**Mozambique**

**PEF Targeted Country Assistance (TCA) Narrative**

**for 2022-2025 Multi-Year Planning**

Use this template to create a narrative that contextualises your TCA plan for the planned duration and how the support that you are requesting from Gavi will help you reach your immunisation goals.

*(Populated by Gavi and EPI)*

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| **Total Envelope** | **Indicative allocation per 2022-2025** | | **%** |
| $4,270,193 | **2022** | $640,700 | 15% |
| **2023** | $1,407,406 | 33% |
| **2024** | $1,407,406 | 33% |
| **2025** | $814,681 | 19% |

1. **Key objectives for the EPI program and known gaps/bottlenecks (0.5 page)**

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| ***1.1 Please note any country context that is significant to understanding the country's vision and request for Gavi TCA support. What specific effects do these factors have on the national immunisation programme?*** |
| The years 2020-2022 were marked by the unprecedented crisis caused by Covid-19, with evidence showing immunisation services in Gavi-supported countries were disrupted. Thousands of children did not receive vaccinations, increasing the potential for new outbreaks of vaccine-preventable diseases, as occurred in 2021 (measles) and 2022 (polio and measles). Such outbreaks further exacerbate existing inequalities, putting the most marginalised and poorest communities at greatest risk.  In addition, in Mozambique, existing inequalities in access and availability of health care have been exacerbated by large internal displacements due to conflicts and natural disasters (cyclones and floods) which have destroyed infrastructure (including health facilities). IOM Mozambique estimates that by 2022 a total of 784,564 IDPs or 2.4% of the country's population, are currently displaced as a result of armed attacks in Cabo Delgado, Manica and Sofala provinces. Only a minority of affected families are in accommodation centres, with the majority relying on shelter provided by host communities and/or family members.  Over the last five years, the vaccination schedule and target groups have expanded and, with the advent of Covid-19, the current EPI team at national and sub-national level is stretched to meet the growing needs of the programme.  The pressing need to address existing programmatic gaps, recover routine post-pandemic vaccination and further strengthen service delivery while responding to a life-cycle vaccination approach and recurrent emergencies resulting from natural disasters and catastrophes all contributed to shaping this TCA planning exercise. |

1. **Current TA needs of your immunisation system (1-2 pages)**

***Please provide the planned allocation of PEF TCA towards investments areas and high-level objectives. Gavi-supported investment areas and a menu of objectives are available for reference in Gavi’s*** [***Programme Funding Guidelines***](https://www.gavi.org/news/document-library/gavi-programme-funding-guidelines)***. The country can plan for the remaining duration of their current HSS grant.***

***Note: Interventions required to achieve each high level objective are expected to change over the course of this TCA Plan.***

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| **High-level Plan** | | **Budget (USD)** | **%** |
| **2022** | | | |
| Service delivery | Extend immunisation services to reach zero-dose, underimmunised children and missed communities by designing targeted strategies and approaches and identifying relevant partnerships and collaborations. | $128,140.00 | 19% |
| Define strategies, mechanisms and tools needed to ensure integration of routine and Covid-19 vaccination within EPI activities (fixed posts, outreach, campaigns etc.) and with other health services, to improve efficiency. |
| Design and implement life course immunisation approaches relevant to Gavi supported vaccine programmes (HPV2, Hepatitis B, IPV2, malaria, cholera etc.) |
| Support the application for and introduction of new vaccines and create standard tools to manage introduction using project management methods. |
| Human resources for health | Improve the professional capacity of health workers as relevant at different levels by strengthening leadership, coordination and management skills. | $64,070.00 | 10% |
| Design an EPI Capacity Building and related M&E Plan to guide and monitor all technical assistance aimed at building EPI capacity, including TCA support, at all levels. |
| Supply chain | Improve the design of the immunisation supply chain (iSC) system for greater efficiency and vaccine availability, especially in the last mile. | $160,175.00 | 25% |
| Improve stock management for vaccines and devices to avoid facility-level stock-outs. |
| Conduct an effective vaccine management assessment (EVMA) to prevent stock-outs at health facility level and develop the related implementation plan (EVMIP). |
| Plan to increase the capacity and quality of vaccine storage and distribution to improve vaccine availability, especially in the last mile. |
| Establish electronic for cold chain inventory systems. |
| HIS, monitoring, evaluation, learning and  vaccine-preventable disease (VPD) surveillance | Review, rationalise and optimise the information systems necessary to ensure the EPI operates effectively, allowing for visibility on progress towards objectives and taking corrective decisions and actions whenever necessary. | $153,768.00 | 24% |
| Design a comprehensive EPI Strategy/ Monitoring Plan to enable tracking of EPI status in key areas (programme management, interventions and coverage. |
| Support the plan for the introduction and implementation of the Electronic Immunization Register and other digital health information interventions based on the country's needs, priorities, plans, strategies and readiness. |
| Implement operational research to enable use of evidence in the design of strategies, action plans and inform decision-making, including for the zero dose approach. |
| Develop mechanisms to sustainably integrate vaccine-preventable disease (VPD) surveillance, which meets EPI needs, into a national resilient disease surveillance system. |
| Support post-Covid-19 recovery by improving MoH's capacity to ensure the availability and use of timely and accurate routine data for decisions on vaccine introduction and targeted preventative campaigns. |
| Increase timely detection of and response to vaccine-preventable disease outbreaks. |
| Establish capacity, mechanisms and routines to ensure the use of surveillance data to identify ways to improve the effectiveness of EPI in disease prevention at national level. |
| Demand creation & community engagement | Update the EPI Social Mobilisation and Demand Creation Strategy, including the design of implementation and monitoring plans and specific guidelines for the different implementation levels, to ensure adequate capacity for achieving social and behaviour change, including evidence-based and gender-sensitive SBC interventions. | $96,105.00 | 12% |
| Improve capacity to design, implement, monitor and/or evaluate demand generation activities at all levels. |
| Design the strategy / progressive approach to advocate for social and political commitment and increase accountability for equitable immunisation at all levels, as appropriate. |
| Governance, policy, strategic planning & programme management | Strengthen leadership, management, coordination and supervisory capacity at all levels, depending on needs and the emerging context. | $64,070.00 | 10% |
| Health financing | Support the planning of Gavi and non-Gavi-supported vaccine procurement costs based on quality vaccine forecasts as part of national and subnational health budgets. | $0 | 0% |
| Improve the use and tracking of immunisation fund flows going to health facility level. |
| **2023** | | | |
| Service delivery | Extend immunisation services to reach zero-dose, underimmunised children and missed communities by designing and implementing targeted strategies and approaches and identifying relevant partnerships and collaborations. | $253,333.08 | 18% |
| Define strategies, mechanisms and tools needed to ensure integration of routine and Covid-19 vaccination within EPI activities (fixed posts, outreach, campaigns etc.) and with other health services, to improve efficiency. |
| Design and implement life course immunisation approaches relevant to Gavi supported vaccine programmes (HPV2, Hepatitis B, IPV2, malaria, cholera etc.) |
| Support the application for and introduction of new vaccines and create standard tools to manage introduction using project management methods. |
| Human resources for health | Improve the professional capacity of health workers as relevant at different levels by strengthening leadership, coordination and management skills. | $112,592.48 | 8% |
| Design and implement an EPI Capacity Building Plan and related M&E Plan to guide and monitor all technical assistance aimed at building EPI capacity, including TCA support, at all levels. |
| Supply chain | Improve the design of the immunisation supply chain (iSC) system for greater efficiency and vaccine availability, especially in the last mile. | $351,851.50 | 25% |
| Conduct an effective vaccine management assessment (EVMA) to prevent stock-outs at health facility level and develop the related implementation plan (EVMIP). |
| Plan to increase the capacity and quality of vaccine storage and distribution to improve vaccine availability, especially in the last mile. |
| Establish electronic for cold chain inventory systems. |
| HIS, monitoring, evaluation, learning and  VPD surveillance | Review, rationalise and optimise the information systems necessary to ensure the EPI operates effectively, allowing for visibility on meeting objectives and taking corrective decisions and actions whenever necessary. | $337,777.44 | 24% |
| Design a comprehensive EPI Strategy/ Monitoring Plan to enable tracking of EPI status in key areas (programme management, interventions and coverage. |
| Support the plan for the introduction and implementation of the Electronic Immunization Register and other digital health information interventions based on the country's needs, priorities, plans, strategies and readiness. |
| Develop mechanisms to sustainably integrate VPD surveillance, which meets EPI needs, into a national resilient disease surveillance system. |
| Support post-Covid-19 recovery by improving MoH's capacity to ensure the availability and use of timely and accurate routine data for decisions on vaccine introduction and targeted preventative campaigns |
| Increase timely detection of and response to vaccine-preventable disease outbreaks. |
| Establish capacity, mechanisms and routines to ensure the use of surveillance data to identify ways to improve the effectiveness of EPI in disease prevention at national level. |
| Demand creation & community engagement | Update the EPI Social Mobilisation and Demand Creation Strategy, including the design of implementation and monitoring plans and specific guidelines for the different implementation levels, to ensure adequate capacity for achieving social and behaviour change, including evidence-based and gender-sensitive SBC interventions. | $154,814.66 | 11% |
| Improve capacity to design, implement, monitor and/or evaluate demand generation activities at all levels. |
| Design and implement the strategy / progressive approach to advocate for social and political commitment and increase accountability for equitable immunisation at all levels, as appropriate. |
| Governance, policy, strategic planning & programme management | Strengthen leadership, management, coordination and supervisory capacity at all levels, depending on needs and the emerging context. | $140,740.60 | 10% |
| Health financing | Support the planning of Gavi and non-Gavi-supported vaccine procurement costs based on quality vaccine forecasts as part of national and subnational health budgets. | $56,296.24 | 4% |
| Improve the use and tracking of immunisation fund flows going to health facility level. |
| **2024** | | | |
| Service delivery | Implement targeted strategies/approaches and approved collaborations to extend immunisation services to reach zero dose, under immunised children and under-served communities. | $253,333.08 | 18% |
| Design and implement life course immunisation approaches relevant to Gavi supported vaccine programmes (HPV2, Hepatitis B, IPV2, malaria, cholera etc.) |
| Support the application for and introduction of new vaccines and create standard tools to manage introduction using project management methods. |
| Human resources for health | Improve the professional capacity of health workers as relevant at different levels by strengthening leadership, coordination and management skills. | $140,740.60 | 10% |
| Implement an EPI Capacity Building Plan and related M&E Plan to guide and monitor all technical assistance aimed at building EPI capacity, including TCA support, at all levels. |
| Supply chain | Ensure effective and timely use, at all levels, of the iSC system to improve efficiency and availability of vaccines, especially in the last mile. | $351,851.50 | 25% |
| Support implementation of the EVMIP. |
| HIS, monitoring, evaluation, learning and  VPD surveillance | Ensure successful implementation of EPI’s health information systems as required and with a focus on identifying and reaching zero-dose and not fully vaccinated children. | $309,629.32 | 22% |
| Ensure successful implementation of the comprehensive EPI Strategy / Monitoring Plan, as required. |
| Support the plan for the introduction and implementation of the Electronic Immunization Register and other digital health information interventions based on the country's needs, priorities, plans, strategies and readiness. |
| Develop mechanisms to sustainably integrate vaccine-preventable disease (VPD) surveillance, which meets EPI needs, into a national resilient disease surveillance system. |
| Increase timely detection of and response to vaccine-preventable disease outbreaks. |
| Establish capacity, mechanisms and routines to ensure the use of surveillance data to identify ways to improve the effectiveness of EPI in disease prevention at national level. |
| Demand creation & community engagement | Ensure successful implementation of the EPI Demand Generation and Social Mobilisation Strategy and monitoring plan, as necessary | $154,814.66 | 11% |
| Improve capacity to design, implement, monitor and/or evaluate demand generation activities at all levels. |
| Implement the strategy / progressive approach to advocate for social and political commitment and increase accountability for equitable immunisation at all levels, as appropriate. |
| Governance, policy, strategic planning & programme management | Strengthen the capacity of governance / technical bodies for planning, coordinating and tracking progress at all levels, particularly for reaching zero-dose children. | $140,740.60 | 10% |
| Health financing | Support the planning of Gavi and non-Gavi-supported vaccine procurement costs based on quality vaccine forecasts as part of national and subnational health budgets. | $56,296.24 | 4% |
| **2025** | | | |
| Service delivery | Implement targeted strategies/approaches and approved collaborations to extend immunisation services to reach zero dose, under immunised children and under-served communities. | $154,879.39 | 19% |
| Design and implement life course immunisation approaches relevant to Gavi supported vaccine programmes (HPV2, Hepatitis B, IPV2, malaria, cholera etc.) |
| Support the application for and introduction of new vaccines and create standard tools to manage introduction using project management methods. |
| Human resources for health | Improve the professional capacity of health workers as relevant at different levels by strengthening leadership, coordination and management skills. | $40,734.05 | 5% |
| Provide the necessary TA to ensure implementation of prioritised interventions as defined in the EPI Capacity Building Strategy (once finalised). |
| Supply chain | Ensure effective and timely use, at all levels, of the iSC system to improve efficiency and availability of vaccines, especially in the last mile. | $211,817.06 | 26% |
| Support implementation of the EVMIP. |
| HIS, monitoring, evaluation, learning and  VPD surveillance | Ensure successful implementation of EPI’s health information systems as required and with a focus on identifying and reaching zero-dose and not fully vaccinated children. | $195,523.44 | 24% |
| Ensure successful implementation of the comprehensive EPI Strategy / Monitoring Plan, as required. |
| Support the plan for the introduction and implementation of the Electronic Immunization Register and other digital health information interventions based on the country's needs, priorities, plans, strategies and readiness. |
| Increase timely detection of and response to vaccine-preventable disease outbreaks. |
| Establish capacity, mechanisms and routines to ensure the use of surveillance data to identify ways to improve the effectiveness of EPI in disease prevention at national level |
| Demand creation & community engagement | Ensure successful implementation of the EPI Demand Generation and Social Mobilisation Strategy and monitoring plan, as necessary | $97,761.72 | 12% |
| Improve capacity to design, implement, monitor and/or evaluate demand generation activities at all levels. |
| Implement the strategy / progressive approach to advocate for social and political commitment and increase accountability for equitable immunisation at all levels, as appropriate. |
| Governance, policy, strategic planning & programme management | Strengthen the capacity of governance / technical bodies for planning, coordinating and tracking progress at all levels, particularly for reaching zero-dose children. | $81,468.10 | 10% |
| Health financing | Support the planning of Gavi and non-Gavi-supported vaccine procurement costs based on quality vaccine forecasts as part of national and subnational health budgets. | $32,587.24 | 4% |

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| ***2.1 Please reflect and describe your immunisation system's current TA needs as they are aligned with investments made by Government, Gavi and bilateral/multilateral donors. Your answers shall provide the context of and rationale for the requested TCA support from Gavi.* *Please explicitly note the duration of the requested support.*** |
| The technical assistance needs identified through this exercise reflect requirements as the country emerges from the Covid-19 pandemic and assesses needs to ensure recovery of primary health care. Throughout the Covid-19 pandemic response and vaccination effort, the Ministry of Health (MoH) has benefited from resources provided by Gavi, United Nations Organisations, the donor community and domestic resources, with the aim of ensuring the best available protection of the population through vaccination. This support included vaccine donations through COVAX, AVAT and bilaterally, in addition to Government investment in vaccines, both direct and through funding from COVAX and the World Bank. Initially, in addition to support from Gavi (HSS reallocation and Bridge funding) and later the World Bank and other donors, the Government of Mozambique covered operational costs associated with Covid-19 vaccination campaigns. As a result of the unpredictability of the delivery, type, expiry date and quantity of vaccines arriving in the country, operational costs increased, with most of the costs related to human resource allocation (subsidies) being borne by different donors such as Gavi and bilateral partners through UNICEF and the MoH itself.  Due to the impact of the pandemic on service delivery, which until recently focused significant human resources on Covid vaccination to the detriment of routine vaccination, current TA needs focus on restoring and strengthening routine vaccination and primary health care generally, together with all associated programmatic aspects supporting implementation of the HSS grant and achievement of programmatic goals by 2025.  The timeframe for this TCA is 2022 to 2025, with different activities to be identified for the high level objectives – different implementation periods are expected, according to the actual activity / area of support. |
| * 1. ***How will the requested TCA support advance Gavi's 5.0 mission per the country's context with focus on:*** * ***identifying and reaching zero-dose and consistently missed children and communities;*** * ***improving stock reporting and vaccine management at sub-national level;*** * ***enhancing strong leadership, management and coordination, including use of data for decision-making;*** * ***introduction and scale up of vacciness;*** * ***programmatic sustainability.*** |
| The current request clearly reflects the close relationship between the country’s focus and Gavi's 5.0 strategy . In particular:   * **Zero dose children and missed communities**: Identifying zero dose children and underserved communities is an MoH priority. To this end, innovative approaches will be implemented using GIS technologies to map zero dose children and underserved communities. The MoH will be supported by partners in the first two years of this ATT and establishing a mapping system that enables MoH to regularly map an didentify underserved communities during the following 2 years. Plan to develop targeted strategies to reach zero-dose children and communities, ensuring skills transfer to the EPI team by 2025. The EPI will lead on service delivery, human resources, supply chain, SIS, monitoring, evaluation and learning, demand creation and community engagement as well as governance, policy, strategic planning and programme management areas. * **Stock reporting and vaccine management:** To improve visibility of vaccine stock management the MoH intends to adapt/change the LMIS systems in use to ensure they are effective, user friendly at all levels and compatible with global systems. This will be done with the support of partners intensively in the early years and phasing out in the later years. The EPI will lead on supply chain, SIS, monitoring and learning areas. * **Leadership, management and coordination:** With Gavi's support, an EPI Capacity Building Strategy (for all levels of service delivery) is currently being developed. It is expected the Strategy will enable development of effective plans for improvement in the various EPI programmatic areas. Implementation of the Strategy would be supported by partners at different levels of operationalisation. The MoH EPI will lead on service delivery, human resources, monitoring and programme management areas. * **Vaccine introduction and scale-up:** In order to better control VPD and in line with global recommendations, Mozambique intends to introduce IPV2, malaria, cholera and Hepatitis B vaccines. These will be phased in over four years and will be supported by partners. The MoH EPI will lead on service delivery, human resources, supply chain, HIS, monitoring and learning, demand creation and community engagement as well as governance, policy, strategic planning and programme management areas. * **Programmatic sustainability**: The PSR process identified a number of priority areas to be addressed to support sustainable and equitable immunisation coverage at programme management level. These areas include building a capable management team at different levels through strengthening human resources, supply chain, financial planning and management skills, demand creation, and a data management and use culture. These priorities for programme sustainability are being addressed through the implementation of the HSS2 grant and this TCA Plan. TCA will be required to develop and implement an EPI financial sustainability strategy, which would also address risk management (climate/conflict) and approaches for resource mobilisation. The support of partners will be needed for this. The MoH EPI will lead from governance, policy, strategic planning and programme management areas. |
| ***2.3 How will you use new vaccine introductions and campaigns planned during this period to further strengthen the areas indicated under question 2.2?*** |
| Over the period of this TCA support, the following new vaccines are expected to be introduced: hepatitis B, malaria e cholera. The second dose of IPV will also be introduced.  Towards the end of the second semester of 2022, there are plans to implement an MR campaign for children aged 9-59 months and Covid-19 vaccinations for under 18 year olds, as well as complete the final rounds of a polio campaign. According to global guidance, another MR campaign should take place in 2025.  The planned MR campaign already includes administration of vitamin A and deworming across the country. It also addresses equity by administering routine vaccines alongside MR in 33 districts where high numbers of zero dose children have been identified. The campaign also aims to increase demand for routine immunisation, intensify timely surveillance for suspected cases of MR, polio and AEFI, strengthen cold chain management and ensure data quality through accurate, complete and timely data collection.  The approach around recovery and integration and TCA for the focus areas described in 2.2. above could leverage vaccine introductions and campaigns in a variety of ways, e.g. enable expansion of service delivery sites through outreach, monitor disease outbreaks to identify and implement actions to include zero dose and under-vaccinated communities in routine services, ensure operational cost budgeting is based on equity (e.g. ensure additional costing to identify and reach out to zero dose children and missed communities, and ensure that the EPI Manual and communication/demand creation strategy reflect the new target groups and life cycle approach to vaccination. |
| ***2.4 Describe how the TCA support will help re-establish routine immunisation services and any other COVID-19 related recovery activities.***  *Please indicate any COVID-19 related reallocation that may have occurred for previous TCA funds (if applicable); does this reallocation remain relevant for this proposal.* |
| In order to improve routine immunisation services, synergies will be created at implementation level so routine immunisation and Covid-19 activities occur simultaneously and in an integrated manner using either HSS or CDS funds.  In this process the EPI will rely on TA from partners to develop tools to guide the integration of Covid-19 vaccination into routine activities and support synergistic operationalisation at district level.  The TA would be used to strengthen routine vaccination in various ways, e.g. through experienced and active Local Partners working at community level and able to strengthen and extend demand creation and social mobilization actions, as well as TA for the mapping of zero dose and under-vaccinated children. This type of partnership would contribute to helping recovery at health facilities and through outreach, as well as at community level. |
| ***2.5 Describe how the TCA support will identify and/or overcome already known gender-related or other barriers to immunisation activities. Please respond to how each partner can help address this.*** |
| **Reaching zero dose children and communities**: Partners can assist in implementing innovative approaches using GIS technology that allow identification of zero dose children and un-served communities, as well as strengthening community engagement with a gender focus.  **Stock reporting and vaccine management:** Partners can assist at local level to ensure quality vaccine management in terms of cold chain storage, documentation of vaccine receipt processes, vaccine distribution and stock monitoring to prevent last-mile vaccine stockouts.  **Leadership, management and coordination:** Partners can assist at sub-national level organising technical groups, supporting planning processes, monitoring and follow-up of health area plans as well as in the implementation of activities e.g. the RED/REC strategy and identification of zero dose children and missed communities, as well as in monitoring performance and designing quality improvement cycles.  **Vaccine introduction and scale-up:** Partners can assist in the operationalisation of vaccination strategies (outreach, mass vaccination sites, door to door, etc.) according to the selected approach, to maximise access to immunisation services.  **Programmatic sustainability:** Partners can assist in in the planning, timely implementation and monitoring of HSS interventions as well as by facilitating contacts and developing proposals for additional funding from other donors, including the private sector and others targeting primary health care in general – including, in addition to immunisation services, the areas of nutrition, maternal and child health, HIV/AIDS, paediatrics etc.  ***Known barriers and potential solutions:***   * **Gender:** Data on access to immunisation services in Mozambique show no gender-related difference. However, there are gender issues related to barriers women face in accessing health and immunisation services (norms, service hours, etc) and the involvement of female community members could improve communication with mothers of zero dose children and in missed communities to increase access to immunisation services. * **Accomodation camps:**Using humanitarian organisations such as UNICEF/IOM/UCHNUR and community workers from the same areas as displaced populations can increase trust and facilitate access to vaccination/primary health care services. * **Remote and hard-to-reach populations:** Involving local administrative structures, religious institutions and using technology can facilitate identification of hard-to-reach and remote populations. * **Outreach (financing and targeting):** Identifying private partners and NGOs working in other primary health areas that can complement Gavi funding and cover non-priority districts. * **Continued uptake:** Local NGOs can support continued uptake of services by creating demand with other health services. * **Demand (religion):** Desiging a communication strategy that is implemented routinely and preventatively, targeting religious communities in general and specifically those communities resistant to vaccine administration (e.g. John Malanga). * **Military conflict:** Including health personnel assigned to military health services and internationally recognised organisations in the provision of health services in areas of military conflict, in the delivery of health services. |
| ***2.6 Describe how you prioritised the interventions to be supported by Gavi under requested TCA support.*** |
| The high level objectives defined here reflect the main areas where EPI continues to require TCA based on how this support has evolved over the past few years. As a result of the pandemic it was not possible to carry out TA in some areas as initially planned; these cases, where support remains relevant have been considered by EPI in developing and prioritising the current need. In addition, some new areas, emerging from the post pandemic context, have been identified and included  In a subsequent phase, EPI will define and prioritise the interventions to be supported by Gavi. The process used to define and prioritise the high-level objectives was as follows:   * Kick-off meeting with Gavi's country team. * Consultation of key EPI documents (cMYP, PSR, C-19 Recovery Plan (RRP) etc. to identify and list, by programmatic area, recurring issues / barriers to implementation and confirm TA needs. * Review of list by programmatic area leaders with their respective technical groups to identify high-level objectives and priority areas that could benefit from TA. This included review of the current TCA plan to ensure continuity of interventions and their transition to the new plan, if relevant. When activities are defined, partners will be identified according to their area of expertise and (if relevant) their previous performance. * Drafting of the TCA Narrative based on the priorities defined by the different EPI programmatic areas. * Finalisation of draft following feedback, and sharing for review by the Director of Public Health. |

1. **Partner diversification (0.5 page)**

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| ***3.1 Describe which partners you have already mapped, including Alliance and Expanded partners (including Global Partners, Local Partners and CSOs) to support the activities implementation? (Refer to the*** [***PEF Targeted Country Assistance (TCA) Guidance for 2022-2025 Multi-Year Planning***](https://www.gavi.org/news/document-library/support/tca-guidelines) ***for the type of institutions considered global versus local partners and CSOs.)*** |
| EPI is in the early stages of partner mapping. We note to date Gavi has only prequalified one local partner in Mozambique. During finalization of the partner mapping process over the coming weeks we expect to work with Gavi to ensure alignment of potential partners who will be invited to propose TCA to EPI. Initial mapping includes current Alliance (WHO, UNICEF, CDC Foundation) and expanded partners plus new partners to EPI and/or immunistaion who meet Gavi criteria for local, global and CSO partners.  The partner mapping process includes consulting other MoH programmes e.g. MNCH, nutrition, HIV/AIDS and Malaria with a view to integration and mutual strengthening of activities, as well as identification of new partners. Examples are included in the table below:   |  |  | | --- | --- | | Local Partners | Global Partners | | * National Institute of Health (INS) * University of Eduardo Mondlane * Iris Imaginações * Catholic University * Manhica Research Centre * ISCTEM (Mozambican Higher Institute of Sciences & Technology) * CCS (Centre for Collaboration on Health) * Ariel Glaser Foundation * ADDP (People-to-People Development Aid) * N’weti * CESC (Centre for Learning and Building Capacity of Civil Society) * Fanelo Ya Mina Institute (men and boys for gender equality) * ADE (Spatial Development Agency) * TV Saúde e Vida | * JSI * VillageReach * CHAI * Zenysis * Acasus * UNDP * USAID * Save The Children * JHPIEGO * CUAMM * Friends in Global Health * PATH * Helen Keller | | |
| ***3.2 Please indicate how exactly you plan to collaborate with Local Partners and how you are building their capacity.*** | |
| As mentioned in 3.1, partner mapping is at an early stage and a more complete identification and analysis of their potential areas of focus for TA provision and also their own capacity/reputation remains to be done.  Initially, EPI aims to select local partners with proven capacity in their areas of focus, these may work through community-based organisations.  Once the TCA activities EPI requires for achieving its high-level objectives have been agreed, EPI aims to contact the Local Partners identified according to their capacity and area of action (thematic and/or geographical), inviting them to apply to deliver services through Gavi funding. This contact may be direct or through a tender process, with terms of reference detailing the support required. All partners will be required to prepare a proposal.  Gavi and DNSP will coordinate to manage the TCA service provider selection process. Local Partner contracting will be with Gavi, according to the proposal, milestones and deliverables previously agreed with EPI. Through its TCA Monitoring process, EPI will monitor the work of the Local Partner; depending on the level at which activities are implemented, collaboration will be at national or sub-national level. |
| ***3.3 Please note the allocation of TCA to Local Partners (only) and describe the approach you will use to comply with the recommendation of allocating 30% of TCA to Local Partners over the course of 2022-25.*** *Please refer to section 2.3 (3. Partner Mapping) of the PEF TCA Planning Guidelines for more information.* | |
| EPI proposes the following approach:   1. Complete the TCA tender process for Local Partners as agreed and in collaboration with Gavi; 2. Develop and agree with Gavi a scoring system for proposed support, to facilitate review of applicants; 3. Review proposals and shortlist applicants, in coordination with Gavi; 4. Negotiate with applicants any changes to proposed services / methodologies / costs; 5. Undertake final selection of applicants and assess the scope of the service and its contribution to the 30% target for the period 2022-2025, keeping a record of all contributions over the period; 6. Agree the contracting with Gavi; 7. Prepare and sign a Memorandum of Understanding between the EPI and the Local Partner; 8. Ensure the TCA Monitoring process is followed to enable informed monitoring and evaluation of the performance of the Local Partner (including the establishment of governance, procedures, ground rules and decision-making mechanisms); 9. When TCA is next selected, review opportunities to adjust the scope of the TCA and, if appropriate, meet the 30% target by 2025. EPI may choose to initiate collaboration with short duration/low value contracts to test implementation capacity. | |
| ***3.4 Please note the allocation of TCA to CSOs only (either Global or Local Expanded Partners) and describe the approach you will use to comply with the requirement of allocating 10% of combined TCA, EAF and HSS ceilings for CSO implementation (e.g. if less than 10% of TCA funding is allocated to CSOs, please indicate how this will be compensated through the allocation of HSS and EAF funding to CSOs).*** *Please refer to section 2.3 (3. Partner Mapping) of the PEF TCA Planning Guidelines for more information.* | |
| Once CSOs are selected, an allocation process will be undertaken for each, with the aim of reaching the 10% of the total TCA, EAF and HSS ceilings, depending on the type of support the CSO will undertake.  With the anticipated gradual increase of TCA funds to be made available to Local Partners (around 30%), the EPI teams are also critical to ensure involvement of relevant local TA providers during the TA planning sessions and selection processes. | |

1. **Lessons learnt from past TA experience (0.5 page)**

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| ***4.1 Please explain how the TCA plan will build on previous performance, lessons learned, and best practices of TCA activities from your previous TCA plan, including contributions to the national programme and knowledge/skill building, and how this has been taken into account in this TCA planning and prioritisation.*** |
| In addition to impacting EPI implementation of routine immunisation activities, the Covid-19 pandemic impacted achievement and monitoring of the previous TCA plan. The new Gavi approach to establishing and sourcing TCA requirements is welcomed as it builds on an internal review of TCA conducted by EPI in 2021. The new Gavi process reflects EPI concerns to improve monitoring of TCA, increase accountability of TCA providers and strengthen country ownership and selection of providers.  Rather than a perception of disenfranchisement due to the direct relationship between Gavi and the service provider, this TCA plan places the onus of leadership on EPI. This includes responsibility both for ensuring TCA meets expectations and requirements as well as for taking corrective action, as required. The current Gavi process responds to EPI’s learning through its focus on identification of goals for any technical assistance required, and informed selection of partner/service provider based on identified requirements and concrete actions.  While development of the annual TCA plan may directly or indirectly refer to skills building, generally TCA partners and EPI have not defined or measured how this is to be achieved in practice. Support is needed to establish a process/mechanism which addresses this gap and to ensure transparency between all concerned, for example, ensuring EPI inclusion in reviewing objectives, participants, scheduling, approaches and materials as well as reporting on results has been inconsistent among partners. In addition, the absence of defined capacity requirements and process to facilitate achieving the desired level of coordination means overstretched EPI managers have accepted an insatisficatory situation.  Previous TCA plans have been weak on monitoring and evaluating both implementation of the plan and the achievements of TCA provided. There are instances when activities have not been coordinated between TCA partners and the EPI and when the expected skills transfer to the Ministry of Health team has not ocurred. This TCA Plan aims to build on this experience, ensuring mechanisms to improve coordination and visibility as well as to monitor TCA progress and, where relevant, skills transfer, which is important to building the sustainability of the programme.  TCA has been provided at national and subnational level using different approaches and to achieve different objectives. Although the TCA Plan is developed transparently, reporting is often bilateral between the TCA partner and Gavi. To date, the capacity building component of TCA has not been approached systematically or holistically by either Gavi or EPI and has not included development of a Capacity Building M&E Plan (see 6.1).  EPI concerns to more closely monitor TCA provision and ensure responsiveness and quality of services provided will be met through a commitment (and requirement) to establish a process to regularly track and monitor progress with service providers, through clearly defined and agreed indicators and agreed ways of working to ensure coordination and streamline efforts.  The TCA Plan will reflect EPI’s concern to increase capability and capacity critical to effective delivery of immunisation services, with greater focus on strengthening subnational levels. The upcoming EPI capacity building strategy is expected to support this focus.  Establishing TCA requirements will therefore consider not only national but provincial and district needs and ensure those activities that should include skills and knowledge transfer clearly define how this will be performed, measured, monitored and evaluated.  Where appropriate, service providers and EPI (at different levels of the health system) will endeavour to embed TCA; to achieve skills transfer in this situation requires specific competencies and focus. Service agreements will include estimated timelines for achieving desired results and the TCA monitoring strategy and system will track progress. |

1. **Alignment of the One TCA plan with future Gavi planned investments (0.5 page)**

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| ***5.1 Please list all planned upcoming Gavi investments (e.g. new vaccine support, CCEOP) that would require TA support within the planned period, including Full Portfolio Planning process and describe how the TCA plan will be aligned with the ongoing and/or planned investments made by Gavi.*** |
| Planned upcoming Gavi investments are:   * MR campaign (2022, 2025) * Vaccine introductions e.g. IPV2, HepB (at birth and for pregnant women, people with HIV and health workers), malaria and cholera * CCEOP (Q4 2022) * Equity Accelerator Funding (not yet applied for) * Full Portfolio Planning (2025) |

1. **TCA Monitoring (1 page)**

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| ***6.1 Please provide an outline of the TCA in-country mechanism to jointly monitor and track implementation progress and generation of results of the TCA plan as a whole. How will that information be used to adjust and improve programme implementation? How frequently are data reviewed and used and who will be responsible to ensure that review and learning occurs?*** |
| As mentioned in 4.1, EPI wishes to improve the transparency and monitoring of TCA to better control the effectiveness, timeliness and quality of assistance as well as to ensure its implementation actually achieves intended results.  EPI plans to include early development of a results-based monitoring and evaluation system in its initial TCA requirement for 2022 with the requirement being for a practical system and tools that allow a continuous flow of information feedback, providing managers with information on progress toward achieving stated targets and goals as well as substantial evidence to allow any necessary course corrections or changes.  The monitoring system is expected to clarify EPI and partner objectives for the agreed TCA, linking these to the resources and activities. Objectives would be translated into performance indicators and targets agreed. There would be a mechanism and process for collecting and jointly reviewing data/information on these indicators, comparing actual results with targets. EPI (the head of programme and programmatic leads) would then keep abreast of progress and be alerted to problems, allowing timely corrective action to be discussed and agreed.  It is envisaged this system would allow for monthly monitoring of TCA implementation during regular EPI technical sub-group meetings at central level. Quarterly review would take place through a specific TCA forum. Every six months (or earlier if urgent), the ICC would include a review of progress and results achieved by the ATT, again providing opportunities for adjustments and course correction.  There will be a need for the system to allow visibility of TCA implemented at both national and subnational level, ensuring EPI managers have sufficient information to take informed decisions on TCA and have any required support for escalation.  For the capacity building component of TCA, specific mechanisms will be needed to monitor skills transfer / development and ensure good coordination between EPI and partners. This may require a capacity development framework (potentially to be suggested in the upcoming EPI capacity building strategy). This is important given capacity development interventions vary from expert-driven consultancy services and trainings to participant-driven peer-to-peer exchanges and because capacity development activities are likely to employ a wide range of intervention types.  Given capacity-building M&E focuses on behaviour change, the success of capacity development is often directly related to the extent participants feel ownership and commitment to the process. This commitment extends to ownership of the design, procedures, and reporting of M&E activities.  Following finalisation of the TCA Plan, EPI will require development of a Capacity Building M&E Plan responsive to the different types of capacity building activity planned and recognising capacity building is not just a simple technical intervention focused on individuals and organisations. Capacity at one level can be influenced by actions at other levels as well as by contextual / external environment factors. As a result, monitoring capacity-building may also need to capture conditions and concepts such as motivation, culture, and commitment, as well as changes in resource availability, skill levels, and management structure – and how these interact.  Development of the Capacity Building M&E Plan may involve a number of steps, including:   1. Capacity mapping: building a conceptual framework for specific capacity building interventions 2. Defining the purpose of the evaluation 3. Defining performance objectives 4. Identifing capacity indicators 5. Identifing appropriate methodological approaches and sources of data   For monitoring and capacity building to be successful, in addition to the tools and plan, there needs to be regular communication that allows for good coordination between the EPI and partners, allowing leadership and inclusion of the EPI in all activities, as appropriate, at all levels. |