WHO continues to monitor the situation closely for any changes that may affect this interim guidance. Should any factors change, WHO will issue a further update. Otherwise, this interim guidance document will expire 2 years after the date of publication.

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Introduction

This COVID-19 vaccine post-introduction evaluation (cPIE) tool is designed to provide a systematic method for evaluating a COVID-19 vaccination programme, using structured interviews at the national, subnational, and health facility level, and with specific target groups, and is supplemented with systematic observations of vaccination sessions and vaccine storage sites. This tool was based on the publication, New Vaccine Post-Introduction Evaluation (PIE) Tool\(^1\) and the Influenza Vaccine Post-Introduction Evaluation.\(^2\)

The purpose of a cPIE is to:

- Highlight deployment activities that went well and should be maintained.
- Identify problems needing corrective action.
- Highlight lessons learned from the COVID-19 vaccine deployment to strengthen the overall national immunization system and services, specifically related to health workers, older adults, essential workers or persons with co-morbidities.
- Inform recommendations to improve roll-out of COVID-19 vaccines, especially in terms of vaccination of phased-in target groups and strategies for booster vaccination.
- Provide lessons learned for other countries for their own COVID-19 vaccine deployment and for future pandemic vaccine deployments.

The implementation of COVID-19 vaccination differs in several key aspects from prior new vaccine introductions into the national immunization programme. The cPIE strategy is adapted to COVID-19 vaccination approaches considering that multiple vaccine products may be in use in a country. Certain vaccine products may be targeted to different priority populations (e.g. health workers, persons 65 years and older, persons with co-morbidities, other essential workers, etc.) or in certain geographies. Certain COVID-19 vaccines require special considerations for ultra-cold-chain capacity and management, which has never been required for prior vaccines used within the Expanded Programme for Immunization (EPI). In addition, countries may undertake phased introduction by priority population, depending on available vaccine supply. The cPIE tools address all of these issues pertaining specifically to COVID-19 vaccines.

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When and where should a cPIE be done?

A cPIE is recommended to be conducted 6–18 months after initial COVID-19 vaccine introduction. More than one cPIE may need to be conducted during this period. In the early post-introduction period (within 2–6 months of introduction), prior to conducting the cPIE, countries are recommended to conduct a lighter, more flexible review known as the mini-cPIE, which uses the WHO intra-action review (IAR) platform. The mini-cPIE covers the same programme areas that are addressed in the full cPIE but does not require facility/site visits and direct observations.

The full cPIE should be performed at all levels of the health system. The minimum and maximum number of site visits at each level of the health service that are required to obtain a comprehensive overview of the system are outlined in Table 1. The maximum number of sites to be visited will depend on the size of the country, the heterogeneity of its health and vaccination services and the human and financial resources available to conduct the evaluation.

<table>
<thead>
<tr>
<th>Health administration level</th>
<th>Minimum number of interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central level</td>
<td>1</td>
</tr>
<tr>
<td>Regional/provincial level</td>
<td>3 – 6</td>
</tr>
<tr>
<td>District level</td>
<td>6 – 12</td>
</tr>
<tr>
<td>Health facility level</td>
<td>18 – 36</td>
</tr>
</tbody>
</table>

*Some countries may only have three administrative levels, and some may have more; the table can be adapted as appropriate.

The decision regarding which regions/provinces, districts and health facilities or vaccination sites to select for evaluation will vary based on country context but should be identified early to allow for site planning. Sites are selected based on a purposive sampling strategy that aims to provide a complete picture of immunization service delivery. This strategy is in keeping with recommendations for past PIEs and is not designed as a statistically representative survey, such that it can be conducted quickly without a need for statistical support for planning and analysis. Using the purposive sampling strategy, a variety of health facilities or other vaccination sites should be selected with consideration for the following criteria:

- Types of sites providing vaccination to priority groups, be they fixed or mobile;
- Priority population(s) served including sociodemographic groups particularly at risk and diversity in ethnic minorities, where appropriate;
- Predicted or estimated performance based on prior immunization coverage rates or other appropriate metrics;
- Estimated COVID-19 disease burden;
- Size range of the catchment population;
- Urban, peri-urban or rural location.

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The sampling frame from which to select sites to be visited would include vaccination services in hospitals, health centres, health facilities, but also in places of work, long-term care facilities for elderly or handicapped persons, educational institutions, military or police barracks, prisons, or private sector facilities/sites, as appropriate to the local situation.

**Conducting the cPIE**

**Desk review and adaptation of the tools**

Pre-planning is crucial for a successful cPIE. A timeline of pre-cPIE activities is provided in Annex 1. A desk review is an important part of the evaluation and should be conducted prior to the field work. Table 2 outlines some of the data and documents that should be sent to participants, if possible, in advance, and reviewed as part of the desk review. These will provide essential background information and orientation on the country context for the cPIE.

<table>
<thead>
<tr>
<th>Data/documents</th>
<th>Examples</th>
</tr>
</thead>
</table>
| Documents relating to COVID-19 vaccine deployment | ▪ National Deployment and Vaccination Plan  
▪ COVID-19 vaccination guidelines or policy documents for each vaccine product used  
▪ Sample microplan used at sub-national level |
| Materials relating to COVID-19 vaccine deployment | ▪ Samples of media campaign/social mobilization/education materials, e.g. brochures, posters, leaflets |
| Data relating to the current immunization system | ▪ COVID-19 vaccination report, including vaccine usage, drop-out, wastage  
▪ COVID-19 vaccine National Adverse Event Following immunization (AEFI) management guidelines  
▪ COVID-19 vaccine AEFI reporting form  
▪ COVID-19 surveillance report(s) or website |

**Conducting the fieldwork**

With advance planning and adequate resources, the PIE can be completed within 10 days. An overview of a typical 10-day evaluation timeline is outlined in Annex 1. Staff should plan to spend a half day at each site. Each questionnaire takes approximately one hour to complete, and completion of the observation checklist approximately 30 minutes. A summary of fieldwork is outlined in Table 3.
<table>
<thead>
<tr>
<th>Health administrative level</th>
<th>Questionnaire</th>
<th>Number of sites to visit</th>
<th>Type of people to interview</th>
<th>Observations required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>Annex A.1 National level questionnaire</td>
<td>1</td>
<td>Responsible individual(s) within the COVID-19 vaccination taskforce, MoH, key partner organizations, etc.</td>
<td>Vaccine stock records, immunization data records</td>
</tr>
<tr>
<td></td>
<td>Annex A.4 Vaccine storage observation</td>
<td>1</td>
<td>Central cold store manager</td>
<td>Central cold store or other private cold storage facilities, dry storage area</td>
</tr>
<tr>
<td>Provinces</td>
<td>Annex A.2 Subnational level questionnaire</td>
<td>3-6</td>
<td>Person responsible for COVID-19 vaccination programme</td>
<td>Vaccine stock records, immunization data records</td>
</tr>
<tr>
<td></td>
<td>Annex A.4 Vaccine storage observation</td>
<td>3-6</td>
<td>Provincal cold store manager</td>
<td>Vaccine stock records, immunization data records</td>
</tr>
<tr>
<td>Districts</td>
<td>Annex A.2 Subnational level questionnaire</td>
<td>6-12 (2 per province)</td>
<td>Person responsible for COVID-19 vaccination programme</td>
<td>Vaccine stock records, immunization data records</td>
</tr>
<tr>
<td></td>
<td>Annex A.4 Vaccine storage observation</td>
<td>6-12 (2 per region or province)</td>
<td>District cold store manager</td>
<td>District cold store or other private cold storage facilities, dry storage areas</td>
</tr>
<tr>
<td>Health facilities and other vaccination sites</td>
<td>Annex A.3 Health facility/site questionnaire</td>
<td>18-36 (3 per district)</td>
<td>Health-care worker</td>
<td>Vaccine management, service delivery</td>
</tr>
<tr>
<td></td>
<td>Annex A.4 Vaccine storage observation</td>
<td>18-36 (3 per district)</td>
<td>Health-care worker</td>
<td>Cold and dry storage areas</td>
</tr>
<tr>
<td></td>
<td>Annex A.5 Vaccine session observation</td>
<td>18-36 (1 per health facility)</td>
<td>N/A</td>
<td>Vaccination session</td>
</tr>
</tbody>
</table>
Annex A.6
Health workers priority group questionnaire
At least 36 (at least 2 health workers per facility/site)
Health workers who have just been vaccinated
Vaccination cards

Annex A.7
Other priority group questionnaire
At least 36 (at least 2 health workers per vaccination site; aim to conduct a similar number of interviews across sites selected)
Individuals in other priority groups who have just been vaccinated
Vaccination cards

The number of health personnel required to conduct the PIE effectively within a 10-day time period will depend on the number of sites selected and whether multiple teams will visit sites simultaneously. A cPIE team leader should be selected, and all team members should have knowledge of the COVID-19 vaccination programme, its target populations, programme monitoring, and data analysis. It is useful to include a mix of local immunization partners WHO, UNICEF, other key in-country immunization partners and nongovernmental organizations active in COVID-19 immunization services. Historically, external staff from WHO/UNICEF and other international partners have participated in PIEs following the introduction of other vaccines, and virtual technical assistance from such partners should be considered. Additionally, Considering the COVID-19 transmission risk at the time of the evaluation, virtual platforms can also be considered for conducting some components of the cPIE including the orientation training at the beginning of the evaluation and the national and subnational interviews, as appropriate.

Data are collected on the following 9 principal evaluation areas (in alignment with the Guidance on National Deployment Planning and Vaccination for COVID-19 Vaccines):⁴

- Regulatory preparedness
- Planning, coordination, and service delivery
- Costing and funding
- Supply chain and waste management
- Human resource management and training
- Vaccine demand
- Vaccine safety
- Monitoring and evaluation
- COVID-19 surveillance

Data management

Data collection can be done using paper forms or electronically using tablets programmed with ODK software. Using electronic data collection is recommended where possible given the variety of circumstances between countries in terms of COVID-19 vaccine products and possible vaccination strategies for priority populations. Whether using paper or tablets, the questionnaires should be reviewed and adapted to the country context prior to implementation of field work.

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Discussion and reporting of findings

Following the fieldwork, the findings and recommendations should be compiled by the cPIE team, ideally during a workshop held over at least one day at the end of the evaluation process. Individual teams should report on their findings so that they can be discussed and compiled into the report. A final presentation (ppt) and MS Word document should be prepared with an overview of the evaluation activities, a summary of the findings by area, and overall recommendations (Annex 5 and Web annex C).

After the workshop, findings should be presented (Annex 3) at a high-level meeting with the COVID-19 Incident Management Task Force and vaccination subcommittee, the Interagency Coordination Committee (ICC), key MoH officials and other entities key to the planning, management and deployment of COVID-19 vaccine. Recommendations should be achievable, based on the evaluation findings, and take into account recommendations from any prior COVID-19 vaccination IARs (mini-cPIEs) or other earlier evaluations conducted. The focus should be on problems that were consistently noted across several locations. It is critical that COVID-19 vaccination programme manager and key staff lead formulation of the recommendations. It is recommended that countries share the report and data with WHO regional offices and headquarters to inform collective learnings on trends, common themes, and challenges related to COVID-19 vaccine roll-out.

How much does it cost to conduct a cPIE?

The cPIE has been designed for countries to self-administer. Costs will vary depending on the size of the country, the number of sites selected, and what parts of the cPIE are conducted virtually versus in person. Prior to the COVID-19 pandemic, PIE costs have been in the range of $40,000 to $50,000. Costs may be significantly reduced during the pandemic due to travel restrictions, smaller teams, and fewer in-person meetings. If human resources are limited, countries may consider spacing site visits out over a longer period of time in order to decrease the number of staff required to conduct site visits and observations. Costs may include allowances for personnel, training, transport and supplies. Planning for a cPIE should form part of the vaccine deployment plan developed prior to vaccine introduction.
cPIE Annexes

Annex 1. Sample timeline for planning and implementing a cPIE
Annex 2. Suggested key findings

Web Annex A. cPIE questionnaires
   A.1. National questionnaire
   A.2. Subnational questionnaire
   A.3. Health facility/site questionnaire
   A.4. Vaccine storage observation
   A.5. Vaccine session observation
   A.6. Health worker priority group questionnaire
   A.7. Other priority group questionnaire

Web annex B. cPIE questionnaire summary tables
Web annex C. cPIE country presentation template
Web annex D. cPIE example figures for presentation
Annex 1. Sample timeline for planning and implementing a cPIE

<table>
<thead>
<tr>
<th>Activity</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Identify and confirm cPIE participants</strong></td>
<td>1 month before evaluation</td>
</tr>
</tbody>
</table>
| • Should include key COVID-19 vaccination programme staff and in-country partners, e.g. WHO, UNICEF and other key technical immunization partners.  
  • The cPIE team leader should be confirmed well in advance. |                          |
| **Conduct desk review**                                         | 2 weeks before evaluation|
| • A desk review is an important part of the evaluation and should be conducted prior to the field work.  
  • All relevant evaluations and assessments conducted (e.g. COVID-19 Vaccination Intra-Action Reviews, Behaviour and Social Drivers (BeSD) evaluations, review of (social) media information on perceived successes and failures of the COVID-19 vaccination effort, etc.) should be compiled and shared. |                          |
| **Select regions/districts/health facilities to be visited**    | 2 weeks before evaluation|
| • It is recommended that at least three regions, six districts and 18-36 health facilities be selected by the national cPIE coordinating team. The number of sites selected may be increased in order to include examples of the different types of sites providing vaccination.  
  • Selection should include: a variety of types of vaccination sites serving different priority groups (in traditional health facility sites as well as in workplaces, educational institutions, long-term care facilities for elderly or handicapped persons, military or police barracks, prisons, and private sector facilities/sites); both well performing and poorly performing areas in terms of immunization services; and geographic (urban, peri-urban, rural) and other socioeconomic diversity (ethnic, migrant or minority populations). |                          |
| **Form cPIE teams, allocate teams to regions/districts/health facilities** | 1 week before evaluation|
| • Teams should be composed of at least two staff members, preferably one from the COVID-19 vaccination programme and one from a partner organization and include subnational (provincial, district) senior staff, as appropriate. Each team should include one driver (if traveling to the field).  
  • One team needs to be allocated to conduct the interviews at the central level (National Task Force, MoH, central cold store, etc.). |                          |
<table>
<thead>
<tr>
<th>Task</th>
<th>Timeframe</th>
</tr>
</thead>
</table>
| Notify selected regions/districts/health facilities that they will be visited  
  - Important to ensure that site staff and vaccinators are present and available at the time of the visit and that immunization sessions will be carried out in the clinics on the days visited.  
  - If appropriate, cold stores may be visited on Saturdays to optimize time available.  
  - National or regional holidays should be avoided. | 1 week before evaluation |
| Organize per diems for team members  
  - If not organized, can delay travel to the field. | 1 week before evaluation |
| Organize transport and accommodation for field locations  
  - Allow adequate travel time; arrange for everyone to return from the field the same days so that all teams can start jointly reviewing data and compiling the report and recommendations.  
  - If some teams need to fly to the field, flights may need to be booked earlier than 1 week before. | 1 week before evaluation (earlier for flights) and confirm 2 days before travel |
| Organize logistics for virtual components – national/subnational interviews and/or training (if applicable)  
  - Organize equipment needed to conduct virtual interviews (e.g. laptops).  
  - Identify platform to be used to conduct virtual interviews (e.g. WhatsApp, Skype, Zoom) and ensure all team members and interviewees will have access to the platform and a stable internet connection. | 1 week before evaluation and test 2 days before |
| Plan timetable and itinerary  
  - Prior to going to the field, teams should have a clear agenda, all necessary materials and tools updated to the local situation and all logistics should be arranged. | 1 week before evaluation |
| Arrange a workshop to compile and discuss findings, and schedule a feedback meeting with the MoH, COVID-19 Task Force and Vaccination Subcommittee, and immunization partners  
  - Allocate at least one day for the workshop to compile all findings, discuss, and develop the report. It may take time to organize this meeting so is better done in advance.  
  - The final cPIE team feedback meeting should include senior members from the COVID-19 Taskforce and Vaccination Subcommittee, MoH, and other key immunization partners, to formulate recommendations and create implementation plan. | 1 week before evaluation |
### Implementation Timeline

<table>
<thead>
<tr>
<th>Activity</th>
<th>Itinerary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Finalize and review data input tools with participants</strong>&lt;br&gt;● Team meets to review objectives and ensure consistent interpretation of PIE tools.&lt;br&gt;  ○ Final adaptation of tools for country situation. Countries planning electronic data collection will need to make updates to the software based on final changes to the questionnaires.&lt;br&gt;  ○ All teams equipped with data input tools (e.g. tablet or laptop), software (e.g. ODK, Excel, etc.) and appropriately trained, so that data can be uploaded daily and/or merged when teams re-convene, depending on the software used.&lt;br&gt;  ○ Report and presentation templates provided to collate data from all teams to record the main strengths and areas for improvement in the areas visited.&lt;br&gt;  ● Teams agree to the roles and responsibilities of each team member.&lt;br&gt;  ● Ensure all team members are aware of field visit logistics, have the appropriate materials needed, and have team contact information in case issues arise.</td>
<td>Days 1–2</td>
</tr>
<tr>
<td>Travel to field (preferably at the weekend if travel times are long).</td>
<td>Day 3</td>
</tr>
<tr>
<td><strong>Field visits to regions/provinces, districts, and health facilities and other vaccination sites</strong>&lt;br&gt;● Meet with COVID-19 vaccination programme representatives at the province and district levels and finalize selection of vaccination facilities/sites to be visited with district authorities.&lt;br&gt;● Conduct interviews and observation sessions (Web annex A).&lt;br&gt;● At the end of each day, team members should discuss and record (upload data if using tablets) the findings (Web annex B), identify key issues and highlight the strengths and areas for improvement of the COVID-19 vaccination service delivery at that site and enter the information into the appropriate templates.&lt;br&gt;● Before returning to the central level, debrief with subnational (provincial and district) COVID-19 vaccination programme authorities at province and district levels.</td>
<td>Days 4–7</td>
</tr>
<tr>
<td>Return from field</td>
<td>Day 8</td>
</tr>
</tbody>
</table>
Joint report back by all teams

- During a joint workshop, all teams should debrief together with individual teams reporting on their findings and ensuring the cPIE team leader has all relevant materials used in the field (Annex 2 and Web annexes A and B)
  - Ideally the workshop format should include a first round, in which the (geographical) teams present their findings according to a predefined template (outlining the 9 themes of the evaluation); and a second round, when the information on these themes is compiled by previously assigned theme leads and presented to the full team in the evening or the next morning for final feedback by all team members.
  - Data from the teams should be used to identify the key findings (Annex 2).
- A final presentation (Web annexes C and D) should be compiled from the individual teams’ findings and then reviewed jointly by the whole group to ensure that all aspects from various interviews are reflected. This forms the final presentation to the COVID-19 Task Force (or other institution) marking the end of the evaluation.
  - Ensure recommendations and action plan are included.

<table>
<thead>
<tr>
<th>Joint report back by all teams</th>
<th>Days 8–9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Final presentation to COVID-19 Taskforce and Vaccination Subcommittee, ICC, and high-level MoH officials</td>
<td>Day 10</td>
</tr>
<tr>
<td>Finalize action plan and report (Annex 3) for dissemination</td>
<td>Following the final presentation</td>
</tr>
</tbody>
</table>
Annex 2. Suggested key findings

To help with analysis, several quantitative key findings are indicated by a ★ in the questionnaires. Unless otherwise indicated, most key indicators are derived from the healthcare facility questionnaire (Annex A.3) with additional key indicators from other questionnaires, indicated in the table below.

Additionally, provision has been made to include qualitative Q key findings to provide more detailed information.

You may select all, some, or add your own findings to summarize your evaluation.

<table>
<thead>
<tr>
<th>Q No.</th>
<th>Key Findings</th>
<th>Numerator/Denominator</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>PLANNING, COORDINATION, AND SERVICE DELIVERY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>207</td>
<td>% of health facilities reporting offering multiple COVID-19 vaccine products</td>
<td></td>
<td></td>
</tr>
<tr>
<td>207</td>
<td># health facilities offering 1 COVID-19 vaccine product # health facilities offering 2 COVID-19 vaccine products # health facilities offering ≥3 COVID-19 vaccine products</td>
<td></td>
<td></td>
</tr>
<tr>
<td>355</td>
<td><strong>(A.5 Vaccine observation session)</strong> Q Describe the infection prevention and control precautions in place for the safe delivery of COVID-19 vaccines – highlighting key ones that are missing.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>377</td>
<td><strong>(A.5 Vaccine observation session)</strong> % of observation sessions where vaccinee received documentation of their vaccination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>223</td>
<td>Q Major barriers identified for administering COVID-19 vaccine to the different priority groups, and how they were overcome.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COSTING AND FUNDING</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>126</td>
<td><strong>(A.2 Province/District level questionnaire)</strong> % subnational areas reporting activities for successful vaccine implementation constrained by financial resources</td>
<td></td>
<td></td>
</tr>
<tr>
<td>126</td>
<td><strong>(A.2 Province/District level questionnaire)</strong> Q Which costs for COVID-19 vaccine deployment have been constrained by funding gaps.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## SUPPLY CHAIN AND WASTE MANAGEMENT

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>230</td>
<td>% of health facilities observed or reported problems with cold chain (vaccine doses compromised due to temperature excursions or other mishandling during transport or storage) since the new vaccine introduction</td>
</tr>
<tr>
<td>232</td>
<td>% of health facilities with vaccine wastage reports on site (information from documents requested at beginning of visit to health facility/site)</td>
</tr>
<tr>
<td>237</td>
<td>% of health facilities reporting following the multi-dose vial policy for COVID-19 vaccine</td>
</tr>
<tr>
<td>241</td>
<td>Q Description of challenges related to delivery or collection of vaccines at vaccination facilities/sites.</td>
</tr>
<tr>
<td>247</td>
<td>% of health facilities reporting stock outs for COVID-19 vaccine in the last six months</td>
</tr>
</tbody>
</table>

## HUMAN RESOURCE MANAGEMENT AND TRAINING

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>249</td>
<td>% health facilities reporting sufficient trained vaccinators to meet demand for COVID-19 vaccine?</td>
</tr>
<tr>
<td>250</td>
<td>% health facilities reporting at least one individual from the health facility having participated in COVID-19 vaccine training</td>
</tr>
<tr>
<td>253</td>
<td>% of health facilities reporting one or more supervisory site visits since the introduction COVID-19 vaccine</td>
</tr>
<tr>
<td>256</td>
<td>Q Description of how confident in their knowledge of the different areas health workers felt.</td>
</tr>
</tbody>
</table>

## VACCINE DEMAND

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>259</td>
<td>% of health facilities reporting local COVID-19 vaccine-specific social mobilization activities conducted</td>
</tr>
<tr>
<td>263</td>
<td>Q Description of questions or rumours about the COVID-19 vaccine</td>
</tr>
</tbody>
</table>
### Health worker priority group questionnaire

- % health workers in priority group interviews reporting to have wanted COVID-19 vaccine but were unable to access it.
- % health workers in priority group interviews reporting to have declined COVID-19 vaccine

### Main reasons people are refusing COVID-19 vaccination.

#### VACCINE SAFETY

- % health facilities with AEFI procedure in place
- Description of whether health workers are hesitant to report AEFI either due to fear that it will lead to personal consequences, lack of confidence about diagnosis, lack of interest, etc.
- % health facilities that reported an AEFI for COVID-19 vaccination in the last year or since COVID-19 vaccination began

### Vaccine observation session

- % of observation sessions where vaccinees were observed for the correct period of time after vaccination

### Monitoring and Evaluation

- % health facilities using electronic recording and reporting system
- % health facilities able to track more than one vaccine product for the programme
- % health facilities able to track more than one vaccine product for a given individual
- % health facilities reporting having updated immunization registers, tally books, or other reporting materials for COVID-19 vaccination
- % health facilities reporting tracking defaulters (if 2-dose regimens are being used)
- % health facilities with overall uptake data available
<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>296</td>
<td>Health facility vaccination overall uptake range</td>
</tr>
<tr>
<td>296</td>
<td>% health facilities with uptake data available by priority group</td>
</tr>
<tr>
<td>298</td>
<td>Drop-out from 1st dose to 2nd dose (Calculated as: (COV1-COV-2)/COV-1), if available by health facility</td>
</tr>
<tr>
<td>299</td>
<td>Q Description of whether existing (childhood or adult) immunization programmes been affected by the introduction of COVID-19 vaccine: improvements or disruptions.</td>
</tr>
</tbody>
</table>

Cover
COVID-19 Vaccine Post-Introduction Evaluation
Date
Country

Executive Summary (1 page)
- Background
- Objectives
- Summary of findings
- Recommendations

Background (1 page)
- Rationale for introduction of COVID-19 vaccine
- Description of introduction

Methods (1–2 pages)
- Evaluation team members
- Objectives of evaluation
- Design of evaluation

Findings (3–5 pages)

Findings should match the major areas listed below. Observed strengths and weaknesses or areas of concern should be noted.
Include Key Findings in the appropriate sections

1. Regulatory preparedness
2. Planning, coordination, and service delivery
3. Costing and funding
4. Supply chain and waste management
5. Human resource management and training
6. Vaccine acceptance and demand
7. Vaccine safety
8. Monitoring and evaluation
9. COVID-19 surveillance
**Recommendations (1–2 pages)**

The team should make a limited number of recommendations per programmatic area. These recommendations should be specific and, whenever possible, should include:

1) person(s) responsible;
2) proposed timeframe for implementation;
3) expected outcome and indicators.

All recommendations should be in accordance with existing national policies.

**Appendices**

- Itinerary
- Team members
- List of persons met
- Data collection instruments
- Key indicator table (Annex 2)
- Presentation made to the COVID-19 Task Force and other key stakeholders
- Action Plan for implementation of recommendations