Joint Appraisal (JA)

The Joint Appraisal (JA) is an **essential element of Gavi's regular monitoring and performance management (MPM).** The JA has evolved to align with Gavi 5.0 strategic shifts.

The JA is an **annual, country-led, multi-stakeholder** review/discussion that represents an important opportunity for countries to engage Gavi Alliance partners and other key stakeholders on annual progress of routine immunisation programmes against national goals and objectives, and to discuss how Gavi support is contributing to this progress. Key stakeholders involved in the country's immunisation programme should be represented at the Joint Appraisal, including civil society organisations (CSOs).

As an integrated part of Gavi's portfolio management process, the JA discussion should review **Gavi's contribution to immunisation programme performance** in 2023/H1 2024, including status of your COVID-19 programme and efforts on integration. A key feature of the JA is the joint discussion about the **promising practices, challenges met and future needs** for improving immunisation performance with a focus on reaching zero-dose children and missed communities. Section 1 forms the analytical foundation to structure the JA discussion with Section 2 summarising the outcome of the JA and follow-up actions.

The outcome of this Joint Appraisal will include a joint assessment of promising practices, perceived challenges and opportunities for Gavi investments, and should elaborate future actions with clear targets and assigned responsibilities which is owned by the full set of in-country stakeholders.

A. Immunisation Programme Performance – Zero-dose, Routine immunisation coverage, Vaccine introductions, campaigns, and outbreak response

1. Learning Question: What progress has been made to reach zero-dose and under-immunised children with vaccinations?

Indicator	2021	2022	2023	% change, 2021-2023	% change, 2022-2023
Number of zero dose children at national level[1]	48,502	112,754	143,791	+66% (+95,289)	+22% (+31,037)
Drop out from DTP1 to DTP3 at national level[1]	3	4	3	0.00%	-33.33%
Drop out from DTP1 to last routine dose of MCV at national level[1]	25	14	8	-212.50%	-75.00%
Percentage of health facilities that reported no stock-outs for the full year for DTP[2]	Not available	Not available	Not available		

[1]Source: WHO/UNICEF Estimates of National Immunisation Coverage (WUENIC), July 2022. https://immunisationdata.who.int/listing.html?topic=coverage

[2]Country data as reported to WHO/UNICEF through the electronic Joint Reporting Form (eJRF), July 2022. https://www.who.int/teams/immunisation-vaccines-and-biologicals/immunisation-analysis-and-insights/global-monitoring/who-unicef-joint-reporting-process

Country comments (please consider the set of cross-cutting questions to structure comments):

The country is making efforts to reach zero dose and under-immunised children. Some efforts are targeted approaches through the country's HSS and EAF grants in 23 districts which is just starting off. Additionally, the country through the Big Catch Up is working to reach these children through enhanced efforts to reach children who have missed doses of vaccines.

Some of the specific activities include:

- Mapped zero dose children through the recent nationwide MR SIA in September 2024.
- Developed routine immunisation tracker to assist in documenting zero dose and under immunised children to be rolled out during the BCU.
- Hold Bi-annual EPI (child health week) in June and November.
- Routine weekly outreach to underserved communities.

2. Learning Question: How well are vaccine stocks being managed?

Indicator(s):

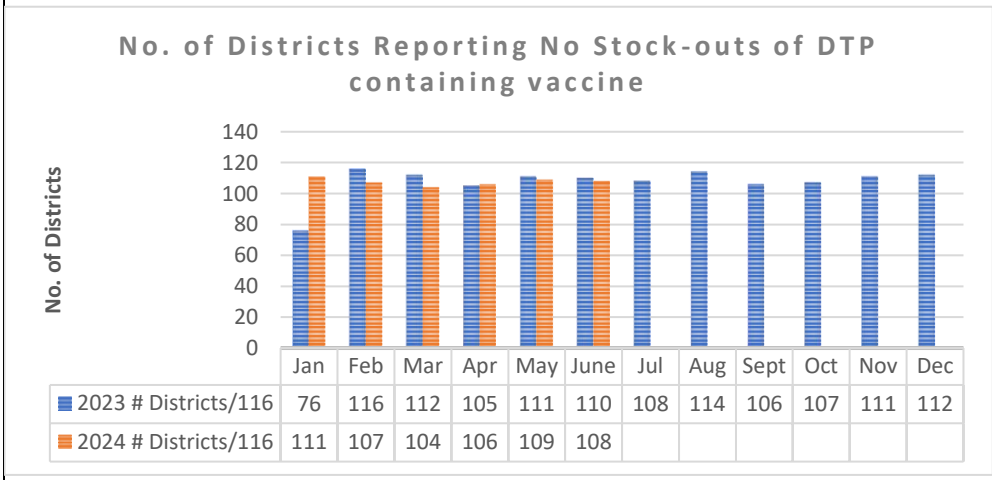
- Number of health facilities that reported no stock-outs of DTP containing vaccine
- Number of health facilities that reported no stock-outs of Measles containing vaccine
- Closed vial wastage of DTP-containing vaccine
- Number of CCE received/installed/ leased through third party providers.
- Equipment maintenance and/or onsite readiness.
- Cumulative volume of C19 doses expired to date (and volume specific to COVAX supported doses, if the data is available)

Graphs:

Country comments (please consider the set of cross-cutting questions to structure comments):

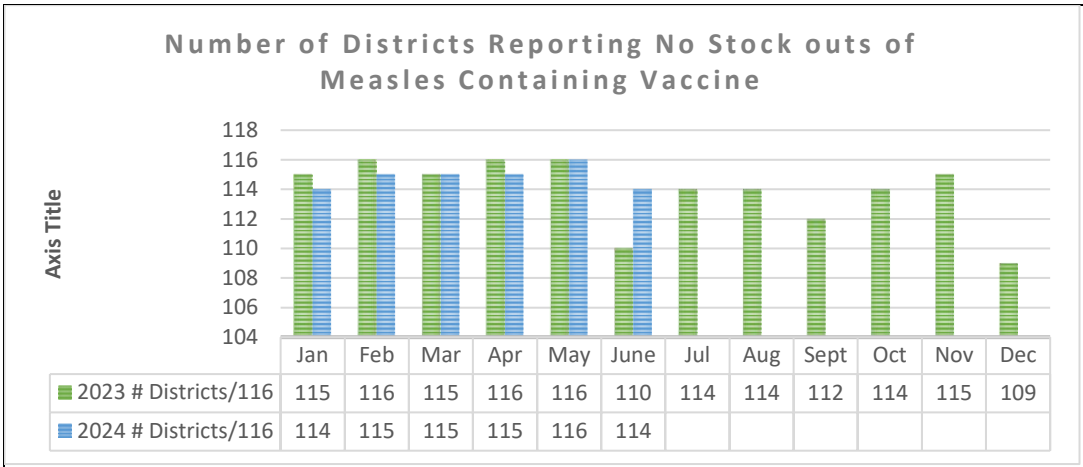
Monthly monitoring was conducted using a google sheet reporting system, which reports contribute to the Thrive360 global vaccine stock visibility system.

As of the 2024 Joint Appraisal, Zambia did not have a stock management systems that provides adequate visibility of stocks at the health facility level. However, based on monitoring, most districts were reporting no stocks of both Penta and MR vaccines. Based on figure below, January 2023 was most severely impacted in terms of Penta vaccine stocks.



	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec
2023 # Districts/116	76	116	112	105	111	110	108	114	106	107	111	112
2024 # Districts/116	111	107	104	106	109	108						

There were adequate stocks of measles containing vaccines, with on average less than 5 districts reporting stock outs monthly.

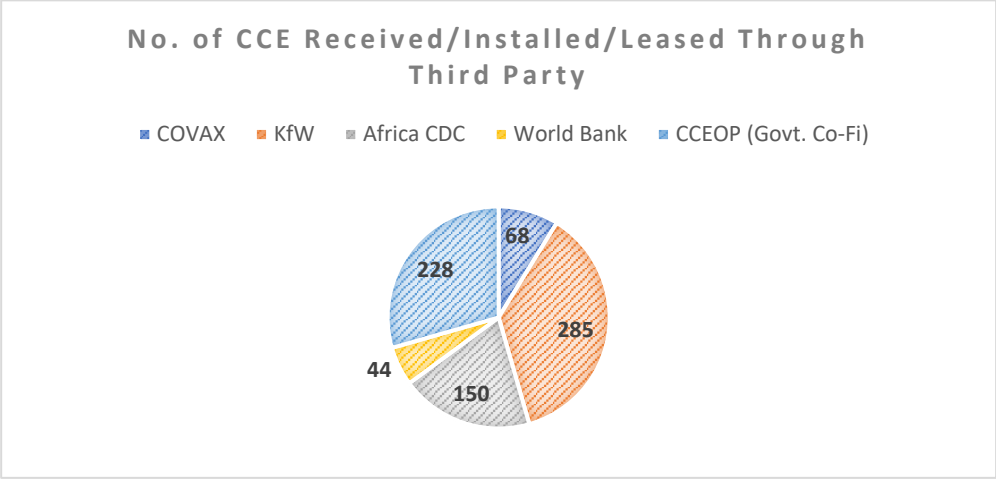


The stockout experienced in 2024 was mainly attributed to the National level stock out of Penta that resulted in the preponement of 2023 stocks towards the end of December 2024 and delays in subsequent distribution of these doses. The other reason for the stockout for some districts for Penta and Measles Containing Vaccines was a challenge in country distribution and stock management especially at subnational levels.

During the period under review there was no closed vial wastage reported for DTP-containing vaccines recorded.

Number of CCE received/installed/ leased through third party

The MOH, with support from cooperating partners, continued to implement the cold chain expansion and scale up strategy to help strengthen the effective management of vaccines at all levels. Several CCE have been procured, received and installed from 2023 to the second quarter of 2024. The graph below shows the share of the 775 vaccine refrigerators received by Government and partners.



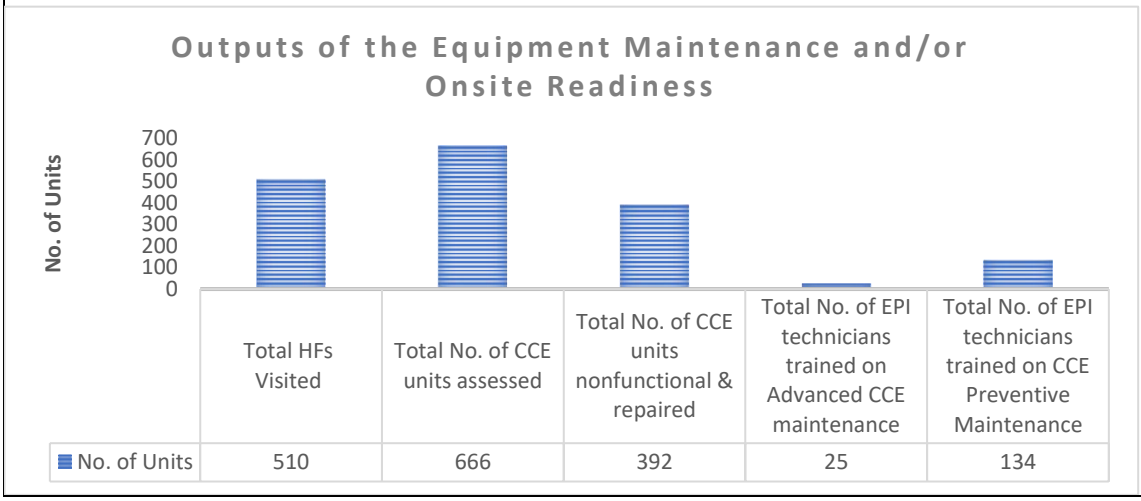
Equipment maintenance and/or onsite readiness

The MoH, through the EPI, with support from the United States Agency for International Development (USAID), partnered with the Project Last Mile (PLM) to obtain technical support and develop tailored strategies for managing regular cold and ultra-cold supply chains and to reduce the risk for COVID-19 and other vaccine wastage during storage and distribution processes.

In the current maintenance service structure, CCE services are managed by the Provincial and District Cold Chain technicians at each level, with spare parts supplied from the National Cold Chain Warehouse upon approval by the Permanent Secretary.

PLM programme activities assessed 510 health facilities for operational CCE, with 666 CCE units assessed during these HF visits. Of these, 392 CCE units that were non-functional were repaired, 25 EPI technicians

were trained on advanced CCE maintenance, 134 EPI technicians were trained on CCE Planned Preventive Maintenance. See the graph below for the completed activities.

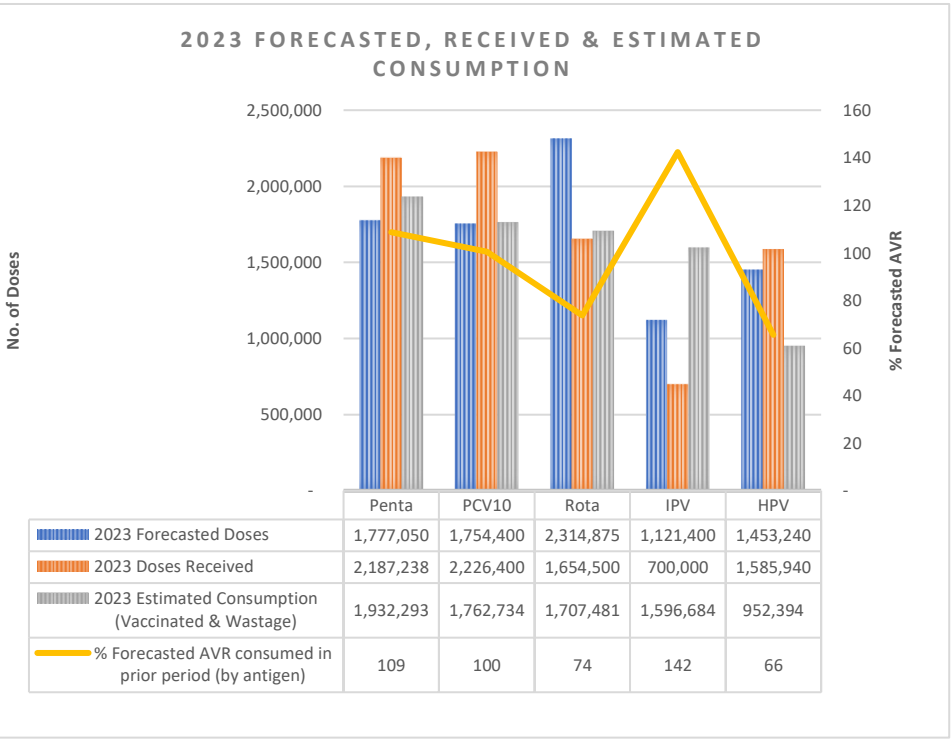


3. Learning Question: Are vaccines being consumed at rates that are in-line with approved forecasts? What are the key drivers of consumption compared to expectation (e.g., stockouts, increased coverage, wastage)?

Indicator(s):

- Percentage of forecasted Annual Vaccine Requirement (AVR) consumed in prior period (by antigen)

Graphs:



Country comments (please consider the set of cross-cutting questions to structure comments):

In 2023, the country received vaccines in excess of the forecasted doses for Penta, PCV, and HPV. Part of the doses received in 2023 for PCV and Penta were the 2022 co-financed stocks received late due to the delays if meeting co-financed funding. In the case of Rota, Gavi co-financed doses for 2022 remained unutilised until the rota April 2023. For HPV, the 2023 stock balance included the 2022 co-financed doses as they were received in 2023, along with the HPV MAC doses.

The country further received, 200,000 doses frontloaded from the 2024 allocation for IPV, and 621,400 doses of the 2023 allocation were preponed in 2022. This resulted in more IPV doses available and consumed in 2023, beyond the 2023 forecasted and received doses.

Another vaccine which had several preponements made in prior years is Penta. In 2022, a total of 221,262 doses from the 2023 allocation were frontloaded and 250,000 doses from the 2024 allocation were received in 2023. These vaccines formed part of the available doses for 2023.

There were more Rota doses forecasted for 2023 compared to the vaccine receipts and estimated consumption (vaccinated and wastage). This was affected by prior procured but undelivered doses (from 2021, 2022 and 2023) due to the delays in the switch which was implemented in April 2023.

4. Learning Question: Is the country complying with co-financing requirements in a timely manner?

Indicator(s):	**Graphs:**
● Country co-financing obligation met in a timely manner	

Country comments:

Zambia's 2023 co-financing obligation, inclusive of all shipping costs, was US$3,073,146.55 and for 2024 it was US$2,749,905.22. The country fulfilled its co-financing obligation in full before the end of quarter 2 as per the agreement during the MOH and Gavi side meeting held at the 2022 World Health Assembly.

Zambia re-entered the preparatory transition phase as of 1 January 2024. Prior to that Zambia had been in the preparatory transition phase in 2022, but due to economic circumstances, returned to initial self-financing phase in 2023.

The year 2024 served as a grace year for Zambia's re-entry into preparatory transition, therefore the cofinancing was at the rate of initial self-financing.

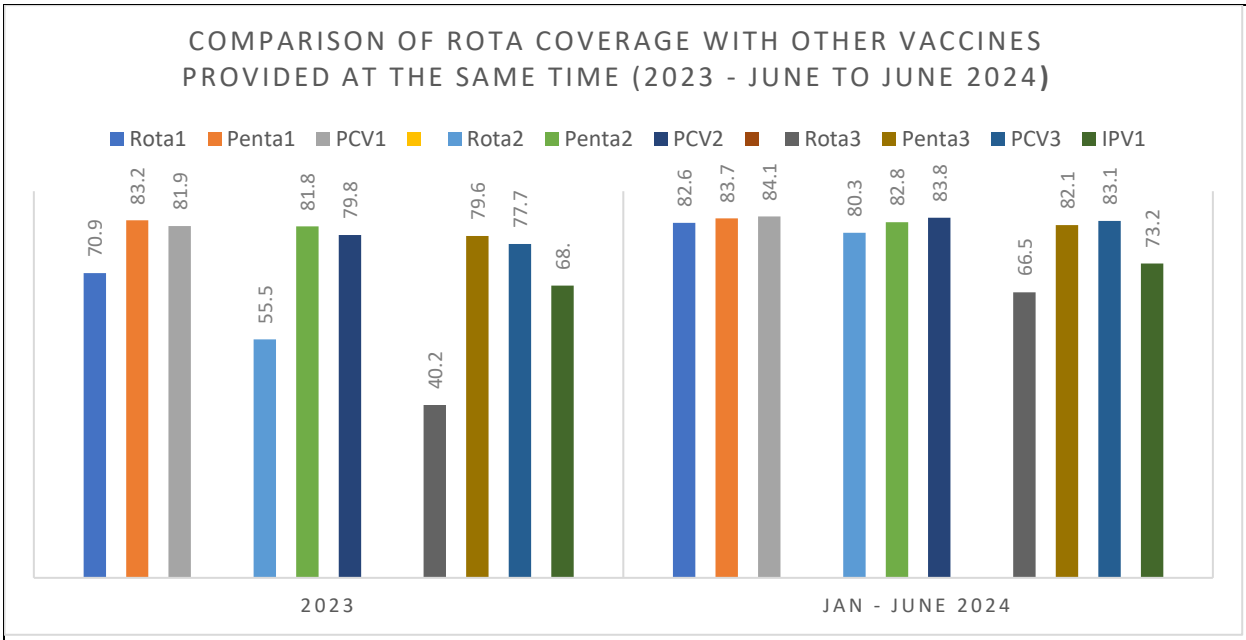
The country further notes that the disparities between forecasted and consumption are due to differences in the target population estimates used during the Multi Year Vaccine Renewal Application Process (2023 - 27) in 2022 using the census projected 2023 target population. The 2023 projected target population used for the projections was 696,995 live birth and 669,951 surviving infants, whereas the 2023 census projected the population as 877,840 live births and 856,372 surviving infants. The 2023 projected coverages used were also higher than the actual coverage reported in 2023.

5. Learning Question: If applicable, have new vaccines been introduced as planned and if not, why? Is coverage of recently introduced vaccines being scaled-up as expected?

Indicator(s):	**Graphs:**
● Number of routine introductions completed over number of targets set for the calendar year ● Coverage of recently introduced vaccines In addition, forecasted routine introduction & campaign dates should be validated during the JA discussion	

Country comments (please consider the set of cross-cutting questions to structure comments):

In April 2023, the country re-introduced rotavirus vaccines into the national EPI following almost a year's stock out of the vaccines due to global supply constraints. The re-introduction was also a switch from Rotarix vaccines (2-dose schedule) to Rotavac (3-dose schedule). The country also introduced novel Oral Poliovirus Vaccine Type 2 (nOPV2) for responding to circulating vaccine derived polio virus type 2 (cVDPV2). A total of 5 vaccination rounds were conducted since its introduction.



There has been significant improvement in rotavirus vaccine coverage across all three doses between January to June 2024 as can be seen in the graph above. However, during the period under review, rotavirus vaccine coverage was noted to lag other vaccines given at the same time. This gap in comparison with other vaccines was noted to have reduced for Dose 1 and 2 but remained significant for Dose 3.

6. Learning Question: If relevant, how effective have recent Gavi supported vaccination campaigns been?[1] Please highlight lessons learned which are applicable for routine immunisation and upcoming campaigns (e.g., timeliness of outbreak response, quality, campaign reach and link back to strengthening routine immunisation).

Indicator(s):

- Number of vaccination campaigns conducted (stratified by type of campaigns, including preventive, reactive, catch-up, follow-up, sub-national and national)
- Coverage of recent Gavi-supported campaigns, compared to target (coverage rate disaggregated by sex if collected)
- Number of reported outbreaks of vaccine-preventable diseases (for which GAVI supports with reactive campaigns)

Graphs:

Country comments (please consider the set of cross-cutting questions to structure comments):

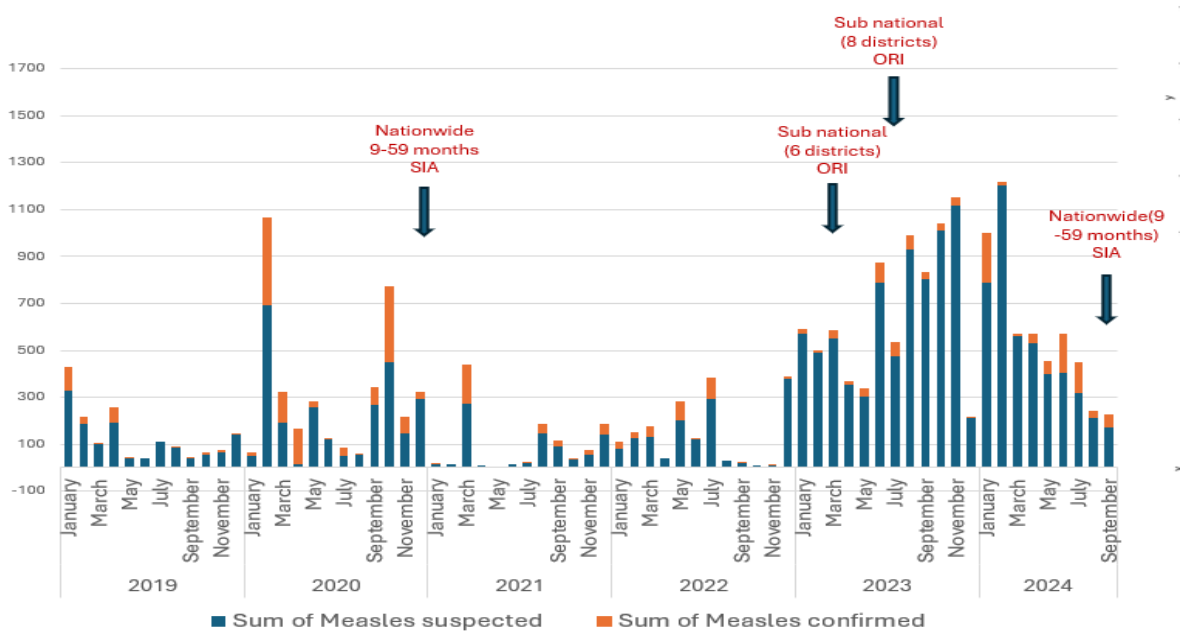
The country has received enormous support from Gavi over the years for implementation of various outbreak responses such as cholera, measles, and polio.

MEASLES

Zambia has experienced a significant measles outbreak over the past three years, spanning from 2022 to 2024. During this period, a total of 14,071 suspected measles cases were reported, of which 1,137 were laboratory-confirmed. Tragically, the outbreak resulted in 37 deaths, underscoring the severe public health implications of this highly contagious disease.

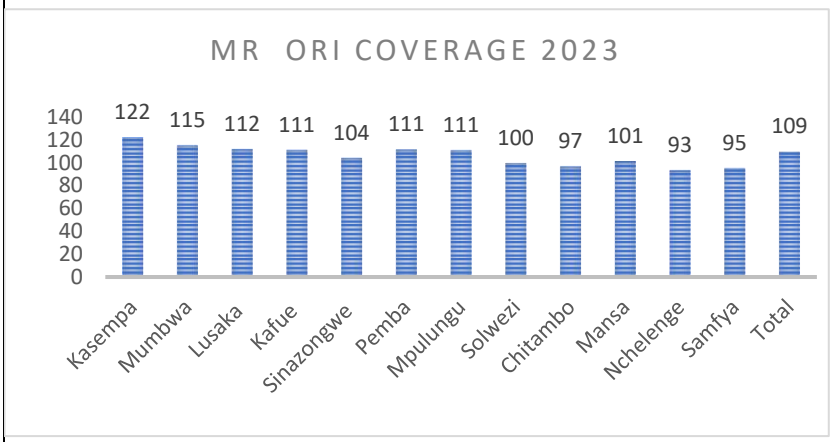
The outbreak affected 105 out of the country's 116 districts, highlighting its extensive geographic spread. Children under the age of five were disproportionately impacted, comprising 48.5% of the total cases, emphasizing the vulnerability of this age group. Gender distribution showed a slightly higher proportion of cases among females (52.05%) compared to males (47.95%).

[1] Please reflect on those campaigns conducted since the last Joint Appraisal/Multi-Stakeholder Dialogue exercise.

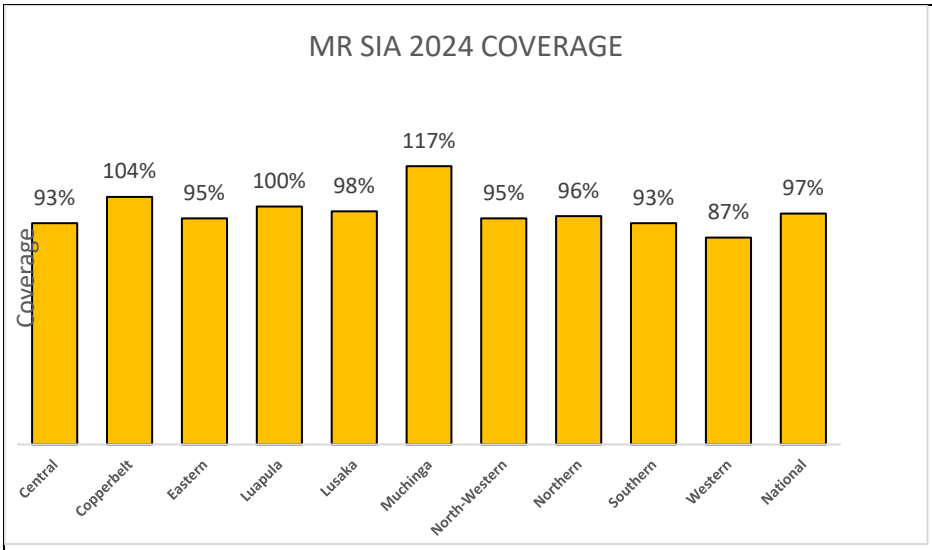


Source: ZNPHI

The country applied for support to implement MR ORI as one of the tools to respond to outbreak in 2022 in selected districts. This was implemented in 11 districts between January and November 2023.



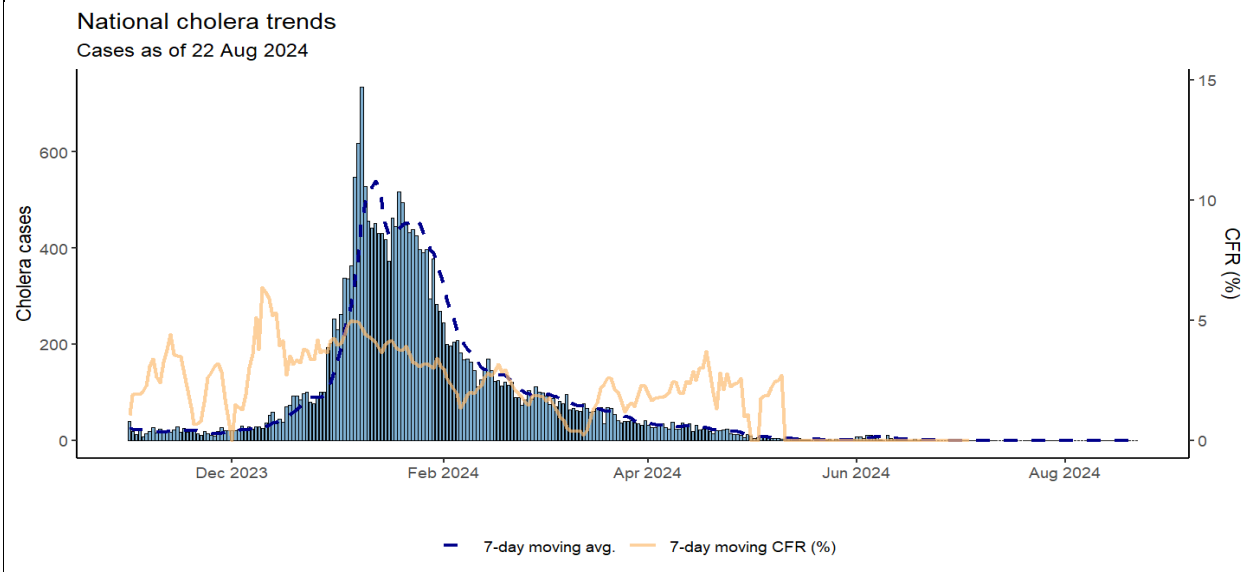
The country conducted a nationwide MR SIA targeting under 5 children from 26-31 August 2024 achieving 97% administrative coverage. The highest was Muchinga with 117% and lowest being Western at 87% coverage as seen in the graph below. . A total of 75 districts achieved minimum required target of 95% with the majority of these from Western province (88%).

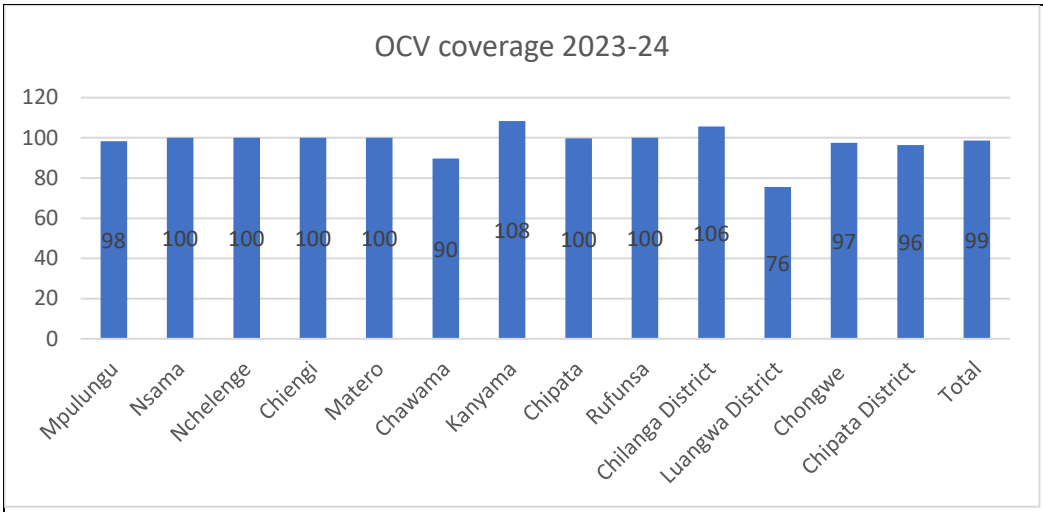


CHOLERA

The most recent cholera outbreak in Zambia, spanning October 2023 to June 2024, emerged as the most severe and largest in the nation's history, with 23,277 cases and 740 deaths (CFR: 3.2%). The CFR significantly exceeded the WHO-recommended case fatality threshold of under 1%. Lusaka Province bore the greatest burden, accounting for 76% of cases (17,809) and 77% of deaths (570), with a concerning 74% of deaths (322) occurring in the community. Copperbelt Province, the second-most affected region, reported 2,126 cases and 69 deaths, with Ndola, Kitwe, and Chililabombwe districts most severely impacted.

- Zambia deployed a total of 2,652,747 oral cholera vaccine (OCV) doses between June 2023-June 2024 responding to the outbreak.
- OCV post campaign coverage survey for the 2024 OCV outbreak response in Lusaka district where more than 80% of OCV vaccines were deployed the estimated coverage was 78% (1-4 yrs); 81% (5-14yrs) and 66% (>15 yrs old)
- Mpulungu, Nsama, Nchelenge and Chienge vaccinated in 2023, the rest in 2024.
- The response in all districts was a percent of the population based on doses allocated, except for Nsama, Chawama, Chipata SD, Luangwa and Chipata districts which targeted the entire eligible population.





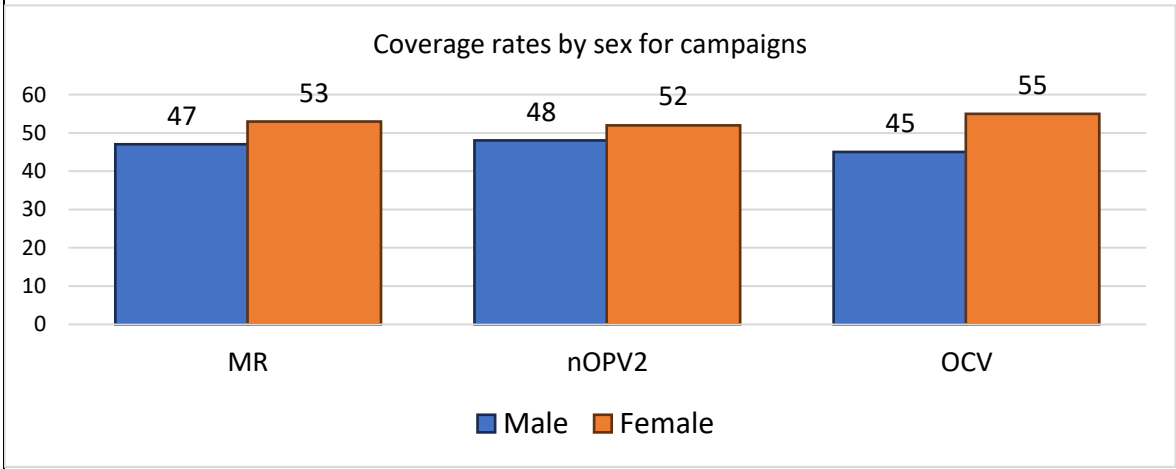
POLIO

The country also responded to wild type polio virus (WPV1) and circulating vaccine derived polio virus type 2 (cVDPV2) following detection of WPV1 in Malawi and isolation of cVDPV2 in Kitwe and Lusaka districts, as well as a case in Mpulungu in a 7-year-old child. In response to these outbreaks, the country conducted vaccination campaigns achieving good administration coverage as shown in the table below.

Polio campaign coverage 2023-24

Province	bOPV		nOPV2									
	R5		R1		R2		R3		R4		R1	
	<5 Yrs Vaccinated	Coverage %	<5 Yrs Vaccinated	Coverage %	<5 Yrs Vaccinated	Coverage %	<8 Yrs Vaccinated	Coverage %	<8 Yrs Vaccinated	Coverage %	<5 Yrs Vaccinated	Coverage %
Central	586,873	109%	560,207	107%	597,771	107%					612,561	102%
Eastern	882,360	103%					880,065	96%	940,193	107%		
Copperbelt	635,247	105%	882,320	107%	913,490	104%					865,864	95%
Luapula	436,328	109%	419,974	107%	438,642	104%	629,080	106%	654,601	104%	452,420	103%
Lusaka	1,626,418	109%					1,952,322	86%	2,351,434	120%		
Muchinga	278,159	105%					385,976	96%	409,338	106%		
North-Western	345,471	109%	338,754	107%	347,131	102%					337,381	97%
Northern	543,780	105%					763,649	98%	791,148	104%		
Southern	557,244	110%					788,057	104%	814,410	103%		
Western	323,459	106%					458,723	100%	472,673	103%		
National	6,215,339	107%	2,201,255	107%	2,297,034	104%	5,857,872	95%	6,433,797	110%	2,268,226	99%

The table below provides coverage rates for each of the campaigns disaggregated by sex.



Campaign lessons learnt

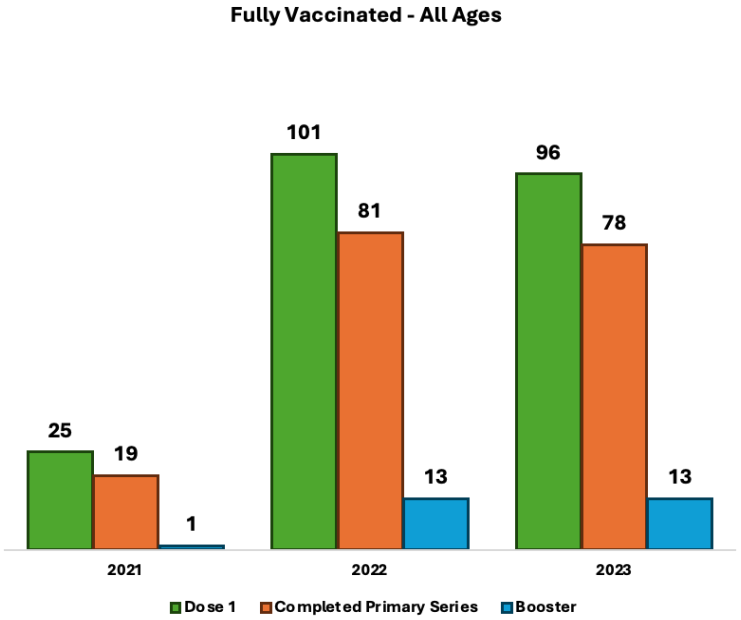
- Identification of zero dose children at lower levels during campaigns resulted in linking the underserved children to care.
- Strong partner coordination and involvement improved campaign performance.

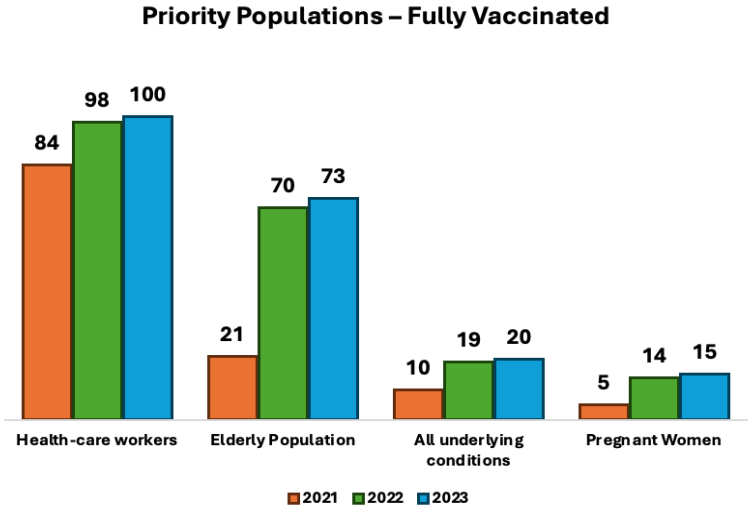
7. Learning Question: What is the current status of your COVID-19 vaccination?

Indicator(s):

- Report and reflect on progress in uptake, with particular emphasis on older adults, health workers and other high-priority population group (as defined by WHO SAGE guidance). Analyse both primary series uptake and boosting.
- Describe if and how the country is integrating delivery of COVID-19 vaccine with routine immunisation & other primary health care services, including reflecting on how Gavi CDS has been used to support these integration efforts (if applicable).
- How have CDS funds been used to strengthen broader RI efforts beyond COVID-19?

Graphs:





Country comments (please consider the set of cross-cutting questions to structure comments):

All-age fully vaccinated coverage in 2023 was 96% for dose 1 and 78% for dose 2. This was down from 2022, where coverage was 101% for dose 1 and 81% for dose 2. Booster doses for both 2022 and 2023 was 13% coverage.

For health care workers, fully vaccinated coverage between 2021-2023 was 84%, 98% and 100% respectively for the elderly population in the same years, coverage was 21%, 70% and 73%, respectively. For individuals with underlying conditions, coverage was 10%, 19% and 20%, respectively. Finally for pregnant women, coverage was 5%, 14% and 15% for the same time frames.

COVID-19 vaccination updates

- There has been low demand for C-19 vaccination after completion of the campaigns conducted in the country.
- The severity of C-19 in the country has declined as the disease has been managed and reduced levels of mortality recorded.

- Options of C-19 vaccine commodities are limited, as most C-19 vaccine options are not available or in stock.

- C-19 vaccination integration validation and dissemination of guidelines drafted, but not finalised.
- Key recommendations from the C-19 integration pilot was for clinic attendees to be screened for C-19 status and unvaccinated and partially vaccinated high risk/priority groups identified.
    - Over 10,000 clients vaccinated during the pilot with most clients vaccinated from the Outpatient Department (OPD) and ART/HIV departments.

Integration recommendations

- Leverage ART clinics for uptake.
- Investment in HRH.
- Ongoing monitoring of vaccination status by updating OPD registers to capture and track vaccination status for high-risk groups.
- Vaccination status prompt in SmartCare to be made mandatory field prompting continued tracking of vaccination uptake/status.
  Adoption of peer-to-peer demand creation modality.

Next steps for C-19 vaccination

- Finalisation and dissemination of COVID-19 integration guidelines.
- Conduct assessments of CCE needs in hospitals.
- Strengthen demand generation activities focusing on high priority-use population.
- Support for data collection and reporting.
- Commodity security assurance and distribution.

With regards to how CDS funds have been used to strengthen RI efforts, the country has developed an EPI Recovery plan—known as the Big Catch-up (BCU). This plan targets children who have missed vaccinations, aims to restore vaccination rates, and strengthens Primary Health Care systems to reach zero dose children. The plan has been approved and funds have been CDS funds have been reprogramed to aid in this effort.

8. Learning Question: Trajectory and progress against targets set

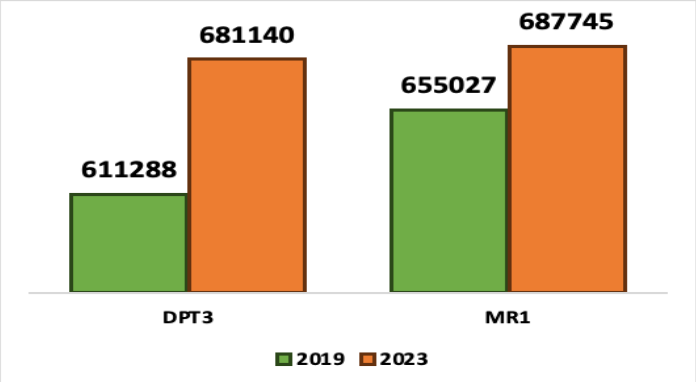
- **How does the progress over the past year compare with your Theory of Change or programme objectives?**
- How has **COVID-19** and **COVID-19 vaccination** impacted your routine immunisation programme, what has been done to maintain and restore immunisation and what has been the impact of it (please include reference to trends in DTP3 and MCV1 coverage)?
- If there are **other factors** (e.g., government transitions, natural disasters, other disease outbreaks, etc.) which have led to disruptions in your immunisation programme over the last year, please also reflect on those.

Indicator(s):

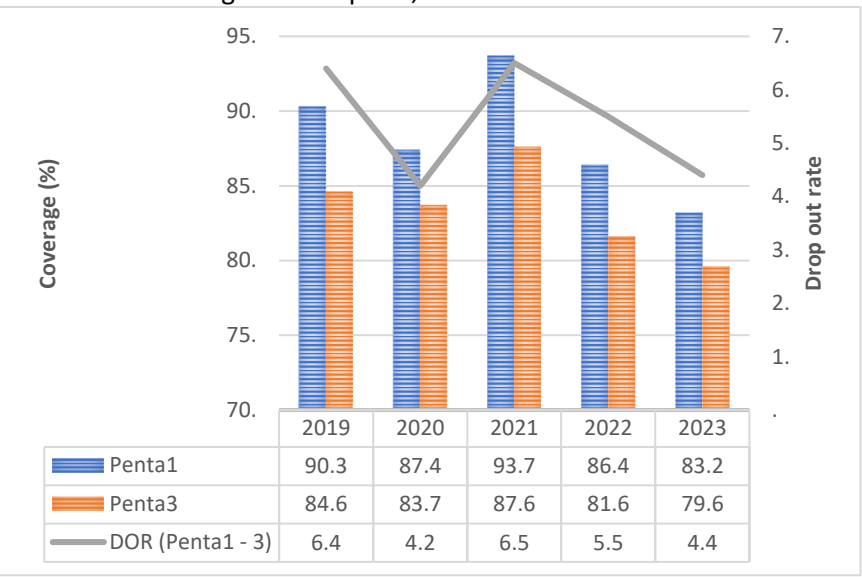
- Number of children who received DTP3 and the number of children who received MCV1 in the past year compared to the number who received those vaccines in 2019.
- Qualitative information

Graphs:

# of children who received DPT3 and MR1, 2019 and 2023

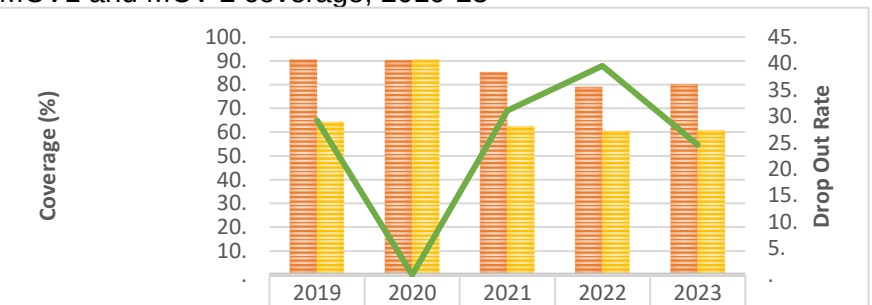


DPT1 and 3 coverage and drop out, 2019-23



	2019	2020	2021	2022	2023
Penta1	90.3	87.4	93.7	86.4	83.2
Penta3	84.6	83.7	87.6	81.6	79.6
DOR (Penta1 - 3)	6.4	4.2	6.5	5.5	4.4

MCV1 and MCV 2 coverage, 2019-23



	2019	2020	2021	2022	2023
MCV1	90.6	90.2	85.3	79.	80.3
MCV2	64.1	90.2	62.3	60.3	60.6
DOR (MCV1 - 2)	29.23	0	31.1	39.55	24.59

Country comments (please consider the set of cross-cutting questions to structure comments):

A comparison of the 2019 and 2023 coverages for Penta3 and MCV1 indicate an additional 69,856 and 32,719 more children vaccination post-COVID-19. However, comparing the coverage rates indicates that the vaccination rates for these vaccines have not yet been restored to post the COVID-19 coverage rates. The 2023 coverage for Penta3 and MCV1 stood at 80% and 80% respectively compared to 85% and 91%, respectively.

	2019	2023
No. of Children Vaccinated (Penta3)	611,288	681,144
No. of Children Vaccinated (MCV1)	655,027	687,746
Target Population	722,804	856,001
Penta3 Cov	84.6%	79.6%
MCV1 Cov	90.6%	80.3%

Looking at the trends of the vaccination coverage from 2019 to 2023, indicate very not much impact on 2021 but a significant decline for Penta 3 coverage in 2022 and 2023 and stagnation on MCV coverage for both doses over the same duration. The country, however, notes that the decline in coverage commenced prior to COVID-19.

Over the recent years, Zambia has experienced has been responding to multiple vaccine preventable disease outbreaks which include Polio, Measles, Cholera and Mumps. During the period under review, Zambia

conducted outbreak responses immunisation for polio, measles and cholera which included expanded targets. These activities were perceived to have taken a lot of staff time and focus away from routine immunisation and other Primary Health Care services. Currently, Zambia is also experiencing a drought which has called response activities in about 84 severely affected districts countrywide. This is anticipated to cause an increase in several diseases such as diarrhoea, malaria, measles and malnutrition. Through the surveillance, the country has already noted an increase in the number of non-bloody diarrhoea cases.

During the period under review, the programme had not fully initiated the Theory of Change in targeted districts.

It is noted that while currently COVID-19 vaccination has minimal disruption on the routine immunisation programme as C-19 vaccination is very low. During the peak of the pandemic, as well as during high C-19 vaccination, the country experienced declines in routine immunisation coverage as well as other PHC services. This is attributed to fear of going to clinics, work and school closures, a focus on vaccination for C-19, and vaccine hesitancy due to myths and rumours.

To maintain and restore immunisation, Zambia plans to implement the Big Catch-up vaccination to reach children missed from 2019 and 2023. Additionally, the country will implement the Theory of Charge as part of the National Immunisation Strategy (2022-26) in 23 priority districts which were noted to have high numbers of Zero Dose Children. In non-Gavi HSS supported districts, the country will replicate a complement of strategies as highlighted in the National Immunisation Strategies such as provision of appropriate transport, improved microplanning, capacity building and tailored advocacy, communication and social mobilisation activities, among others within the scope of available support.

Additionally, as part of the country's JA discussions, it was identified that based on more recent data (since the FPP submission) there are 9 additional districts in the top 23 high zero dose children districts that require additional attention. Part of the additional support for these 9 districts will be the full roll out of the HSS GIS digital microplanning with support from Akros.

B. Programme Management
Financial implementation of Gavi cash grants

Cash[2] Support Summary*

Grant	Recipient	Period	Status as of 30 September 2024					Cash Bal	Compliance**	
			Grant Value	Appr.	Disb.	Expenditure	Utilisation (in %)		Fin. Rep	Audit
CDS NB	CHAZ		1,999,303	1,999,303	1,999,303	1,435,824	72%	563,209		
CDS NB	CIDRZ	Dec 2022-Dec 2025	3,124,107	3,124,107	3,124,107	2,374,369	76%	749,738		
CDS NB	UNICEF		601,969	601,969	601,969	587,730	98%	0		
CDS NB	WHO		989,286	989,286	989,286	891,905	90%	97,381		
			6,714,665	**6,714,665**	**6,714,665**	**5,354,674**	**80%**			
CDS3	CHAZ		1,281,067	1,281,067	583,293	45,042	8%	538,251		
CDS3	CIDRZ	Feb 23-Dec 25	5,286,661	5,286,661	2,419,261	275,268	11%	2,143,993		
CDS3	UNICEF		4,107,688	4,107,688		2,207,323				
CDS3	WHO		846,296	846,296		12,227				
			11,521,712	**11,521,712**		**2,539,860**				
HSS	CHAZ		1,332,806	,332,806	479,581	507,838	106%	-28,257		
HSS	CIDRZ	Mar 24-Dec 26	1,048,778	1,048,778	805,687	146,219	14%	658,468		
HSS	MOH		839,517	839,517	518,469	35,107	7%	483,362		
HSS	UNICEF	2023-2025	2,244,055	2,244,055	2,244,055	540,563	24%	1,703,493		
HSS	WHO		2,356,817	2,356,817	2,202,633	20,530	1%	2,182,103		
			7,821,973	**7,821,973**	**6,250,425**	**1,250,257**	20%			

[2] All HSIS grants (HSS, VIGs, OPS, Switch), EAF and CDS cash support as applicable.

EAF	CHAZ		669,656	669,656	125,585	168,918	135%	-43,333		
EAF	CIDRZ	Mar 24-Dec 26	1,048,794	1,048,794		0	0%	1,048,794		
EAF	MOH		638,794	638,794	415,962	0	0%	415,962		
EAF	UNICEF	2023-2025	331,160	331,160	331,160	0	0%	331,160		
EAF	WHO		Added to HSS funds							
			2,688,404	**2,688,404**						
ITU	CHAZ		788,783	788,783	236,635	271,541	115%	-34,906		
ITU	CIDRZ	Mar 24-Dec 26	576,492	576,492		0	0%	576,492		
ITU	MOH		131,837	131,837	131,837	0	0%	131,837		
ITU	UNICEF	2023-2025	Added to EAF funds							
ITU	WHO		Added to HSS funds							
			1,497,112	**1,497,112**						
PEF TCA	CHAZ		458,087	458,087	96,128	85,778	89%	10,350		
PEF TCA	CIDRZ	Mar 2024 -Dec 2025	901,203	901,203	300,401	114,912	13%	185,489		
PEF TCA	UNICEF	2023-2024	620,818	620,818	620,818	620,818	100%	0		
PEF TCA	WHO		653,342	653,342		52,000	8%			
			2,729,097	**2,729,097**		**873,508**	***32%***			
HPV TCA	CHAZ		109,890	109,890	54,900	26,263	48%	28,637		
HPV TCA	CIDRZ	Dec 23-Nov 25	237,172	237,172	237,172	116,294	53%	120,878		
HPV TCA	UNICEF	2023-2025	120,000	120,000	120,000	6,379	5%	113,621		
HPV TCA	WHO		64,867	64,867	64,867	0	0%	64,867		
			531,929	**531,929**		**148,936**				

MR SIA	CHAZ		107,119	107,119	107,119	53,386	50%	53,733		
MR SIA	CIDRZ	Sep 24-Dec 25	1,033,047	1,033,047	1,033,047	360,494	35%	672,553		
MR SIA	MOH		23,819	23,819	23,819	0	0%	23,819		
MR SIA	UNICEF	2023-2025	709,524	709,524	709,524	708,195	100%	1,329		
MR SIA	WHO		682,044	682,044	682,044	588,861	86%	93,193		
			2,555,553	**2,555,553**	**2,555,553**	**2,204,895**	**85%**			
HPV HSS	CHAZ		107,128	107,128	107,128	20,818	19%	86,310		
HPV HSS	CIDRZ	Mar 24-Dec 26	225,009	225,009	225,009	0	0%	225,009		
HPV HSS	MOH		79,034	79,034	78,999	0	0%	78,999		
HPV HSS	UNICEF	2023-2025	133,909	133,909	133,909	101,400	76%	32,509		
HPV HSS	WHO		172,483	172,483	172,483	0	0%	172,483		
			717,563	**717,563**	**717,563**	**122,218**	**17%**			
HPV VIG	CHAZ		25,470	25,470	25,470	0	0%	25,470		
HPV VIG	UNICEF		144,621	144,621						
HPV VIG	WHO		69,408	69,408	69,408	0	0%	69,408		
			239,499	**239,499**						
IPV2	UNICEF	2023-2025	121,301	121,301	121,301	17,894	15%	103,407		
IPV2	WHO		145,541	145,541	145,541	124,990	86%	20,551		
			266,842	**266,842**	**266,842**	**142,884**	***54%***			
OCV	WHO	2 2024 Grants	2,449,719	2,449,719	2,449,719	956,715	40%	1,143,917		
MR ORI	WHO		633,285	633,285	633,285	633,200	100%	85		
Rota switch	CIDRZ	Mar 23-Dec 25	337,754	337,754	337,754	153,728	46%	184,026		

*All amounts are in USD

**Comment below in case of non-compliance

9. Learning Question: How well is the country able to absorb Gavi funding and what are the drivers? (This should cover all funding including funds channelled through partners.)

- Comment on the financial implementation progress of grants including but not limited to the utilisation rates. What are the key issues?

Indicator(s):	
• Percentage of grant funds utilised • Amount of cash balance in-country	

Country comments:

Over the past year there have been delays in spending on grants. This is mainly attributed to changes in country programming and approvals for the BCU, project inceptions, responding to VPD outbreaks (cholera, polio, measles) and proposal writing for new grants. It is anticipated this will improve significantly towards the end of 2024 and beginning of 2025 as most submissions have been completed and inception processes are well underway. The burn off rates for the total grant are as follows:

- CDS needs based - 80% expenditure with remainder of activities to be utilised in the BCU
- CDS3 - 22% expenditure with majority of funds reprogrammed for BCU
- HSS – 16% expenditure
- EAF - 6% expenditure
- ITU - 18% expenditure
- PEF TCA - 32% expenditure
- HPV TCA - 28% expenditure
- MR SIA – 86% expenditure
- HPV HSS – 17% expenditure
- HPV VIG - 0% expenditure
- IPV2 – 54% expenditure
- Rota switch – 46% expenditure
- OCV – 40% expenditure
- MR ORI – 100% expenditure

10. Learning Question: How well is the country resolving issues arising from assurance activities? What issues are left to solve and what is the path forward?

Currently the programme and financial capacity assessment are ongoing, and any issues raised are being addressed. The path forward: Improvements to enhance accountability, minimise risks, and foster a more resilient assurance framework, ultimately leading to stronger public trust and effective programme implementation.

What is the progress of Grant Management Requirements implementation?

Zambia has made significant progress in implementing Grant Management Requirements for Gavi support, focusing on enhancing financial management, programme oversight, and health system strengthening.

How has the country addressed recommendations arising from past audit recommendations (annual external audits + Gavi Programme Audit)?

- To ensure adequate follow up on implementation of audit recommendations, MoH/EPI management makes sure that regular monitoring and validation mechanism is in place supported by scheduled/periodic status update meetings
- All internal audit recommendations are followed up and these are reviewed by the Internal Audit Oversight Committee.
- Management actions in the internal audit management letters are followed up in a timely manner.

Improvements that have been made to financial management and risk assurance activities with support of assurance providers (e.g., Fiscal Agents, Monitoring Agents, Financial Management TA)?

- Financial Management in the public sector is guided by the Public Finance Management Act No. 1 of 2018 and the Public Financial Management (General) Regulations of 2020.

- These documents have been shared with all the subnational accountants and were explained during the HSS3 inception orientation.

What actions have been taken to enable a larger % of Gavi funds to be channelled back through government systems?

- The Government also shares the internal management reports on the use of funds on a quarterly basis with GAVI.
- The Government submits all documents relevant to annual health sector reviews as requested by GAVI.

Country comments:

PricewaterhouseCooper (PwC) was appointed as the Assurance Service Provider for Zambia for the period of 1 January 2024 to 31 December 2025. At the time of the Joint Appraisal, Zambia was undergoing the programme and financial capacity assessment are ongoing, and any issues raised are being addressed.

Zambia received an updated copy of the updated copy of the Grant Management Requirements (GMRs) which was reviewed with key observed noted for further clarification and correction. However, there was progress on the implementation of some of the requirements while on others such as recruitment of the Gavi HSS Coordinator and Gavi Accountant had been delayed. Clarifications were sought on the reporting frequency as some of the contracts indicated a biannual reporting period while the GMRs reflected quarterly reporting. The GMRs also indicated the position of an MOH M&E Specialist which was not initially planned in the HSS and thus did not have budgetary support.

The country has continued to adopt and follow up on the audit recommendations from the annual external audit and Gavi Programme Audit recommendations. This was further verified during the additional Gavi mission held in June 2024. The programme continues to follow up on the implementation and adherence to the Public Finance Management Act No. 1 of 2028.

Actions that have been taken to enable a larger percentage of Gavi funds to be channelled back through government systems include enhanced programme coordination and oversighted through the established Planning and Coordination subcommittee that meets monthly to review, monitor, and assess the implementation of Gavi supported activities. Additionally, the ongoing Programme Capacity Assessment is being conducted to assess government systems and the possibility of increase funds to be channelled through government systems.

11. Learning Question: Please comment on any other financial management-related bottlenecks for implementation and compliance.

Country comments:

The country faced the following additional finance related bottleneck during period under review:

1. Delayed recruitment of a programme finance officer leading to budget execution delays and challenges in development and submission of financial reports from MoH.
2. Lack of a project implementation unit with a dedicated team of officers to track activity and budget implementation status.
3. adequate visibility and communication following contracting and resource disbursement to sub-recipients making it difficult for MoH to track funds for activity implementation

12. Learning Question: Is the country effectively addressing gender related barriers (e.g. faced by caregivers or adolescents in accessing immunisation services and barriers faced by health workers in delivering immunisation services)?

Indicator(s):	**Graphs:**
● Did (when) the country conduct a gender analysis that identified barriers faced by health workers, caregivers and adolescents (yes/no)	

Yes, for all levels

- Has the country implemented initiatives that remove or reduce gender related barriers?

Yes

Country comments:

The country conducted an initial gender barrier analysis using existing information from gender barriers that affect other health and non-health related programmes. This data has been incorporated into EPI to improve programming. However, a more comprehensive gender barriers analysis is anticipated to be supported through UNICEF as part of the HSS/EAF support. The tables below report on initiatives that remove or reduce gender related barriers in the country.

Barriers faced by caregivers

Barrier (state the barriers that restricts the caregiver from access the service)	Intervention that addresses barriers (state the interventions planned)	Was the intervention implemented? (no, partially, fully)	What was the impact (provide evidence)?
Limited access to information on immunisation resulting in myths and misconceptions	Support printing/distribution of IEC materials outreach services and door-to-door information sharing, use of community radio stations and community engagement meetings	Fully	Increased uptake of health services
Male caregivers deprioritising or obstructing immunisation access	Conduct awareness campaign targeting male caregivers	Partial	Increased levels of male involvement in immunisation activities
Increasing alcoholism among women	Collaborate with programmes supporting women's group and advancing their empowerment agenda to emphasise the importance of immunisation	No	
Caretaking burden placed on mothers forcing them to choose between immunising children or engaging in economic activities couples with seasonal economic activities and flooding resulting in seasonal migrations	-Extend vaccination clinic hours to evening/weekends -Schedule outreach points where women are conducting economic activities to increase vaccine uptake -Collaborate with programmes supporting women's group and advancing their empowerment agenda to incorporate messages on the importance of immunisation -Awareness campaigns & multi-pronged reminder systems	Partial	
Distance to health facility	-Consideration to integrate vaccination with other Primary Health Care services such as Antenatal visits -Increase outreach frequency and points of service delivery to reduce on distance to the health facility	No	
Limited access and involvement in decision making including on household income	-Advocate for platforms that encourage women empowerment and men's groups to encourage involvement of women in decision making	Partial	
Women in many settings are the primary decision-makers regarding children's health, yet	-Tailor communication which also target women with low literacy level for them to	Partial	

their level of health literacy may be lower, leading to confusion or reluctance toward immunisation	understand the basic concepts on vaccination and its importance		

Barriers faced by health care worker

Barrier (state the barriers that restricts the caregiver from accessing services)	Intervention that addresses barriers (state the interventions planned)	Was the intervention implemented ?	What was the impact (provide evidence)?
Limited information on new intervention for health promotion/ACSM	Conduct supportive supervision and mentorship	Partial; on going	Improved services delivery and experience of care
Low levels of human resource for ACSM activities	Mobilisation of volunteers to support ACSM activities	Partial; on going	Improved services delivery
Missed opportunities to link pregnancy care with immunisation	Sensitising HCWs	Partial; on going	
Shortage of skilled HCWs	New training modalities	Partial; on going	
Funding shortages impacting outreach and supervision services	Leverage resources across departments	Partial; on going	
Some communities may have biases toward male or female health workers due to cultural restrictions on gender interactions, resulting in the less preferred gender to effectively reach women and children	Continuous community engagement and assurance including involvement of key gatekeepers such as headmen	Partial; on going	
Limited women in raising to reach top key leadership positions	Advocate for the appointment of women to occupy to leadership positions	Partial; on going	
Cultural perspectives and expectations of female health workers expectations take on greater caregiving or family duties may affect their availability to engage in outreach or attend professional development for immunisation training.	Provision of alternative learning platforms that encourage women participation	Partial; on going	
Limited financial resources and limited provision of social amenities may also affect the retention of female health workers	-Continue to advocate for the provision of social amenities especially in remote rural areas -Provision of incentives such as rural hardship allowances to health workers in remote rural areas	Partial; on going	
Health workers may also face challenges when engaging male decision-makers, as men may defer vaccine-related decisions to female family members but still exert control over family finances, limiting access to vaccines if costs are involved.	Explore platforms to engage male participation in immunisation activities	Partial; on going	

Barriers faced by adolescents

Barrier (state the barriers that restricts the adolescents from accessing services)	Intervention that addresses barriers (state the interventions planned)	Was the intervention implemented?	What was the impact (provide evidence)?
Limited Awareness and Knowledge on certain vaccines. There is inadequate health	Developed targeted information for adolescents and young people	Partial	Improved uptake of

information targeting adolescents and young people			health services
Health System Barriers: Limited Healthcare Provider Knowledge, poor documentation to effectively tracking of immunisation records and consistently follow-up on missed doses or delayed schedules and Stigma or lack of adolescent friendly spaces that will ensure they are comfortable when accessing services	-Creation of adolescent friendly spaces such school health services, and community -Capacity building of health care providers -Roll out of Individual client level data registries	Partial	Improved access to information and services
Inadequate training human resource to work with the adolescents and young people	-Oriented and trained health care providers in managing adolescent health issues -Orienting more peer educations	Partial	Improved access to information and services
Limitation in access and availability due to location, transportation (financial constraints in accessing transport to distant facilities) and service delivery mode for the vaccine (e.g. lack of a strong school-based programme or limited strategies to identify and reach out to school girls)	-Increasing tailored outreaches points and platforms of service provision -Incorporating feedback of adolescents in planning and implementing services targeting them	Partial	
Consent and autonomy issues for those vaccines where they may be required to seek parental consent and there is a barrier if parents are hesitant or opposed to vaccines.	Increased community sensitisation	Partial	
Cultural and Social Barriers such as negative community Beliefs, misinformation and negative peer influence	Increased community sensitisation	Partial	
Psychological Barriers such fear of needles and trust issues	-Conduct evidence generation activities to inform SBC interventions for adolescents -Assurance and use of peer champions	Partial	

13. Learning Question: How well is the country implementing its health information systems and data strengthening, monitoring and learning activities?

- What is the progress of planning and implementing health information system and data strengthening, monitoring and learning activities? Do these collectively constitute at least 10% of your HSIS/EAF grant budget?
- How will the country address remaining data-related gaps or barriers to immunisation programme performance?
- Comment on key results or findings for identified learning priorities based on country's application. Specifically, what actions have been taken to improve immunisation programme performance based on these data? e.g. better understand specific barriers to immunisation, successfully guide implementation, inform course correction for grant activities
- *Please share any documentation of learning results if available (e.g. reports, evaluations, assessments, etc).*

Country comments:

What is the progress of planning and implementing health information system and data strengthening, monitoring and learning activities? Do these collectively constitute at least 10% of your HSIS/EAF grant budget?

- Implementation of Health Information Systems (HIS) and Data Strengthening, Monitoring, and Learning Activities: Zambia's immunisation programme has seen considerable engagement in data quality improvement, marked by the Data Quality Improvement Plan (DQIP) and a series of workshops focused on improving data collection, reporting, and analysis through its Health Management Information System (HMIS) on the District Health Information System 2 (DHIS2)

platform. Initiatives implemented include regular desk reviews, system assessments, field reviews, and supportive supervision. However, challenges persist, such as data completeness issues, consistency of denominators, and the need for accurate population targeting.

- Progress in planning and implementing HIS and data strengthening activities: Activities for strengthening HIS and data quality have steadily progressed, with structured systems assessments, regular data reviews, and comprehensive planning sessions. The 2019-2021 DQIP aimed at tackling data quality gaps, while recent workshops have focused on training, tool adoption, and practical data review exercises. Some key advances include employing integrated supportive supervision and data review tools, although issues like timely report submissions, data completeness, and local-level planning remain areas for improvement. The implementation of DQIP activities have been severely limited due to inadequate dedicated funds, ME activities embedded in other levers also limited in scope to cover cost of implementation. There is need to explore alternative funding sources.
- HSIS/EAF grant budget allocation: Significant resources (11%) have been allocated toward data quality, suggesting a focused investment in HIS and data quality improvement processes.

How will the country address remaining data-related gaps or barriers to immunisation programme performance?

To address gaps in immunisation data, Zambia's strategy includes regular assessments of HCW practices, data entry consistencies, and training on data management systems. Recommendations from the DQIP include improved feedback mechanisms, enhanced data consistency checks, and strengthened supervisory systems to mitigate errors, data quality reviews, and enhance the reliability of immunisation data.

Key results or findings for identified learning priorities based on country's application. Specifically, what actions have been taken to improve immunisation programme performance based on these data?

Key actions that have been undertaken include reinforcing the DHIS2 feedback loops and implementing the data quality review tool to improve data visibility and accuracy. Efforts are underway to better understand barriers to immunisation, notably by refining data entry practices and enhancing local-level data use to inform programme adjustments. Training workshops and supportive supervision exercises have been implemented, helping facilities to identify and correct data inconsistencies, ultimately supporting better immunisation coverage outcomes.

Share documentation of learning results

Several reports document learning results, such as the Data Quality Improvement Plan (DQIP) for 2019-2021 and the Immunisation Data Quality Review Technical Report 2023, both of which compile findings from systematic reviews and assessments. These documents reflect on data quality metrics, system constraints, and programmatic adjustments needed to enhance immunisation data accuracy and coverage.

This responses are drawn from findings from three key sources:

1. Immunisation Data Quality Review Report 2023
2. Evaluation of Zambia's Immunisation Programme Report 2020
3. Data Quality Improvement Plan (DQIP) Report 2019

C. Implementation of Technical Country Assistance (PEF-TCA)

14. Learning Question: Is the country implementing PEF TCA and COVAX TA as expected? Please explain how the TCA has helped to support the achievement of the country objectives.

Indicator(s):	**Graphs:**
● Country analysis on partner performance as per workplans	

Country comments:

Please see the TCA updates in the table below.

Milestone	Complete	Major Delays	Minor Delays	On Track	Re-programme	Un reported	Total $	Achievement
CIDRZ							383,061	
Support monitoring, evaluation and learning activities associated to delivery strategies selected								M&E TA supported MOH to provide additional support for data EPI analysis. TA aided with coordination, data compilation, and analysis working to improve the use of vaccination data for decision-making through relevant subcommittee meetings.
Support coordination of activities to consolidate microplans, troubleshoot challenges, validate, and communicate microplans to the implementation level								Completion of an integrated microplanning tool. TA supported the development of the microplanning training concept note, budgets, training materials and the integrated microplan tool for both paper and digitised microplanning. TA provided expertise, feedback and solutions in all EPI subcommittee meetings for microplanning coordination and preparations
Identify and implement evidence-based approaches, including establishing non-facility-based vaccination sites to improve coverage and equity								Development of the RI tracker and Finalised Recovery plan. TA supported the development of the EPI recovery plan--the Big Catch-up (BCU). TA supported reporting/analysis of Health Management Information System (HMIS) data and generated reports for subcommittee meetings and decision making to inform strategies for COVID-19 vaccination and overall performance of the immunisation programme. TA supported the development of the RI tracker that will be used to collect data for the BCU.
Support the development of models for integration of C-19 immunisation as an integral part of PHC to achieve UHC								Integration C-19 into PHC guidelines and strategy documents completed and awaiting approval/adoption to be finalised. TA provided support to EPI for C-19 vaccination and RI activities. Actively involved in drafting guidelines/strategy to integrate C-19 vaccinations into RI and PHC services. The TSS supported, provided an opportunity for the district and provincial supervisors to visit HFs and provide mentorship. Reviewed, finalised, and updated various vaccination campaign tools including implementation plans, field guides, supervisory checklists, etc.
Supply Chain Stock Management								TA activities in SC subcommittee, supporting vaccine forecasting, data triangulation, stock review and shipment coordination is on-going and on track. The TA facilitated the forecasting and quantification that was part of the Mid-Term Expenditure Framework Planning for 2024-27 and an analysis of stocks to inform shipment plans was conducted. Supported the pre- and post-vaccine and safe injection shipment process for vaccines and dry materials. This included applying for relevant import permits, obtaining clearance letters at the ports of entry for the dry materials, and preparing vaccine arrival reports submitted within 72 hours of vaccine receipt.
CDS NB								
Technical/Admin support							38,434	TA support for microplanning training conducted built capacity in subnational level staff to develop microplans not only for C-19 vaccinations but also for RI. Grants officers provided support for funding objectives, implementation, and indicator progress, including reporting and invoice management. This role is critical to ensuring that the project was implemented according to the agreement.

Administrative/coordination							41,550	TA support includes administrative and logistics support to the programme, coordinate logistics and finances, procurement, and other various administrative tasks and issues. A finance staff also ensured that monetary disbursements for activities were coordinated
Provide TA to extend immunisation services to reach zero-dose children/missed communities through strengthening use of microplans through TSS in targeted high zero dose districts,	.							TA supported TSS during the MR SIA, nOPV rounds, Child Health Week/Polio integration, zero dose assessment, rota switch, HPV MAC and cholera response.
Provide technical assistance to analyse and develop plan to reach zero dose children								TA to conduct assessment on the barriers to immunisation; gathered information that effect access/utilisation of immunisation. Report provides recommendations to reach these populations.
Provide technical assistance for skills transfer of immunisation forecasting, receipt and reporting to avoid facility-level stock-outs and ensure appropriate planning and forecasting								•TA supported submission of quarterly cost estimates for 2023. •TA for engagement of the department of Finance and Ministry of finance and national planning to initiate process to release the funds for procurement of vaccines. •TA supported the process of 2023 remittance of funds for vaccine co-financing. •TA ensured import permits, clearance letters and submission of the report within 72hours of vaccine receipt. •TA supported the vaccine supply and cold chain sub-committee on the vaccine stock levels and forecasting for BCU.
Improve EPI policy and programme decision-making through NITAG meetings								TA supported ZITAG meetings including guidelines on COVID-19; Malaria vaccine introduction recommendations; and Measles Rubella Supplementary Immunisation Activity (MR SIA) recommendations.
Provide technical assistance to support national EPI planning and coordination including the adaptation/development of relevant strategic/ policy/ documents to include focus on reaching on zero-dose children and missed communities								•TA supported FPP process submission for EAF, HSS and TCA, along with NIS and immunisation financing report •TA supported MR outbreak response documents i.e., vaccinators guide, implementation plan. •TA supported nOPV vaccinator's guide and training material •TA supported the development and of Rota switch and HPV MAC; Implementation plan, training modules, training plan, and conducting orientations. •TA supported the COVID 19, targeted implementation plan. development and coordination of activities through this process. •TA supported the Child Health Week/Polio integration planning and coordination as well as TSS. •TA supported Cholera vaccination activities •TA supported the development of the BCU plan •TA supported workplan and budget development for HSS/EAF/ITU, HPV and BCU.
TCA							901,203	
Provide TA to extend immunisation services to reach zero-dose children through strengthening use of microplans through TSS in targeted high zero dose districts								TA supported the development of the Gavi FPP Application, National Immunisation Strategy (2022 -2026) and Zambia EPI Recovery plan. During the implementation of the of the MR SIA campaign, supported the finalisation of the MR SIA microplanning template and orienting the subnational level. TA also supported the development of the BCU digitised microplanning and training modules.
Analyse and develop plan to reach zero dose children								TA supported the evaluation of drivers of zero dose children and the analysis of missed opportunities of vaccination.

Skills transfer of immunisation forecasting, receipt and reporting to avoid facility-level stock-outs and ensure appropriate planning and forecasting								TA supported vaccine stock analysis and forecasting and quantification for the vaccines. Additionally, supported the tracking of vaccine shipment and advising on shipments including preponement of shipments.
Support for national EPI planning and coordination including the adaptation/development of relevant strategic/ policy/ documents to include focus on reaching on zero-dose children and missed communities								•TA supported the setting up of the planning and coordination subcommittee and subsequent meetings. •TA supported the ZITAG meetings that review the Malaria Vaccine Introduction in Zambia, COVID-19 Updated Priorisation Matrix and Schedule, HPV Vaccination Schedule for Zambia and the overall immunisation and catch-up policy for Zambia. •TA supported development of EPI documents including the concept note for the recovery plan, microplanning concept note, EPI manual, RED/C guidelines and job aids. • TA supported the cholera outbreak response through adaptation of training modules, conducting tracings/TSS. •TA supported the nOPV R5 activities with the adaptation of EPI documents and conducting of orientations •TA supported the MR SIA documents development including development/adaptation of training modules, training plan, implementation plan, vaccinator's guide, supportive supervision checklist, Pre & Post test; conducting orientation and TSS visits. •TA supported strengthening HPV routinisation activities through the adaptation of abridged modules and conducting of orientations in selected provinces. • TA supported the Child Health Week & IPV 2 introduction activities through adaptation of training modules, pre & post-test and conducting orientations.
Strengthen vaccine safety surveillance at all levels including reviews of AEFI reports,								•TA supported updating and maintaining the National AEFI Line list and provided remote support on the investigation of serious AEFIs. The support also included coordinating the introduction of Vigimobile in five Phase 1 implementing provinces. •TA for implementation of the AEFI/AESI surveillance for nOPV2 that contributed to global data based prior to the WHO prequalification. •TA supported the National AEFI Committees as co-secretariat guiding and documenting the deliberation on causality assessment.
UNICEF								
COVAX Technical Assistance								
Immunisation Supply Chain (iSC) Assessment report draft							103,680	-IGA done -eLMIS inception report pending
Comprehensive VPD response integration framework and draft report							155,520	-Both COVID-19 Vaccine Integration Strategy & Guidelines were submitted to GRZ in May 2024 -Both documents pending validation, launch and dissemination
Q1-Q3 behavioural and social data use reports for COVID-19 vaccine uptake, demand and integration, with status report on recommendations from Q1 and Q2							103,680	-Quarterly COVID-19 Convenient Rapid Assessment reports were timely done and data used as planned -Additionally, more data was collected through at least 1 BeSD exercise. Data also used appropriately including in the developed COVID-19 Vaccine Integration and Strategy

TCA								
TA to support the CCEOP 2.0 development and submission								The CCEOP 2.0 application development was supported and submitted in July 2023. It was subsequently approved, pending implementation after receipt of the Decision Letter dated 16 November 2023. With Zambia being included in the Health Facility Solar Electrification (HFSE) Learning Agenda initiative being implemented through the CCEOP, implementation of the CCEOP has been delayed. This is because the country needs to revise the Operational Deployment Plan (ODP) to update the facilities that will benefit from the HFSE. On 2 June 2024, an assessment of 261 facilities commenced for the HFSE component. This will run through to 5 July 2024. Following this, the final ODP will be updated and submitted for approval to facilitate commencement of the implementation of the CCEOP.
TA to support the roll-out of the vLMIS as a key priority area.								UNICEF facilitated the technical discussion with the Ministry of Health and Gavi on the country's selected open-source logistics management information system (OpenLMIS) and facilitated the requirement gathering workshop from 20-24 November 2023, which resulted in defining the high-level requirements, business process workflows, report requirements, governance framework and cost estimates for OpenLMIS roll-out in the country. UNICEF issued a Request for Proposal (RFP) from potential bidders on 20 May 2024, which will be closing on 13 June 2024, in order to facilitate selection of a supplier for the provision of OpenLMIS for Immunisation Supply Chain Management in Zambia.
TA to support the MOH to develop the full vaccine forecasting for 2023-27								TA was provided to the Ministry of Health to develop the 2024 vaccine forecast, which was completed and submitted on 30 October 2023. UNICEF will continue to provide TA to the Ministry of Health to develop the 2025 vaccine forecast in the fourth quarter of 2024.
TA to support the Ministry of Health with tracking and implementing the EVMA cIP								Implementation of most of the key recommendations in the EVMA cIP relies on the Full Portfolio Planning (FPP) resources/funds, the receipt of which by the country has been delayed. However, some preparatory activities have commenced for two key recommendations: eLMIS activation and central warehouse renovation, with UNICEF providing technical support in commencing procurement processes to recruit institutions to support implementation of these activities; the recruitment is still ongoing.
TA to support the improvement of stock management for vaccines and devices to avoid facility-level stock-outs and ensure appropriate planning and forecasting								This is an ongoing process to support the Ministry of Health with vaccine management across the supply chain. UNICEF participates and provides technical guidance on the stock management and monitoring of immunisation supplies during the weekly logistics technical working group meetings. Additionally, UNICEF receives, analyses and uploads monthly vaccine consumption data into Thrive 360, and provides feedback to the Ministry of Health to ensure appropriate planning to avoid stock-outs.
TA to provide SOPs or guidelines for collection and disposal of medical waste to the relevant stakeholders								Development of the terms of reference to conduct an assessment of HCWM was completed and submitted to UNICEF HQ. Through UNICEF HQ, a consultant (advertisement closes on 12 June 2024) to support the HCWM assessment will be recruited. Subsequently, the consultant will also develop a detailed action plan on HCWM for implementation by the country. Following this, UNICEF will provide TA to the Ministry of Health for implementation of the action plan and development/updating of SOPs/guidelines on HCWM.
TA to provide SOPs or guidelines for vaccine management to the relevant stakeholders								The SOPs for vaccine management were drafted with technical support from UNICEF during a workshop conducted from 4 to 6 October 2023. The draft SOPs were then consolidated and further reviewed. The revised finalised versions were shared with the Ministry of Health in February 2024 and are currently pending clearance for printing.

TA to implement the ACSM interventions at all levels with skills in Human Centred Design in reaching zero dose and under-immunised children and missed communities								UNICEF provided technical support to the Ministry of Health in planning and organising the monthly ACSM/Social Behaviour Change (SBC) meeting to strengthen review, planning and implementation of Routine Immunisation and Vaccine Preventable Disease (VPDs) outbreak response, including review of social/immunisation data to update ACSM micro plans for Routine Immunisation, polio and measles Supplementary Immunisation Activities (SIAs), orientation of health workers, field monitoring and to provide action-oriented feedback to improve performance. SBC United Nations Volunteers (UNVs) have been deployed at all 10 Provincial Health Offices (PHOs) to support the PHOs and District Health Offices (DHOs) to design, plan and monitor the implementation of ACSM activities, including community engagement through involving local Non-Governmental Organisations (NGOs), Civil Society Organisations (CSOs), and Faith Based Organisations (FBOs), coordinated under the platform of ACSM Working Groups.
TA to conduct research to determine social and behavioural drivers of increased number of ZDC; Develop evidence-based NIS-aligned Essential Program of Immunisation (EPI) Communication Plan								UNICEF recruited an external TA institution to support development of the ACSM strategy and deliver the following: (a) An EPI ACSM/SBC Strategy 2024–2030; and (b) A costed Operational Plan 2024–2026 for the EPI ACSM/SBC Strategy. The contracted institution commenced the assignment in April 2024 and is currently finalising the Inception Report for the assignment, following iterative engagements with UNICEF.
TA to support integration of COVID-19 vaccination into RI and PHC.								UNICEF provided TA for the development of the costed COVID-19 Strategy and Implementation Guidelines. National stakeholder consultations were conducted in July 2023, and provincial stakeholder consultations in December 2023. The costed draft strategy and guidelines have subsequently been developed, and their finalisation is in process.
CHAZ								
CDS3								
Vaccine Acceptance & Uptake demand & public Confidence - influencing social norms & enhancing community engagement							57,196	Demand generation activities engaging with Health Workers - (EPI, PHO, DHO) using media houses (TV programmes and Community Radio Stations) to improve vaccine acceptance and uptake of vaccines. These discussions are also help improve public confidence and influence social norms. The development of the Immunisation Communication Strategy is key to achieving this objective and CHAZ has been part of the process of this development including CSOs providing input.
Vaccine Acceptance & Uptake demand & public Confidence - tools & guidance developed for generating social & behavioural data for action							57,196	Tools have since been developed and they were approved for use in the target Districts, the country is discussing the tools to cover the whole country and not just the target Project Districts, these are defaulter tracing and client satisfaction survey tools.
TCA								
Increase demand for immunisation services in communities with zero dose, under-immunised children, and missed communities.							57,384	CHAZ engaged Parliament through the Health Committee on the 2025 Draft Bill on Finance. A paper was submitted which included the need to increase domestic financing to immunisation and the placement of the EPI from a Unit to a Directorate. Another important achievement was the creation of the Parliamentary Caucus on Immunisation.

Extend immunisation services to reach zero dose, under-immunised children, and missed communities.							162,000	CSOs were selected with support from EPI and have been oriented on issues to do with zero dose children defaulter tracing, community engagements have also started. These demand generation activities are being done through CSOs at community level using community-based volunteers, community radio stations, religious leaders/groups. Stakeholders' meetings were held with gate keepers on the importance of vaccines including C19 vaccine and HPV.
Program Officer provides day-to-day project management, support to CSOs, coordinate reporting by CSOs							50,499	This activity was done, with an outcome of the increased number of CSOs receiving grants not just ZCSIP members. The members were oriented, and an annual meeting was held with a capacity building component.
Accountant provides financial support to CSOs, Project financial support							73,203	A continuous support for financial management for the CSOs and CHAZ. Having financial reports in-time.

WHO								
TCA								
Provide Assistance to strengthen ZITAG members capacity to deliver evidence-based policy/technical recommendations fr reaching ZDC and UIC, and support National AEFI Causality Assessment Meetings and provision of updates on new vaccines safety concerns								Continuous TA provided for strengthening ZITAG members capacity to develop quality recommendations using the Evidence-to-Recommendation using framework for various immunisation topics; continuous support provided for AEFI surveillance strengthening and causality assessments including the provision of new vaccine concerns such as nOPV2 and Mpox.
Provide Technical Assistance to support development adaptation and/or dissemination of strategies, policies, guidelines, proposals, reports such as JAs, other strategic documents including preparations/ readiness for implementation of service delivery interventions and/or other switch as necessary.								TA continuously provided for ongoing needs for domestication/ adaptation of guidelines / strategies such as Integrating COVID-19 vaccination into immunization programmes and primary health care for 2022 and beyond to local context, HPV multiage cohorts and Schedule switch guide, Rota vaccine re-introduction, Inactivated Polio vaccines, Draft Measles Outbreak Response Vaccination Guide; being technical lead in the EPI program review and subsequent National Immunisation strategy ensure that minimum standards were met. TA provided also in the development and review of Theory of Change (FPP) at the various stages; Leaving no one behind in the context of the Big Catch Up (Recovery Plan), Outbreak and Preventive Vaccination Campaign Readiness (OCV and Measles) as well as preparations of operational guides, monitoring tools, plans and preparations Post Campaign coverage surveys for PCV and Measles; vaccine safety using Vigimobile. TA provided for Planning and coordination of Immunisation Programming including. The TA also provided support for the drafting of Immunisation Joint Reporting Form and review of other program reports including evaluation of interventions such as OCV Outbreak Immunisation Post Campaign Coverage Survey.

TA for strengthening VPD surveillance, conduct risk assessments for vaccine preventable diseases and support evidence generation/review/analysis for preventive immunisation campaigns and timely support predicting of VPD outbreaks; regular review of surveillance data, conduct statistical and descriptive analyses) and translate analytical results, support evidence-based decision making								TA recruitment was significantly delayed with recruitment processes recently completed in late Q3, 2023. This currently running systematically strengthening linkages between surveillance and Immunisation program, reviewing draft guidelines for VPDs (measles Outbreak immunisation response); review of surveillance data for flag VPD outbreaks. Prior to recruitment, TA was limited to intermittent support from other units at WCO to support OCV. Measles and Polio Outbreak Immunisation responses. Additionally, support was provided for triangulation of surveillance data to inform strategy for measles control.
Provide TA to strength availability of fit-for purpose data and all levels, publication and regular sharing of information to all levels and build capacity to triangulate data, including the use of outbreak and surveillance data, to identify and reach zero dose, under-immunised children and missed communities in targeted geographical areas; perform advanced analytics and infographics								TA recruitment was significantly delayed with recruitment processes recently completed in late Q3, 2023. This dedicated TA is currently running to review Measles Rubella Campaign performance results and supervision ODK data. This TA also worked to support the development and uploading of Vigimobile evaluation tools and their analyses. Prior to the availability of the dedicated TA, WCO leveraged internal resources from Data angles of EPI to conduct M&E Immunisation coverage analyses for various uses including, the development of draft Immunisation dashboards as well as eJRF reporting, supporting the real time monitoring od supervisory activities through ODK tools and analyses of outputs to identify key issues.
Support 1 day Clinical Meetings @ Health facilities on AEFI surveillance 23 districts (meeting logistics at HF/hospitals)								This is yet to be supported once targeted inception interventions are implemented in the target districts
Review and Updating of EPI manual to align with ZITAG recommendations								Delayed by ongoing with recruitment process of consultant and related activities deferred to Q-1.

Support Data reviews, monitoring and learning activities; Support AEFI Causality Assessments								Data reviews no scheduled to start early 2025. Dedicated TA recruited in late Q3 2024 and plans already underway for define modalities for conducting regular meetings including Data Quality Review meetings; AEFI Causality assessments somewhat delayed due to delays in follow up of serious cases reported and fully investigated. With dedicated TA in place, plans are underway to actively follow up serious cases with adequate documentation of investigations and timely causality assessments.

Briefly summarise the **key discussion points**, including **identified needs** and **follow up actions** resulting from the Joint Appraisal review and dialogue. This may include

- Identified (future) needs and priorities
- Follow-up actions to accelerate planned activities
- Expected adjustments to activities and as applicable the Gavi workplan, targets and budget, such as budget reallocations, modifications in TCA planning, revision of dates for anticipated new vaccine applications or introductions, etc. [3]
- Roll-out or expansion of promising practices and innovations
- Other aspects and follow up actions

Identified (Future) Needs and Priorities

#	Identified Issue	Summary of Issue & Follow Up Action	Timeline (Completed By)	Responsible person/partner
1	Zero dose agenda	- According to 2023 administrative data, 9 of 23 priority districts are no longer in the top 23 districts for zero dose children. There are 9 new districts identified in the top 23 with zero dose children that are being requested for additional support. ▪ Consensus among Government and partners that reopening the prioritisation would be unhelpful at this point as engagements with 23 priority districts had commenced. ▪ Discussion were held on how best to ensure immunisation is progressing in all districts given the low coverage. Platforms identified were the Big catch Up and to try and expand the Akros support for digital microplanning to these additional districts. Additional works have been added to the Akros subaward with CIDRZ to expand the digital microplanning to these additional districts, DRIVE, COVID-19 integration, HPV routinisation, etc -Plan for the revitalisation of the outreach generally and particularly in the 23 prioritised districts -Maximise the use of BeSD data to improve motivation for vaccination -Prioritise ZDC tracking so that data keeps guiding the agenda -Detailed partner mapping to be developed to ensure the rest of the districts are covered with essential immunisation services. This remains an open Independent Review Committee recommendation for Zambia.	Ongoing February 2025	National EPI Manager Cheryl Rudd, CIDRZ
2	Malaria vaccine	-Need for revision of the deployment plan to remove the expanded cohort -Prepare to engage the IRC on the application -Strengthen 2YL platform in view of additional vaccine to be provided through this platform and devise and implement strategies to address the issue observed in other implementing countries of high dropout rates	October 2024 November 2024 Ongoing	National EPI Manager
3	COVID-19 integration	-Need to complete, launch, and disseminate the COVID-19 Integration Strategy and Guidelines -Integrate COVID-19 into PHC and extend immunisation services to underserved areas. -Conduct projection and submit requests for remaining CDS funds yet to disbursed to the country	December 2024	National EPI Manager

[3] This refers to all types of Gavi support

4	Cholera and rota switch	-Need for further engagement on the rota switch and tentative timelines -Submit additional request for the preventive cholera campaign in line with the MCEP targeting a specific submission window.	April 2025	National EPI Manager
5	Immunisation gender programming	-Embed gender mainstreaming (planning, implementation, and reporting) in immunisation programming and partners -immunisation Gender barrier Analysis (iGBA) to be conducted through UNICEF -Consider utilising GIS microplanning to enhance the gender footprint amongst service providers -Engage MOH Gender Focal Point and possibly Gender Division Unit to gather input in the immunisation Gender Programming -Additional priority actions to be identified and costed and indicators with targets proposed.	Ongoing February 2025 December 2025 November 2025	National EPI Manager/UNICEF
6	Audit recommendations	-Develop a stand-alone audit recommendations response plan or imbed the responses to the recommendations in an existing annual plan	December 2024	National EPI Manager
7	EPI SBC/ACSM Strategy 2024-30 and ACSM Strategy Implementation Plan 2024-26	-First drafts will be ready by mid-November 2024, will need validation, printing, launch and dissemination -Expedite completion of the two documents so that coordinated programming can precede implementation	January 2025	National EPI Manager
8	IPV2 introduction	- IPV1 coverage in 2023 was as low as 67.9% -EPI to collaborate with ZNPHI to continue contributing towards polio surveillance. -Facilitate IPV2 introduction and routinisation and improvement of the IPV1 coverage	November 2024	GPEI Coordinator
9	MR	-2024 SIA preliminary results indicate 72 of the 116 districts reached at least 95% coverage with a national coverage of 97% (administrative). -the Post campaign Coverage Survey (PCCS) was planned for the fourth quarter of 2024 -Full execution of the measles 5-year plan required	PCCS: December 2024	
10	Using campaigns to strengthen RI	--Zambia had implemented several VPD outbreak responses during the period under review which were noted to disrupt RI; campaigns are usually better resourced and weak RI leads to need for more campaigns. -EPI therefore need to plan for how to use campaigns to strengthen RI and break the cycle. -Consider pragmatic approaches to minimise the disruptions to RI during outbreak response: e.g., coordinated and integrated campaign efforts, surge capacity, leveraging Community Based Volunteers.	Ongoing	National EPI Manager
11	Recurrent vaccine stock-outs at subnational levels	- Zambia consistently report vaccine stock data through the Thrive360 with 128 stores reporting - The main reason for the stockouts was in country distribution. -JA agreed that 2024 would focus on using Thrive data to improve visibility into stock management issues, while efforts to launch the vaccine eLMIS continues. -Focus particularly on subnational stockouts, rapid VVM changes and expiries requires urgent attention by the national VMCCL committee. -Vaccine eLMIS system deployment, to be completed in 2025. -Additional strategies to improve in country distribution such as the DRIVE initiative were also to be explored	Ongoing	National EPI Manager
12	CCEOP, cIP & HFSE	-Cold Chain Equipment Optimisation Platform (CCEOP) support contributed to improved vaccine access. -HFSE to provide reliable power supply and assure vaccine integrity	December 2024	National EPI Manager

		-Renovation and solarisation of the National Vaccine Store with support from UNICEF. - Country to review available country funds and assess the feasibility of support both renovating the dry storage space and solarisation of the National Vaccine Store - In case the country was considering reprogramming funds for the rehabilitation of the Dry Storage Space, the country should send this through a comprehensive reprogramming request on available funds.		
13	HCWM	-Waste management programming for EPI poorly defined; large cities and towns produce a lot of waste; - Implementation of the action plan and development/updating of SOPs/guidelines on HCWM. - through UNICEF(HSS support) and MOH procuring environmentally friendly incinerators	February 2025	National EPI Manager
14	Big Catch Up (BCU)	Zambia had approved the BCU plan but had not commenced owing to pending vaccine receipts (only one shipment received at time of JA) and pending approval of the CDS reprogramming. There was also a notable gap in the funding required for the implementation of the BCU. -Implement pilot of the BCU in three targeted districts: Kabwe, Mansa and Itezhi tezhi -Expedite BCU implementation of preparatory activities including the approval of CDS3 reprogramming and finalisation of package -Pursue the stated potential WB funds for the BCU gap	December 2024	National EPI Manager
15	Financial performance and management	-GAVI and UNICEF have notable similarities in their financial/ grant management systems. This includes assurance activities which include spot checks, programmatic visits, and audits. UNICEF and WHO are not subject to GAVI audits, but they will audit the partner (MOH) for funds that we have given them. It is recommended that to have HACT training for the teams handling the funds based on the issues of record-keeping raised by MOH. -The HSS grant expenditure was low at 0.3% with the need to increase utilisation. -The HPV was at 5% with low expenditure and needs to increase utilisation. -GAVI recommended that the MOH separate the HSS and EAF expenditure in the reporting. -MOH requested that account maintenance costs should be factored in for subnational-level funds. (PHO/district accounts). -GAVI is closely monitoring grants that are above 18 months and may request increased utilisation or recalling funds with high balances above 18 months aging. -Gavi would like to have any balances of funds on expired grants to be released so that they could be used elsewhere	Ongoing	National EPI Manager & Implementing partners
16	National Immunisation Strategy (NIS)	-Non dissemination of the NIS and very high NIS Costs -Need for finalisation and Dissemination of the NIS & Review NIS Costs	March 2025	National EPI Manager
17	EVMA Comprehensive Improvement Plan	-Suboptimal implementation of EVMA recommendations (comprehensive improvement plan) -Need to review the EVMA recommendation and prioritise some key recommendation for potential Gavi support and consideration in any country reprogramming of funds	December 2024	National EPI Manager
18	Undisbursed CDS funds	-Huge balance of undisbursed CDS funds for the country. These required to be disbursed by the third quarter of 2025. -Submit disbursement schedule for CDS3 funds and any reprogramming on available funds	February 2025	National EPI Manager

19	ZITAG	-ZITAG maturity assessment conducted in 2023 indicated Overall rating of assessment criteria as 63% and provided areas for improvement. -Implement the recommendations of the ZITAG Maturity Assessment	Ongoing	National EPI Manager, ZITAG Secretariat & WHO
20	Multi-year vaccine renewals	-The country analysis had noted several years of preponements of vaccines especially on Penta and excess stocks on Rota owing to the delayed switch which results in several years of accumulation of Rota vaccines. The country's latest census projection indicates the 2025 number of live births. -Insufficient Vaccine Allocations in the Multi-year vaccine renewals (2023 - 2027) especially on Penta -Request for adjustment on multi-year vaccine renewals (2023 - 2027)	November 2024	National EPI Manager
21	Partner Gavi Grant Agreement	-MoH was lacking visibility on bilateral Grant Agreements and subsequent Disbursement of Funds on Partners Agencies. -Gavi to review and possibility identify how communication to MoH on sending and submission of Grant Agreements & Subsequent Disbursement of Funds on Partners Agencies	Ongoing	National EPI Manager & Gavi
22	Effectiveness of ICC	-ICC ToRs indicated that the committee should be chaired by the Permanent Secretary and the membership as heads of agency across RMNCAH-N and meeting frequency as quarterly. However, it was noted that meetings were not always quarterly, sometimes the chair of the meeting was delegated to Directors and representation was delegated to technical staff from agencies. This was noted to affect objectives such as resource mobilisation. -Assessment of the ICC to be further amplified during the PCA and recommendation provided -Need for WHO to share requirements for an effective ICC	December 2024	National EPI Manager
23	Declining coverage	-Concerns regarding continuous declining DTP3 coverage since 2019 noted at the JA. Coverage lagging behind for vaccines offered at the same time, eg IPV (72% vs DTP3 82%). -It was noted that MCV 2 coverage remains suboptimal (WUENIC 2023 - 75%). This, led to discussions for MOH/EPI partners to be more deliberate about unpacking the issues and proposing a way forward on strengthening the Second Year of Life (2YL) platform, including opportunities to integrate into other 2YL interventions. It was agreed that there was a need to develop a plan of action to improve the second year of life. ▪ Microplanning gaps noted; new digital microplanning system being developed by Akros was noted to be a promising innovation. Improvement of the Second Year of Life activities especially in view of the introduction of the malaria vaccine that will also be delivered during the second year of life.	Ongoing	National EPI Manager
	Programme Management (Programme	- It was noted that two key positions in the EPI team remain vacant for over 12 months (I.e. Senior accountant and HSS coordinator)	December 2024	National EPI Manager

	Implementation Oversight)	-It was noted that ICC revitalisation was key in the context of a complex implementation arrangement of the Gavi support in Zambia that is via five implementers across various Gavi funding levers. -Gavi had introduced a new strategic approach for Fiduciary Risk Assurance and Financial Management of cash grants for its current strategic period that was approved by the Board in June 2020 through Assurance Providers selected for countries. A detailed workplan of the assurance provider as well as roles and responsibilities were reviewed and discussed with MOH/EPI and partners. The Country was encouraged to support the work of the AP and schedule regular update meetings with the AP/PWC to obtain direct updates on the status of their work. This was noted to be particularly important for the ongoing EPI capacity assessment that was yet to be concluded. Regarding the Gavi Programme Audit, both audit reports, programme and financial, had been shared with the country and published on Gavi site. There were several recommendations from the programme part of the audit that were noted to have been addressed. However, the response to the financial part of the audit was still yet to be provided by the country and an accompanying reimbursement request for US$802,085 by 30 November 2024. It was also noted that there was also need for special attention to the systematic implementation and tracking of the recommendations from various reviews: effective vaccine management (EVM) assessment, data quality audit (DQA), GMRs, audits. Zambia's co-financing was also acknowledged as part of ensuring uninterrupted delivery of vaccines to Zambia.		
	Portfolio Optimisation	A discussion on the planned new vaccine introductions, campaigns and applications included: Upcoming vaccine introductions included: ● IPV 2nd Dose (Scheduled for November 2024) ● Rota 2nd Switch (Timelines for this pending updated communication on supply availability of RotaVac5D) ● Malaria Vaccine Introduction (Application submitted awaiting IRC process) Planned campaigns included: OCV Preventive Campaigns (Country had received additional 2,246,140 doses of Oral Cholera Vaccines that they were seeking to repurpose from outbreak response to pre-emptive campaigns in selected response especially in view of the drought) Proposed applications included: ● HepB birth dose (in line with the National Health Strategic Plan 2022 – 2026) ● Hexavalent Switch (ZITAG consultations yet to be concluded) ● PCV Switch (ZITAG consultations yet to be concluded)	Ongoing (application to be submitted through various Application windows)	National EPI Manager

		● Cholera Preventive Campaigns (Country considering application of additional vaccines for pre-emptive campaigns) ● Mumps Containing Vaccines (Country considering introduction of Mumps Containing Vaccine in view of the number of mumps cases and outbreaks experienced. Clarification given that this vaccine was not under Gavi support) ● Mpox (Country had recorded one case of Mpox and was considering a vaccination campaign for target groups to be informed by the epidemiology). Country notified that at the time, there were no found allocations specific for Mpox and WHO was to be consulted on vaccine access/application processes)		