Disasters

  The country experienced floods during the last summer season which also spilt into the period when the HPV campaign was being conducted resulting in some areas being inaccessible for long periods of time. The flooding resulted in cancellation of vaccine and gas deliveries as well as scheduled outreach sessions. In some cases, caregivers also failed to access services due to isolation created by washed away bridges and damaged roads. These occurrences cause stock outs, low access and missed opportunities which all lead to low vaccination coverage. The government has put in place a contingency plan where health facilities in the affected areas are given adequate stock of vaccines and LP gas to last them the period of adverse weather.

- Fragility

  According to the World Bank, Zimbabwe is classified as a low income country with a GNI per capita of $910 in 2017. It is also very fragile with weak government institutions, socio-economic instability, and internally displaced people and is experiencing frequent disease outbreaks. As a result of weak government institutions, Gavi grants management was transferred from government to UNICEF in 2016. At present there is acute shortage of cash and this has created a liquidity crunch. The country is relying on donors to fund some health care services including procurement of vaccines. Cross border movement of people puts the country at risk of importing diseases from other countries, for example there was a cholera outbreak in neighbouring Zambia that over spilled to Zimbabwe.

Polio Transition Plan

The country has developed a polio transition plan mainly focusing on how to deal with polio assets for the benefit of routine immunisation. Polio assets in Zimbabwe consist of physical equipment at the Polio lab and three staff members at WHO country office who are doing both routine and polio work. As the Government has been funding personnel costs at national and in the field, the proposal is that equipment at the laboratory may be donated to Government for them to continue with the AFP and other disease surveillance work. As for personnel at the WHO country office, alternative funding has been sourced from Gavi for one position that the Polio Emergency Programme (PEP) will not fund beyond 2018. Funding for the other two positions is secured up to 2019. The long term solution will be commencing a discussion with the Family and Reproductive Health (FRH) directorate at WHO/Afro to get a more secured funding since the officers are the only ones at country level doing both routine and polio.

AFP lab surveillance will need to continue even beyond the elimination targets hence there is justification for donating the equipment to Government. The investment developed over the years needs to be retained and utilized for routine immunisation hence the proposal that the FRH directorate consider absorbing the investment. The existing assets are well linked with programme priorities i.e. measles and MNT elimination and sentinel surveillance for new vaccines introduction. Handing over the assets to government does not require a budget. The three staff members require a total budget of about $300,000 per annum to meet their salaries. The Government and ICC have been sensitized on the plan and are aware of the transition plan.

- Environmental Factors

The rains that fell incessantly during the first quarter of 2017 affected the immunization programme since some bridges were washed away and some roads were eroded making it difficult to access some of the areas with vaccines and vaccination. Districts in Mat North, Masvingo and Mash Central provinces were affected. The rains also affected attendance by care givers leading to low

coverage and increase in the numbers of unvaccinated children. Constructions of huge water reservoirs such as Tokwe-Mukosi Dam led to displacement of people to new resettlements where social amenities such as schools and health facilities are yet to be constructed. Zimbabwe experiences frequent droughts and if these occur, the norm is people concentrate on searching for food instead of attending to health issues. This normally affects vaccinations because they are normally given when someone is not ill.

- Immunisation Financing

The comprehensive multi-year plan (cMYP) provides the financing requirements and sources of funds for all immunization activities. Gavi and other partners like UNICEF and WHO have been supporting the programme. All traditional vaccines are being procured by UNICEF/HDF while Gavi supports new and underutilized vaccines. In addition, Gavi also funds the country's immunisation program through the Performance Based Funding, Health Systems Strengthening, MR Campaigns as well as the proposed CCEOP. Considering the current economic challenges being faced by the country it is anticipated that the country will continue to seek support from Gavi for funding of existing NUV and some operational activities.
Meanwhile, a discussion has commenced with MoHCC top management to lobby for government to take over funding of traditional vaccines. There are other sources of funding like Health Levy which has already started gradual funding of key health service interventions. Partners will be continuously engaged.

- Vaccine Hesitancy

Vaccine hesitancy, refusal, and increase in the proportion of children with no vaccinations are major concerns. Caregivers' hesitancy and refusal to have children immunized against vaccine-preventable diseases or use child health care services for child illnesses is influenced by socio-economic, cultural, religious, political, and health institutional factors, which affect child healthcare seeking behaviour and vaccination uptake. In order to address vaccine hesitancy, the government has continued to pursue a persuasive approach through interpersonal communication, media briefings, community dialogues, and effective responses to AEFIs. The country is planning to conduct a KAP study and community dialogue which will be used in the development of the immunization communication strategy.

- Socio Economic Environment

The difficult economic times which have led to high unemployment and shortage of cash resulted in a lot of people becoming informal traders to earn a living. The situation continues to date. People are spending a lot of time queuing for money at the banks. The economic instability in the country implies that there will be continued cross border movements which further exposes the population to risk of disease outbreaks.
There is a proposal to map the settlements and conduct head counts to establish the correct number of eligible children for vaccinations. The programme will engage those communities, share information on immunization, risks of diseases and agree on how best immunization and other health services can be delivered to them. Local authorities will be engaged in order to address the issue of illegal settlements.

- Adverse Events Following Immunisation

All staff at implementation level were trained on how to manage and notify AEFIs, while committees at district, provincial and national levels were trained on investigating of AEFIs. All this is in place to boost public confidence in the EPI programme.

3. PERFORMANCE OF THE IMMUNISATION PROGRAMME

3.1. Coverage and equity of immunisation

Figure 1

Immunization Trends 2013 - 2017

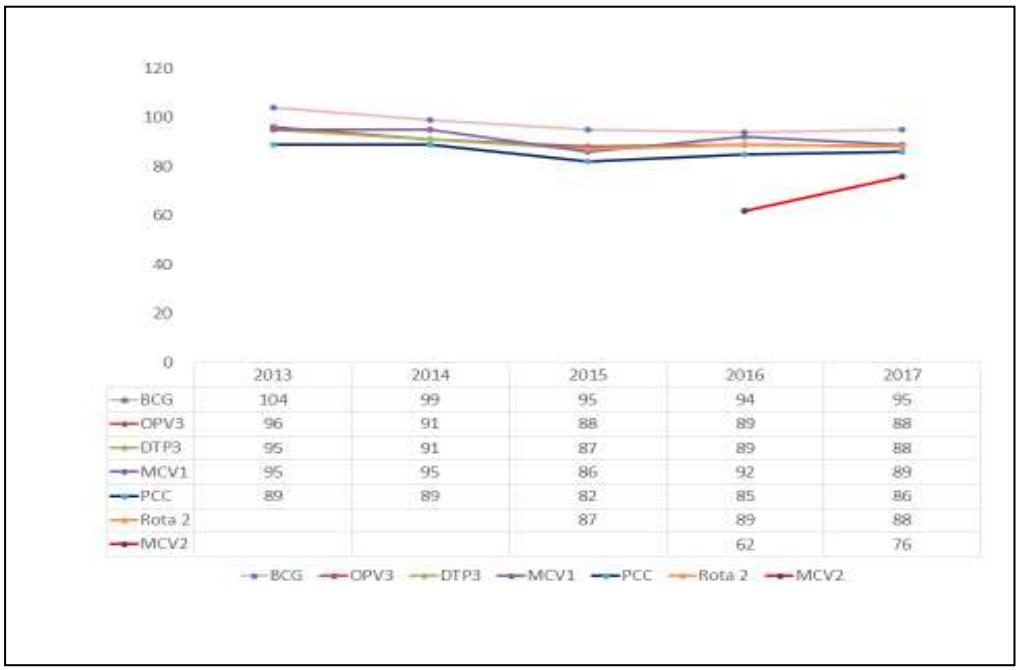


Table 4 CHILDREN UNDERVACCINATED FOR DTP3 AND MR1 IN 2016 AND 2017

Province	Total Population< 1 2017	Total Population <1 2016	Total unvaccinated for Penta3 in 2017	Total unvaccinated for Penta3 in 2016	Total vaccinated for MR1 2016	Total not unvaccinated for MR1 2017
Bulawayo	19823	19627	2945	3017	1942	3865
Chitungwiza	13286	13154	1973	1273	470	2118
Harare	54559	54019	1522	-2434	-7971	1522
Manicaland	61974	61360	7213	7189	6304	6535
Mash Central	43380	42951	7391	4924	7120	5655
Mash East	53840	53307	9271	6888	470	10120
Mash West	54024	53489	5772	4342	3663	4514
Mat North	23309	23079	2306	1092	2221	1660
Mat South	20637	20432	3226	1678	2281	1873
Masvingo	50076	49581	3755	5595	4869	6936
Midlands	55565	55015	11267	9750	11498	9727
National	450473	446013	51781	43312	32865	54525

DTP3 coverage was 88% in 2017 down from 89% attained in 2016. MR1 and 2 coverage was 92% and 63% respectively by end of 2016 while in 2017 MR1 tumbled to 89% and MR2 rose to 76%. Dropout rates for all antigens remained below 10% except for MR1 – MR2 that was 14%.
Harare had the highest DTP3 coverage of 97% while Bulawayo and Mash East had the lowest of 81%. For MR1 coverage, Harare City, Masvingo and Mat North had coverage above 90% while Midlands was the least at 80%. For MR2, Harare City, Mat South and Mat North had coverage above 80% Chitungwiza and Midlands had a coverage <70%.
Mash East and Mash Central provinces and their respective districts such as UMP and Centenary attribute their low performance to overstated denominators. Districts such as Gokwe North, Chiredzi, Gokwe South and Mbire have hard to reach populations by distance and terrain as well as sparsely distributed health facilities. Urban areas such as Chitungwiza and Mutare have been adversely affected

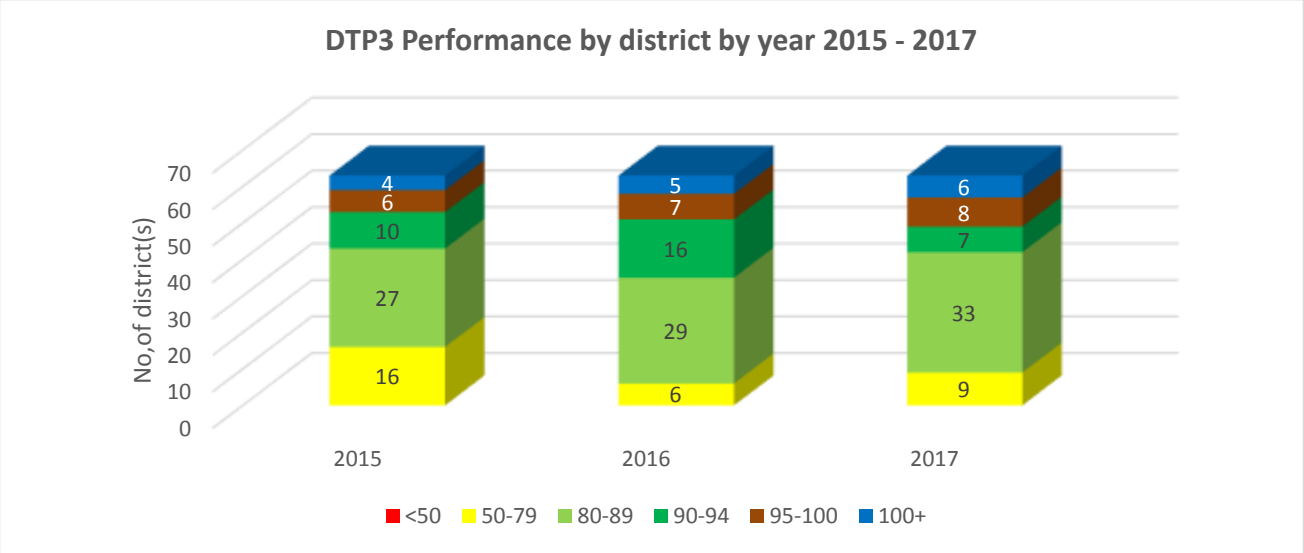
by low morale of health workers due to prolonged none payment of salaries. Mutare, Gwanda, Makoni, Buhera, Shamva and Gutu's low performance is attributed to vaccine hesitancy groups. The table below shows these and other factors influencing coverage in specified provinces and districts.

Table 5 Factors Influencing Immunisation Coverage & Strategies

GROUP	CHALLENGE	STRATEGIES TO REACH GROUPS
Elite in major cities e.g. Harare, Bulawayo, Mutare and Chitungwiza.	• Misconceptions about vaccines. • Minimal involvement of private sector	• Develop messages to address misconceptions • Engage private health care providers using existing fora e.g. Zimbabwe Medical Association, Zimbabwe Nurses Association, Paediatric Association of Zimbabwe, Zimbabwe College of Primary Care Physicians, Zimbabwe Midwives Association, Zimbabwe Private Hospitals Association. • Provide cold chain equipment, vaccines and syringes and safety boxes and data collection tools to approved private practitioners for free and provide vaccination services to their clients. • Training on the MR campaign, routine immunisation, surveillance including AEFIs, EVM and data management and monitor reporting through respective local authorities. • Technical supportive supervision visits to include private facilities.
Vendors in Harare, Bulawayo, Mutare and other cities and towns	• Too busy to take children for immunization • Not accessible at usual vaccination points (HF/outreach) as they will be busy in the streets vending almost daily	• Setting up outreach points at major markets and vending sites • Reach out with immunization promotion activities/materials
Urban Slums e. g. in Harare, Bulawayo and Mutare	• Not recognized • Underserved • Vulnerable due to poverty, education • Post crisis issue of retrenchment • High risks of outbreaks • Inadequate WASH	• Local authorities and adjacent provinces to be supported in mapping, characterization and engaging with responsibilities to provide regular integrated outreach services. • Engage private sector and local partners within reach for support in mobile services. • Advocacy to responsible parliamentarians, local authorities • Establish outreach points during the campaign which will continue to be used after the campaign for routine immunisation. • Allocate funds to cities to support urban immunisation. • Engage local authorities to sustain urban immunisation.
Distance and geographic barriers.	• Communities stay more than 10kms from health facilities or they have geographical barriers to reach the facility even if they are within 5 kms.	• Prioritise allocation of resources to districts with hard to reach populations by distance and geographical barriers, e.g. add more people in teams, more vaccination teams and vehicles. • Engage motorized EHTs to mobilise and come up with new points beyond the recognized points to reach care givers. • Use of Village Health Workers, school leadership and Community Based workers and leadership to sensitise, mobilise and follow up care givers and increase coverage.
Minority nomadic ethnic groups- Khoisan in Tsholotsho, Bulilima and Doma.	• Marginalised and underserved • Language barriers • Cultural beliefs and practices that limit them from mixing with other communities and	• Engage the leaders and involve them in the planning process to reach the community, the engagement process will continue to cater for routine immunisation. • Identify members from this group to be part of mobilisation and vaccination teams • Develop IEC materials, radio and TV productions in local languages • Use known and appropriate channels (with help of traditional/local leaders) of communication to reach them

	shy away from service providers.	
Vaccine objectors	• Vaccine hesitancy	• Engage and involve religious leaders in planning and implementation of immunisation activities at all levels
Gold Panners	• Too busy to send children for vaccination • Their trade is illegal hence they are always playing hide and seek with the authorities • Highly mobile	• Reassure immunisation sessions will not involve law enforcement agents • Set up vaccination points service in gold panning sites • Motorized EHT's to engage panners in social mobilisation and programme communication activities.
Newly resettled farmers	• Reduced access to health facilities due to long distances of more than 10kms	• Establish more vaccination points • More teams in heavily affected districts such as Mazowe, Mwenezi, Hurungwe and Makonde. • Use of motorized EHT's to reach areas with low populations

Figure 2 DTP3 Performance by district 2015-2017



The maps in Annex 6 show that 86% districts had DTP3 coverage ≥80% in 2017 which is below the 90% districts that was achieved in 2016. There was a significant increase in the number of districts who achieved ≥80% MCV2 coverage, that is, from 11% in 2016 to 43% in 2017. This can be attributed to increased knowledge on MVC2 vaccination among health workers. For MR1 only 14% districts had coverage ≥95%. MR2 only 2 districts 3% achieved ≥95% coverage, 2% between 90 -94%, 38% were between 80 -89% and 57% were below 80%.
From Annexe 6, it can be seen that there are seven districts who failed to achieve 80% coverage for DTP3, MCV1 and MCV2. These districts have common problems like few health centres, long distances to service points, poor road network, and low socio-economic status as indicated in Fig. 5 table above. There are districts with very high dropout rates for example, Guruve had DTP1 coverage of 103%, DTP3 coverage of 94% but MR1 and MR2 coverage rates were 81% and 73% respectively. There is need to enhance ACSM activities in such districts to improve utilization of EPI services.

3.2. Key drivers of sustainable coverage and equity

- **Leadership, management and coordination**

The immunisation programme remained under the Curative Services Directorate of the MOHCC. Headed by the EPI Manager at Central level, the reporting structure is that the Manager reports to the Deputy Director, Community Nursing; who reports to the Director of Nursing Services; who reports to the Principal Director, Curative Services who then reports to the Permanent Secretary. The placement of EPI in the Curative Services Directorate has been an issue of concern in most programme surveys and assessment. The major concern raised in the assessments was that of divorcing the programme from other preventive services that fall under the Preventive Services Directorate. Please refer to Annex 3 for the Ministry organogram.
At provincial level EPI is headed by the Provincial Nursing Officers (PNO) who reports to the PMDs while at district level the District Nursing Officers does the same to the DMOs. The PNO is assisted by the Provincial EPI Officer who is solely for EPI activities in the provinces. While integration is good, the programme tends to suffer at times due to inadequate allocation of resources. Micro-planning is an essential part in budgeting and planning cycle and should be strong at service delivery level, yet there is lack of capacity to do so.

- **Health workforce**

The Service Availability Readiness Assessment (SARA) of 2015 revealed that Zimbabwe core health workforce density (36%) was below half of the WHO standard rate of 23/10,000 recommended for adequate coverage for key primary health care interventions as prioritised in the MDGS. The SARA also found out that the health workforce was inequitably distributed with a higher density in urban areas than rural. In an effort to address the shortage of the health workforce, the Government of Zimbabwe has employed more nurses in 2017 and deployed them to all levels for health service provision. Though positive in a way, the employment of these nurses into government service posed a challenge to some local authorities as nurses moved to government employment for better conditions of service. Some local authorities such as Chitungwiza and Mutare were left with inadequate staff thereby affecting health service delivery including immunisation services in those cities. There are no established posts for Cold Chain Technicians and Store officers at provincial level. The only qualified cold chain technician is at national level and reacts mainly to breakdowns. There are no programme specific posts for M&E, Accounting and Health Promotion officers' thereby compromising program monitoring, financial management and demand creation and promotion activities respectively.

- **Service delivery and demand generation**

Zimbabwe was able to conduct Community Dialogues in the 18 Gavi eligible districts where over 6480 community members were reached. Community Dialogues were used to better understand bottlenecks, barriers, weaknesses, strengths and enablers to uptake of immunizations, and to design effective evidence-based interventions. The community dialogues targeted health facilities/hotspot areas that districts regarded as underserved and as having under-immunized/unimmunized children. However, there were inadequate financial resources to implement and evaluate EPI demand generation activities at National and Sub-National Levels.

The country was able to commemorate the African Vaccination Week, an annual event that assisted in garnering up political/traditional leadership commitment for childhood immunization and child health services. Local Immunization Days were conducted in priority low performing districts. These were done to improve coverage and equity within the country. Village Immunization Days were conducted to ensure each and every eligible child got due and over-due vaccines. This was complimented by "My Village My Home" initiative in Chipinge and Makoni Districts of Manicaland Province and "Bereka Mwana" in Zaka District of Masvingo Province.

- **Gender-related barriers faced by caregivers/ others**

There were a number of gender related factors which contributed to differences in immunisation coverage in Zimbabwe and these were religion, socio-economic status (rural/urban residence, household wealth status, educational level of the mother) gender and birth order of the child.

Members of these faith groups have a strong belief in their religion where the use of holy water and prayer as a form of therapy is relied on. In 2015

- **Supply Chain**

Zimbabwe has a well-defined immunisation supply chain structure consisting of four levels. These are the Central, Provincial, District and Service Delivery levels. The Central and all eleven Provincial Vaccine stores are equipped with cold rooms and conventional vaccine refrigerators for storage of vaccines. All facilities at all levels have adequate cold chain capacity for both vaccines and dry materials.

The Central Vaccine Stores have four qualified personnel headed by the Logistics Manager for effective and efficient management of vaccines and supplies. Of the four, three posts (1 National Cold Chain Technician, 1 Stores Officer and 1 Stores Assistant) are funded by Gavi. In 2017, the Central and Provincial level vaccine stores were equipped with state of the art remote temperature monitoring devices. EVM SOPs were developed and printed in 2017. SMT submission was 100% at provincial level and 50% at district level. Low performance at district level is attributable to lack of capacity to run computer based SMT by some health workers, limited internet accessibility.

The central and provincial levels have cold chain maintenance plans in place as recommended in the last EVMA. However, implementing the activities outlined in the plans remained a challenge due to multi-tasking especially at provincial level where there are no substantive cold chain technicians and Stores Officers posts. The other reason for not following the plan was lack of funding for daily subsistence allowances and transport. Despite all these challenges, the cold chain system remained intact with no vaccines reported to have been damaged due to exposure to adverse temperature at all levels. Vehicles were maintained on a quarterly basis to give them long life, and keep them on the road for outreach services and distribution of vaccines and supplies.

3.3. Data

Status of the health and immunisation information system

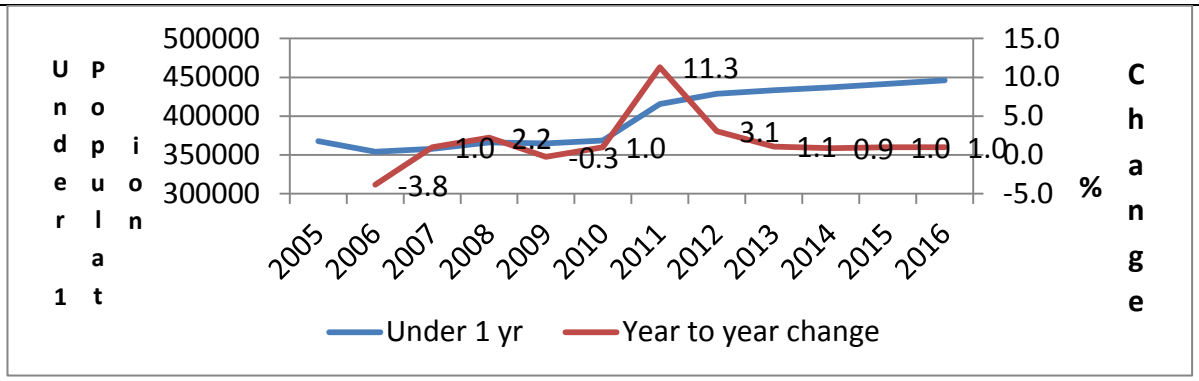
The country has an integrated Health Information System where data including immunisation data is stored in the DHIS2. The NHIS plan expired in 2014 as it ran from 2009 – 2014. Data is collected at health facilities manually. The manual forms are sent to district level by the 7th of every month. The data is entered into a web based DHIS2 system at district level. Refer to Annex7 for data flow chart. Case based VPD surveillance data remains manual at all levels. Forms are completed at HF level. They are then sent to national level via district and provincial levels. Feedback is provided to lower levels via the same route. A weekly bulletin is produced that covers major diseases of public health importance including Measles, AFP and Neonatal Tetanus. However there is no regular bulletin for routine immunization.

Timeliness & Completeness by Province

The country does not have problems on completeness of reporting which stood at 97% in 2017. Timeliness of reporting was at 75%. The main reasons for low performance in timeliness were poor internet connectivity and frequent power cuts in some districts.

Denominator related information,

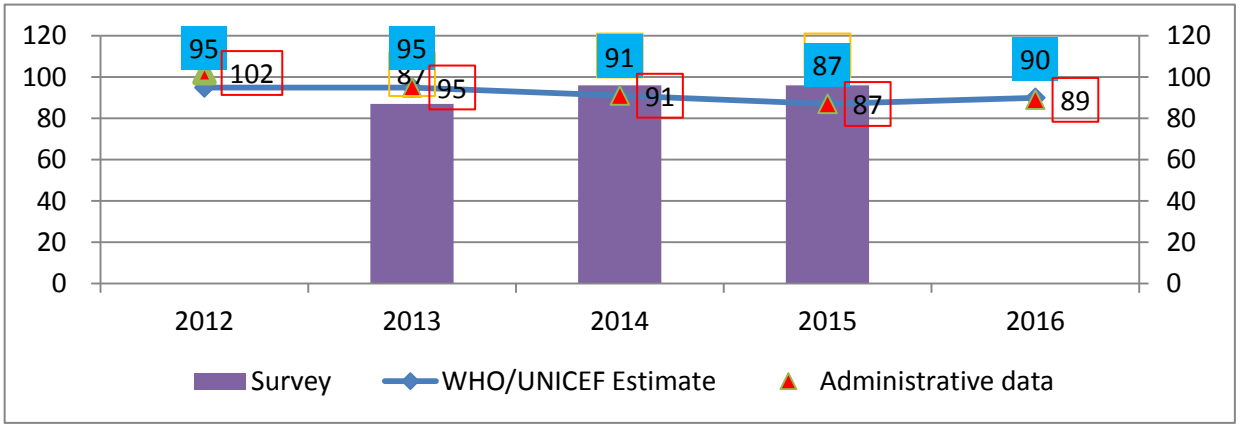
Figure 3 Inconsistency in population growth from 2012 to 2016**.**



Source-Year to year denominator change as analysed from ZIMSTAT figures 2017

The denominator provided by ZIMSTAT is not consistent from year to year. The year to year change varied from 11.3% from 2011-2012, 3.4% from 2012-13, 1.1% 2013-14, 0.9% 2014-15 and 1.0 2015-2016. This denominator issue may, with no doubt, have effect on coverage, for example the sharp drop in Penta 1 coverage from 2012 to 2013 might be attributable to the sharp increase in under 1 population by 3.4%.

Figure 4 Triangulation of DTP3 Administrative, WUENIC and Survey data



The graph shows differences in coverage rates from the mentioned sources. In 2013, survey showed a much lower coverage compared to administrative report and official estimates. In 2015, the official estimate and survey coverage were much higher than administrative coverage and WHO/UNICEF estimate. This could be a result of the denominator challenges mentioned above together with data quality issues such as under tallying and completeness less than 100%. It is encouraging to note that in 2016 official estimate, administrative coverage and WHO/UNICEF estimates were equal. In 2017 the DTP3 administrative data was 88% and the WHO/UNICEF Official Estimate was 89%.

Key challenges pertaining to data availability, quality and use

The country continued to experience shortages of man power mainly at service delivery level. Data collection tools were in short supply in some districts due to shortage of spare parts for printing machines. There was no evidence of utilization of data at point of generation. The denominator problem remained evident in districts and provinces.

Compliance with Gavi's data quality and survey requirements

Annual Desk Review

The annual data desk review was conducted in 2017 in accordance to Gavi data quality tool kit. See attached 2017 Desk Review. See Annex 4.

Periodic in-depth assessments of routine administrative immunisation coverage data

These were conducted in accordance to the Gavi guidelines. The country conducted a DQS in 2013 and DQR in 2017. The country conducted a routine coverage survey in 2015. The next coverage survey is planned for 2019. However the data quality improvement plan was still at draft stage.

Periodic population-based surveys to measure immunisation coverage

- Inter-censual Demographic Survey (ICDS) 2017
- Zimbabwe Demographic Health Survey (ZDHS) 2016
- Multiple Indicator Cluster Survey (MICS) 2014

HMIS strengthening activities

- New HMIS Strategic Plan under development
- Drafting of data quality improvement Plan. See Annex 5
- Training of all health personnel on data quality management focusing also on use of data at point of generation.
- Improvement of the availability of data collection tools through timeliness production and distribution of the tools.

Main efforts / innovations / good practices focused on evidence-based data improvement interventions and level of scale up.

- Data harmonization is done between the Lab, MCAZ and the NHIS regularly
- Timeliness and completeness is monitored monthly
- Integrated data collection has been introduced (DHIS2)
- Health Strategy is being developed and a draft is now in place
- Strengthening RED Strategy and use of vaccination coverage monitoring charts at all levels
- Electronic health registers under pilot in 2 districts.

AFP Surveillance

The country achieved an AFP annualized rate of 4.8 per 100,000 under 15 years population in 2017, an increase from 3.1 attained in 2016. Stool adequacy of 90% was attained in 2017 which was less than the 93% recorded in 2016. Total AFP cases reported in 2017 were 182. The AFP surveillance at national level is above minimum requirements. However, there are notable subnational gaps. Ten districts (Kariba, Mwenezi, Bubi, Mangwe, Umzingwane, Gweru, Kwekwe, Shamva, Centenary and Rushinga) had AFP case detection rate below the WHO target of 2/100,000 under 15 population. Bulawayo City (70%) and Masvingo province (74%) had stool adequacy below the target of 80%. Inadequate knowledge among health workers as identified during the 2016 Comprehensive EPI Review and inadequate support supervision are some of the reasons for the underperformance.

- **Measles Surveillance**

On Measles surveillance, the country performed well in 2017. The annual suspected Measles case detection rate was 4.7 per 100,000 population (645 cases) in 2017, much higher than the 3/ 100,000 (430 cases) detected in 2016. All districts managed to report a Measles suspected case with a blood specimen. The only challenge was shortage/delayed supply of measles test kits resulting in delays in processing samples. The recently developed Measles Elimination Strategic Plan needs to be finalised and fully implemented in order to comply with the Measles Elimination Goals. There is also need to support operations of the recently appointed Measles Elimination Verification Committee.

Three cases of NNT were reported in 2017 higher than 2 reported in 2016. The MNT elimination status has been maintained at <1/1,000 live births since 2002. Zimbabwe attained the MNT elimination status in 2002. The country, with technical support from partners, has drafted a MNT elimination sustainability plan. In the plan, there is need to strengthen community level NNT surveillance to take care of NNT cases in the community.

- **Sentinel surveillance: Rotavirus, PBM and CRS**

The country is conducting sentinel surveillance for Rotavirus, PBM and CRS with technical and financial support from WHO. There are 3 sentinel surveillance sites for Rotavirus which are Harare Central Hospital, Parirenyatwa Group of Hospitals and Chitungwiza Central Hospital. The challenges faced by Rota surveillance include occasional shortage of test kits and shortage of staff.
The PBM and CRS sentinel surveillance sites are located at Harare Central Hospital. For confirmation of isolates using PCR technique, the samples are sent to South Africa National Institute of Communicable Diseases (NICD). The challenges include inadequate supply of reagents including test kits and sheep blood (no syringes to collect).

- **AEFI Surveillance**

In 2017, 41 AEFI cases were reported (case reporting rate 8/100 000) and the cases comprised of 13 abscesses, 10 fever, 2 seizures, 1 severe reaction, 7 hospitalisations and 8 deaths. 26 AEFI cases were classified as follows by the Pharmacovigilance committee: 2 coincidental, 9 immunization error, 14 vaccine product related and 3 were unclassified due to inadequate information. The country has challenges in getting histology results, so usually the Pharmacovigilance Committee relies on clinical/verbal autopsies for classification. The country has committees at district provincial and national level to manage AEFIs and to respond to any issues related to AEFIs.

- **Key Challenges in Surveillance**

- Shortage of test kits especially for Measles and Rota
- Inadequate funding for the production of case investigation forms
- Inadequate funds for provincial/district surveillance review meetings
- Inadequate resources to roll out new technologies in surveillance e.g. electronic Integrated Support and Supervision tool
- Inadequate funding and fuel for transportation of specimens and to conduct investigation
- Surveillance knowledge gaps amongst health workers

3.4. Immunisation financing

- **Availability of national health financing framework and medium term and annual immunisation operational plans and budgets** **Joint Appraisal (full JA)**

The Ministry of Health has a costed National Health Strategy running from 2016 to 2020. The basis of the annual health budget is derived from the national health strategy. However due to financing constraints facing the country the government is partially honouring funding for micro activities.
The government contributed $7,500,000 to HDF in end of 2017 to assist in the procurement of medicines in the primary care package and vaccines. In demonstrating its commitment to health financing, the government launched the Health Financing Policy and Strategy in 2018 which seeks to find other sources of domestic funding for health which in time will assist in the financing of vaccines. The Health Financing Policy is also strongly linked to the National Health Strategy which are positive steps towards financial risk protection for the population and ultimately Universal Health Coverage.

- **Allocation of sufficient resources in national health budgets for the immunisation programme/services**

Due to the financial status of the country the government is not capable of self-financing vaccines. The government is currently co-financing the procurement of vaccines with partners for example Gavi. For the year 2018, government co - financing budget is $1,750,000 and a commitment to pay $1,200,000 has already been given.

- **Timely disbursement and execution of resources**

The disbursement of resources to province and district levels has been done timeously from the national level. The disbursements from UNICEF have also been received timely.

- **Adequate reporting**

On an operational level, acquittal reporting from the districts through the province to the national level has been experiencing extended delays. The challenge of delays in acquittals is cascading to delays in requesting reimbursements from UNICEF for activities that would have been pre-financed by the Ministry. Therefore there is need to provide budgets for acquittal collection at national level to follow up on overdue acquittals every quarter.

4. PERFORMANCE OF GAVI SUPPORT

4.1. Performance of vaccine support

- **Overall Implementation Progress of Gavi vaccine support**

Gavi continued to support the government of Zimbabwe by providing adequate funding for procurement of new and under-used vaccines (DTP-HepB-Hib, PCV13, MSD and Rotavirus) such that the country had adequate vaccines in 2017. The country successfully applied for HPV vaccine support in 2017. The HPVV was rolled out in 2018.

- **Campaigns**

There was no major vaccination campaign conducted in 2017 besides local immunisation days conducted in some districts. However the country submitted an application to Gavi for measles campaign planned for 2018. The 2017 application was not successful and the country was requested to re-submit a new application in the January, 2018 window. The application was successful and the measles campaign is now planned for 2019.

- **Describe key actions related to Gavi vaccine support in the coming year**

The country submitted a vaccine renewal support for 2019 to Gavi in May 2018. The country will continue to co-finance Gavi supported vaccines. The country also applied for support in oral cholera vaccine (OCV) and typhoid conjugate vaccine (TCV) for emergency response in Q3 and Q4 2018 and TCV for routine immunisation country wide in Q4 2019. The emergency response applications were in response to cholera and typhoid outbreak in the City of Harare.

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

Table 6 Performance of Gavi HSS Support

Objective 1	
Objective of the HSS grant (as per the HSS proposals or PSR)	To strengthen the Cold Chain Capacity, Stock Management and Distribution System at all levels countrywide
Priority geographies / population groups or constraints to C&E addressed by the objective	• 104 SDD refrigerators for health centres without electricity. • Fuel for standby generators required because 8 Provincial and 63 District. • Non-availability of reliable transport for vaccine distribution. • Shortage of fuel for vaccine & supplies distribution. • No funds for vehicle service and maintenance at all levels.
% activities conducted / budget utilisation	• 100% planned SDDs procured and installed. • 100% fuel for generators and vaccine delivery procured. • 100% planned vehicles for vaccine distribution procured.
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	• 104 SDD refrigerators were procured have improved cold chain management, increased access and utilisation of services. • Provision of fuel for standby generators at central, provincial & district levels has improved cold chain management. • 9 trucks procured have increased vaccine availability and reduced vaccine stock outs at lowest distribution level. • Provision of fuel for vaccine distribution has reduced incidence of stock-outs at provincial and district levels. • Funding for vehicle maintenance timely availed, thus greatly improving on transport availability. • Trained 1,748 Vaccine Managers and supervisors at all levels, this has led to a significant reduction in stock outs and over stocking as reported in the quarterly VMAHS reports. • Trained 118 Designated Cold Chain Technicians for maintenance of sound cold chain integrity at all levels countrywide
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **needs for technical assistance**[11]	HSS2 Objective # 5 "To strengthen cold chain and vaccine logistics management system in Zimbabwe", planned activities are; • Procurement of computers for EVM, RTM system for districts, refrigerator spares, WIFR, fuel for generators and co-financing under CCEOP. • Capacity building for EVM and Cold Chain • Cold Chain Maintenance • Recruit human resource for cold chain maintenance • Construction of the dry stores
Objective 2:	
Objective of the HSS grant (as per the HSS proposals or PSR)	To strengthen EPI Data Management at all levels in the context of the existing National Health Information and Surveillance (NHIS) system (so as to provide quality strategic information for effective and efficient management and delivery of EPI services to communities countrywide)
Priority geographies / population groups or constraints to C&E addressed by the objective	• The objective sought to improve data management at all levels. • Inadequate human resource capacity in terms of data collection, recording and analysis • No computers for data management • Lack of survey information to validate administrative data
% activities conducted / budget utilisation	• 76% activities conducted • 100% budget utilised for implementing 76% of the planned activities.
Major activities implemented &	• Trained health workers at all levels

Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	• 72 desktop computers, 13 laptops, and 72 external drives have enabled introduction of the SMT at district level and improved vaccine management. • Conducted a Data Quality Review leading to development of a Data Quality Improvement Plan. • Conducted an evaluation of the RED Strategy implemented in 3 provinces. Results will be used to come up with a RED Strategy for the country which will be used for training and guiding health workers.
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **needs for technical assistance**[11]	HSS2 Objective # 3 "To ensure availability & use of high quality data to inform timely & evidence based interventions" planned activities are; • Update of ZEPI Register • Comprehensive EPI Review and HSS 1 End Term Review • Cold Chain Assessment with Technical Assistance • Effective Vaccine Management Assessment • Data Quality Assessment • On Site Data Verification
Objective 3:	
Objective of the HSS grant (as per the HSS proposals or PSR)	To strengthen EPI outreach services in hard to reach communities countrywide in the context of integrated health service delivery
Priority geographies / population groups or constraints to C&E addressed by the objective	• 18 priority districts selected on the basis of low DTP3 coverage • 30 health centres with inadequate demand for immunisation services in the priority districts. • Communities whose demand for immunisation services was low (by DTP3 coverage) • 29 districts without vehicles for conducting outreach services and one province without a vehicle for surveillance
% activities conducted / budget utilisation	• 100% budget utilised
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	• Trained 54 trainers from Health Prom. Officer, Community H. Nurse and EHT.ie 3 per each of the 18 Priority Districts. (NGOs/CBOs) in conducting Community Dialogues. • Carried out community dialogues on EPI in hard-to-reach communities. • Procured 31 vehicles for districts to enable them access hard-to-reach areas to deliver integrated outreach services. • Provided fuel for EPI outreaches and support for maintenance of vehicles. • Paid travel and subsistence allowances for health workers undertaking EPI outreach services in hard-to-reach areas.
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated needs for technical assistance[4]	• Conduct monthly outreach activities in 20 districts and bimonthly in 43 districts • Construction of 4 health posts in Gokwe North district • Quarterly support & supervision • Training & implementation of RED/REC • Procurement and distribution of LP gas • Procurement & maintenance of vehicles

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

No approved CCEOP support. The 2018 November IRC will re-review the CCEOP application.

4.4. Financial management performance

Grant reference	Starting date	Ending date	Total Programmable allocated budget	Cumulative absorption (spent + commitment) by 31 Dec 2017	Cumulative absorption (spent + commitment) by 03 Nov 2018	%
SC170265 (HSS bipartite)	08.05.2017	31.05.2018	1,633,150	1,493,302	1,633,150	100
SC170422 (HSS tripartite)	26.05.2017	31.12.2019	1,043,737	478,624	959,435	92
SC180125 (HPV tripartite)	12.02.2018	31.12.2018	853,108	N/A	487,265	57
SC180642 (PCV switch grant)	17.07.2018	31.12.2019	116,122	N/A	73,193	63
SC180268 (TCV/PEF)	15.03.2018	30.06.2019	486,750	N/A	90,770	19

SC170265 (HSS Bipartite): The Grant supported mostly procurement activities which included vehicles, fuel for vaccine delivery and EPI outreach services, tyres for vehicles, community dialogue stationery and equipment including supporting installation of 104 solar direct drive (SDD) refrigerators in rural health facilities. UNICEF effected a change of funding source into Grant SC170422 to realise a 100% utilisation of the Grant given that funds not exceeding $10,000 were returned to UNICEF as part of over budgeted/incomplete activities.

SC170422 (HSS Tripartite) These were from funds transferred from MOF to MOHCC as balances after failing to fully utilise due to access issues. The funds were subsequently deposited into the UNICEF HDF pooled account. There were some noted delays in processing and disbursing requested funds from UNICEF to the Ministry and this in a way contributed to none utilisation of the funds. Ministry of Health and Child Care realised they could not fully utilise the funds within the required period of December 2017 and sought approval for a no cost extension from Gavi which was granted to April 30, 2018 and then again to Dec 2019 when the equity bonus funds were added into this grant. The Ministry would like to explore the possibility of having some of the funds managed through WHO to improve on funds utilisation.

Worth to indicate is that all grants are/were being utilized in line with UNICEF financial regulations and audit requirements. However, UNICEF audit findings from 2017 found instances where payments issued for current activities were used to pay for retrospective activities. Specifically these retrospective payments were for outreach work conducted but not paid for. The Ministry and UNICEF took up this audit finding and presented the HACT procedures to provincial teams at EPI quarterly review meetings as a way of trying to ensure provinces complied with the procedures.

Gavi audit recommendations to the Ministry were addressed and the country has already implemented them. The country shared the implementation status with Gavi which shows how the country has enforced checks and balances which are in line of complacency with the audit findings.

All reports to Gavi were submitted in due time without delay.

SC180125 (HPV tripartite), SC180642 (PCV switch grant) and SC180268 (TCV/PEF) are activities for year 2018 which are still running. These will be reported fully in the 2019 JAR but implementation seems to be on course so far**.**

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

Country not in transition phase

4.6. Technical Assistance (TA)

Technical Assistance

- **World Health Organisation Country Office**

The WHO, Zimbabwe Country Office received a total of $125,000 from Gavi as TCA in year 2017. The TA was used to;

- Support the rejuvenation and setting up Zimbabwe National Immunisation Technical Advisory Group (ZIMNITAG).
- Send three members of ZIMNITAG to attend international vaccinology courses
- Support the Immunisation Supply Chain
- Trained district Vaccine Storekeepers and their supervisors in EVM
- Support in the development and printing of the EVM Standard Operating Procedures
- Participate in all quarterly vaccine management supportive visits.
- Conduct the data quality self-assessment (DQA
- Facilitate the introduction of the Human Papilloma Virus vaccine (HPV) including

WHO requires support in;

- ZIMNITAG operational costs
- EVM activities including EVMA
- Funding one NPO/Logistics position
- Conducting the post NIDs
- Routine immunisation coverage surveys,
- Temperature monitoring study
- HPV vaccine post introduction evaluation.

UNICEF Country Office

The TCA supported the salaries of two national officers, specifically recruited to provide technical support in the areas of logistics, strengthening routine immunisation, data management and introduction of new vaccines.

The two officers played key roles in closely monitoring Gavi HSS grant utilisation, providing regular updates to management to ensure compliance with programme policy and audit requirements as well as full utilisation of the grants. They also supported the MoHCC with preparing responses to the Gavi IRC for PSR and MR proposals. They participated in the country office desk review on the immunisation equity barrier analysis which was shared with all partners to inform programming. The officers provided technical support during revision and printing of AEFI Surveillance guidelines which were delivered to health facilities. This was followed by training of a cross section of health workers.

TA requested include;

- Continued support for the two EPI Officer and Logistician
- TA for MR campaign and IPV introduction.
- TA for supporting low performing districts
- TA for supporting Social Behaviour Change Communication for Adolescent Health.
- Technical assistance to MOHCC with salary and other perks of HPO.

JSI TCA

JSI received funding as TCA in year 2017 to support salaries of two national officers, the National HPV Coordinator (100% LOE) and the Senior Immunisation Technical Advisor (50% LOE), to provide TA to HPV Vaccine introduction in Zimbabwe. Based on JSI's discussions with colleagues at the EPI as well as observations from the country's in-country technical assistance, there were several areas to which JSI could provide support in helping Zimbabwe to move forward with the next stages of HPV vaccine introduction. JSI was prepared and well equipped to provide technical assistance to the following priority activities:

- HPV 2nd dose of bridging project
- National introduction planning and preparation
- During and Post-introduction support

Preparation for HPV Vaccine Introduction in Zimbabwe

Through the TA provided by the two Officers JSI was able support planning, training, implementation and post implementation activities for the HPV vaccine. This resulted in the successful winding up of the bridging project in three selected districts. The coverage for the bridging project was 94% for Beitbridge, 92% for Marondera and 74% for Kwekwe.

JSI Other TA to Zimbabwe EPI in 2017

- Participated in JAR report writing
- Participated in ICC , NITAG & other TWGs
- Provided TA during the HPV bridging in Kwekwe
- Participated in EVM review meetings

JSI TA to Zimbabwe EPI in 2019

- To provide TA during the training of Health Workers on RED/REC
- To provide TA in the evaluation of MVMH and HBR in Manicaland
- To provide TA in the training of health workers, VHWs and Village Heads on MVMH and HBR before planning for national roll out
- To provide TA in the Planning Implementation, monitoring and evaluation of the HPV 2nd dose of the MAC and 1st dose of the routine HPV vaccination of girls in grade 5
- To provide TA in the Planning Implementation, monitoring and evaluation of the MR Campaign
- To provide TA in the Planning Implementation, monitoring and evaluation of any other new vaccine introduction e.g. IPV

Financial Support needed for Urban Immunisation

- JSI o provide TA in urban considerations / future work that should be incorporated into rolling out the RED guidelines and the recent urban guide that has been developed.

PATH TCA

PATH provided support for a successful national HPV application to Gavi early 2017. They will continue its support for the program implementation and coverage evaluation. Specifically, PATH will:

- Execute monitoring and reporting of HPV vaccine uptake and coverage data after national introduction;
- Advise on mitigation strategies if uptake is low;
- Plan coverage survey in three districts.

Additional support needed from PATH is the following:

- Hire and train data collection teams for coverage survey;
- Conduct field work for coverage survey;
- Share results of coverage survey and suggest program improvement, if warranted;
- Support planning and preparation activities for the next round of vaccination;
- Support the PIE.

PATH also worked with the MOHCC to sensitize stakeholders on TCV introduction since Q4 2017 and to write and submit the application for routine immunization in 2018. PATH assistance is requested to:

- Participate in the planning and preparation for TCV introduction;
- Plan and conduct TCV coverage survey;
- Participate in the PIE. PATH will also assist the communication technical working group in developing messages and social mobilization tools before TCV introduction.

5. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

Table 7 Findings from Previous Joint Appraisal

Prioritised actions from previous Joint Appraisal	Current status
Building Capacity for Private Sector participation	Conducted a meeting with public health physician in Harare to sensitize them on immunisation. Urban local authorities were sensitized on engagement with private medical service providers to provide immunization services. A standard guideline on private sector engagement will be developed.
Training of Health Worker	Health workers trained in EVM, cold chain, and data management. Three provinces have already been trained in RED/REC. The country applied to Gavi for RED/REC training in the remaining provinces.
Funding for supportive supervision	Integrated supervision was conducted at sub-national level. However, there was inadequate funding for the activity. The Ministry has proposed funding for this activity under Gavi HSS2.
Provision of adequate funding for the immunization programme	The programme has continued to mobilize funding from Gavi and other partners to support operations. The funds have not been adequate but the programme has continued to run with some implementation challenges. Outreach services had to be reprogrammed to suit the available funding. The Ministry has proposed funding of this activity from Gavi HSS 2.
Provision of adequate transport	The Ministry received 17 Land cruisers to support outreach and surveillance activities in districts and provinces. The vehicles alleviated the transport shortage in provinces and districts. However, there still remains a transport gap in 21 districts that have been included in the Gavi HSS 2 proposal.
Increasing staff at all levels	Have applied for critical posts to be filled in at national and sub-national levels. The Ministry has recruited and deployed more nurses to cover health facilities.
Create demand for immunisation	A KAP and EPI Communication strategy consultant has been recruited. This will facilitate the development of evidence based demand generation activities and robust M&E frameworks. Vaccine hesitancy remains a major concern. Continuous engagement of vaccine hesitant populations by all levels. My Village My Home initiative was implemented in Manicaland Province. The country is proposing it be rolled out to all provinces.
Effective Vaccine Management (EVM) and Cold Chain	Recommendations from the 2016 EVM were implemented. EVM standard operating procedures were developed, printed in 2017 and issued out to all levels. National and Provincial cold rooms had remote temperature monitoring devices installed in 2017. Cold chain equipment plans are now in place at central and provincial levels. There was no vaccine and supplies stock outs at National and sub-national levels in 2017. According to the VMHS report of December 2017 the proportion of health facilities with at least 70% of vaccines stock was 96.8%.

Data Quality and Surveillance	A Data Quality Review (DQR) was conducted in 2017 and draft improvement plan developed. The country worked towards implementing the recommendations of the DQR.
Additional significant IRC / HLRP recommendations (if applicable)	**Current status**
IRC Comments raised in the PSR application.	All comments were responded to and submitted to Gavi. Country awaiting approval of the PSR. In response to IRC comments, the country is developing evidence based communication strategy with the support of UNICEF, and has resubmitted the CCEOP application with the relevant attachments.

Most findings have been addressed but some will be implemented as part of the PSR already submitted to Gavi.

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

Table 8 Summary of Findings

Overview of key activities planned for the next year: **PSR activities- HPV, MR campaign, IPV introduction, Typhoid, CCEOP rollout, Construction of dry stores, Staff recruitment**	
Key finding / Action 1	**Service Delivery** DTP3 coverage below 90%; environmental Factors: drought/floods, terrain, construction of dams, lack of health facilities, long distances from health facilities- rely on outreach, new resettlements, WASH issues leading to disease outbreaks. This leads high number of unvaccinated children, low coverage, high dropout and VPD outbreaks.
Current response	Outreach activities though inadequate and inconsistent, Mapping of mobile population, rehabilitation of water and sewer reticulation system, hygiene promotion and clean up campaigns.
Agreed country actions	• Construction of Health Post in Gokwe North • Targeted outreach in low performing districts, • Mapping of mobile populations in cities, emergence and routine typhoid vaccine application, • MR campaign, • KAP study & Community dialogue • RED/REC training, Introduction of IPV and HPV dose, • Monitoring of vaccine coverage • Surveillance, IDSR
Expected outputs / results	Improved access and utilisation of healthcare services, Increase in coverage, reduction of unvaccinated children and availability of communication strategy.
Associated timeline	IPV- Q1 2019, Outreach- monthly in 20 low performing and quarterly in the remaining 43, HPV-Q2, MR Campaign- Q2, Typhoid- Q4, RED/REC-Community dialogue, Continuous monitoring.
Required resources / support	IPV introduction VIG, DSA, fuel and transport for outreach, promotional materials, data collection tools, financial resources.
Key finding / Action 2	**Program Management & Financing:** Inadequate funding for program activities: outreach, campaigns, supportive supervision, trainings and staff salaries. Grant Management, Audit & Financial Reporting Inadequate human resources at different levels

Current response	• Government Support: co-financing of NUV, pre-financing for MR, HR & infrastructure • Gavi Financial Support • All Gavi grants being managed by UNICEF, • Partner Support ; UNICEF, WHO, World Vision, JSI • Country Financial Reporting to Gavi & UNICEF • Human Resource Funding from Gavi
Agreed country actions	• Recruitment of key personnel to strengthen program management at all levels: accountant, M & E Officer, provincial Cold Chain Technicians to improve CCE management, Health Promotion Officer to strengthen demand generation activities • Sustain current Gavi supported staff • Annual Internal Audits • Support Quarterly ICC Meetings • Gavi Program Support Rationale: HSS, CCEOP • Health Development Fund to provide support, • Advocacy for increased government support. • Targeted Country Assistance through alliance partners
Expected outputs / results	• Improved Program Financial Management • Availability of an adequate M & E framework throughout the year • Demand Generation strengthened • Achieve at least 80% CCE functionality at all levels • Gavi to continue funding salaries for 8 members (4 security guards, Cold Chain Technician, Stores Officer, Program Assistant & Stores Assistant • Financial Management Control enhanced at all levels • ICC meetings conducted as planned • Funding available for all program activities from Government and partners • TCA partners to provide technical & financial support • Program Review Meetings conducted quarterly
Associated timeline	• All staff recruitments to be done by latest Q2 2019 • Timely Financial Reports availed Q1-Q2 2019 • Program to satisfy performance indicators quarterly - 2019 • Achieve at least 80% CCE functionality for Q1-Q4 2019 • Internal Audits conducted Q2 & Q4 2019 • ICC meetings conducted quarterly Q1-Q4 2019 • Funding available timely • Program Review Meetings held quarterly Q1-Q4 2019
Required resources / support	• Human Resources • Infrastructure • Technical Support • Funding
Key finding / Action 3	**Immunisation Supply Chain**
Current response	• Installation of Remote Temperature Monitoring System (RTMS) at central & provincial • CCE Inventory Validation • Temperature Mapping Study at central & provincial levels • Installation of Solar Direct Drive refrigerators, • EVM Review Meetings,

	• Support Supervision • Stock Management Support • Construction of Midlands Provincial Vaccine Stores & relocation
Agreed country actions	• CCEOP Application • Effective Vaccine Management Assessment • Construction of CVS Dry Stores • Construction of 4 Health Posts in Gokwe North district • Procurement of RTMS for 60 districts, LP Gas, office equipment & vehicles • Maintenance of Vehicles & CCE • EVM & Cold Chain Management Capacity Building • Asset Verification
Expected outputs / results	• Rehabilitation & expansion of CCE capacity, • 2019 EVMA Report available and EVMA Improvement Plan developed • CVS Dry Stores constructed • 4 Health Posts constructed in Gokwe North district • No stock outs of vaccines and supplies at all levels • Training Reports available •
Associated timeline	• 831 refrigerators/freezers deployment Q2-Q4 2019 under CCEOP • EVMA conducted and report available Q3 2019 • EVMA Improvement Plan developed Q4 2019 • Vehicle Maintenance Q1 to Q4 2019 • CVS Dry Stores constructed by Q3 2019 • 4 Health Posts constructed by Q4 2019 • Health Workers trained in EVM & CCM by Q2 2019 • Training reports available by Q3 2019
Required resources / support	• Funding, • Human Resources, • Technical Support, • CCE & Office Equipment
Key finding / Action 4	**Data & Surveillance**
Current response	• Quarterly review meetings • On Job trainings • Support supervision • Review of data collection tools • Active Search • Data Harmonisation Meetings • Monthly reporting
Agreed country actions	• Data Verification • Capacity building in bio risk management • Revision & Production of ZEPI Register • Active search & sensitisation
Expected outputs / results	• Improved data quality • Improved management of specimens • Improved collection of data and tracking of defaulters
Associated timeline	• Data verification 4quarters of 2019 • Active search all quarters of 2019

	• Bio-risk capacity building for health workers Q1 2019
Required resources / support	• Funding, • Human Resources, • Technical Support, • Training materials • Transport
Key finding / Action 5	**Demand for Immunisation Services**
Current response	• KAP Study • EPI promotional activities • Engagement with traditional and religious leaders • Production of IEC materials and multimedia scripts and talk shows • Production of IEC materials for minority groups • Interpersonal communication
Agreed country actions	• Development of Immunization Communication Strategy • Development of IEC materials • Training health workers on Community Dialogue • Implementing Community Dialogue
Expected outputs / results	• Communication Strategy developed, produced and shared • Increased uptake of EPI services by vaccine objectors • IEC materials produced • Training of health workers • Community Dialogue implemented • Increased EPI coverage • Increased surveillance reporting
Associated timeline	• Communication Strategy Development Q1 – 3 2019 • Capacity building for health workers Q1 2019 • Community Dialogue Q2 -4 2019 • Advocacy Communication and Social Mobilization activities Q1 – 4 2019
Required resources / support	• Funding • Human Resource • Technical Assistance • Printing services

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

- The ICC is co-chaired by a Rotarian and the Director of Epidemiology & Disease Control who represents the Permanent Secretary. Although some members do not participate in regular ICC meetings, the membership meets Gavi requirements. The ICC minutes which have been submitted indicate the review process and endorsement.
- A power point presentation on the JAR thematic areas was prepared based on the feedback from the stakeholder meeting. The presentation covered the achievements, bottlenecks, mitigations done, planned activities that were included in the HSS2 and other activities deemed important but had no funding to support them. Members deliberated on the presentation and queries raised were addressed. Members wanted to know what challenges the programme had, issues of sustainability and funding gaps. Members recommended that a sub-committee be set up to mobilise resources for the programme. Development of a marketing flier articulating the TORS of the ICC to be circulated and recruit members.

8. ANNEX: Compliance with Gavi reporting requirements

	Yes	No	Not applicable
Grant Performance Framework (GPF) * reporting against all due indicators	Yes		
Financial Reports *			
Periodic financial reports	Yes		
Annual financial statement	Yes		
Annual financial audit report	Yes		
End of year stock level report (which is normally provided by 15 May as part of the vaccine renewal request) *	Yes		
Campaign reports *			
Supplementary Immunisation Activity technical report			N/A
Campaign coverage survey report			N/A
Immunisation financing and expenditure information			
Data quality and survey reporting			
Annual data quality desk review	Yes. Send copy to Gavi		
Data improvement plan (DIP)	Yes. Send a copy to Gavi		
Progress report on data improvement plan implementation		No. To be completed and send to Gavi	
In-depth data assessment (conducted in the last five years)	Yes. To send the final copy to Gavi		
Nationally representative coverage survey (conducted in the last five years)	Yes.		
Annual progress update on the Effective Vaccine Management (EVM) improvement plan	Yes. Updated and sent to Gavi		
CCEOP: updated CCE inventory	Yes. Updated and sent to Gavi		
Post Introduction Evaluation (PIE)			N/A
Measles & rubella situation analysis and 5 year plan	Yes. Send copy to Gavi		
Operational plan for the immunisation programme	Yes.		
HSS end of grant evaluation report		No	
HPV specific reports		No	
Reporting by partners on TCA and PEF functions	Yes		

HPV Report will be submitted when the data cleaning exercise is complete.

Annexe 1. JAR Stakeholders
Annexe 2. African Vaccination Week Report
Annexe3. Ministry of Health Structure 2007
Annexe 4. Desk Review
Annexe 5. Data Improvement Plan
Annexe 6. Maps
Annex 7: NHIS information Flow chat