



GAVI/12/309/mi/mg/ac

The Minister of Health and Child Welfare  
Ministry of Health and Child Welfare  
P.O. Box CY 1122  
Causeway  
Harare  
Zimbabwe

20 December 2012

***Zimbabwe's 2012 application to the GAVI Alliance for health system strengthening cash support***

Dear Honourable Minister,

Following a meeting of the GAVI Executive Committee (EC) in July 2012, I am pleased to inform you that Zimbabwe has been approved for GAVI Health System Strengthening (HSS) cash support. This approval is dependent upon satisfactory response to the clarifications requested by the Independent Review Committee (IRC) in the attached Annex C. As you know, the IRC has recently found that your initial response was insufficient and has set out the areas remaining for clarification (Annex C1). The clarifications must be satisfactorily completed within 60 days of the date of this letter, although because of the intervening holidays, I am content to extend the deadline exceptionally, to the end of February 2013.

Further, based on the GAVI Board decision in November 2011 to roll out performance based financing (PBF) as the default mode of cash-based support for HSS from 2012, I would like to inform you that GAVI's HSS support for your approved application will be implemented through the PBF instrument. This is designed to provide incentives to improve immunisation outcomes by strengthening health systems, rewarded by linking the cash support to performance. Please see Appendix B for initial information.

More comprehensive information on PBF, including a detailed implementation framework, will be shared in coming months. This will be complemented by additional information sessions at sub-regional or country meetings in 2013.

Please do not hesitate to contact my colleague Charlie Whetham at [cwhetham@gavialliance.org](mailto:cwhetham@gavialliance.org) or email [pbf@gavialliance.org](mailto:pbf@gavialliance.org) if you have any questions or concerns.

Yours sincerely,

A handwritten signature in blue ink that reads "Hind Khatib-Othman".

Hind Khatib-Othman  
Managing Director, Country Programmes

Attachments: Appendix A: Decision Letter for Cash Support.  
Appendix B: Update on GAVI's performance based funding instrument.  
Appendix C: Report of the Independent Review Committee (IRC)  
Appendix C1: IRC response to your most recent clarifications submitted  
Appendix D: GAVI Alliance Terms and Conditions.

cc: The Minister of Finance  
The Director of Medical Services  
Director Planning Unit, MoH  
The EPI Manager  
WHO Country Representative  
UNICEF Country Representative  
Regional Working Group  
WHO HQ  
UNICEF Programme Division  
The World Bank

**DECISION LETTER FOR HSS CASH SUPPORT**  
*LETTRE DE DÉCISION POUR LE SOUTIEN SOUS FORME D'ESPÈCES*

**APPENDIX A**

**This Decision Letter sets out the Programme Terms of a Programme.**

**Complete in English**

*Cette lettre de décision décrit les conditions d'un programme*

*Complétez en français*

<b>1. Country: Zimbabwe</b> <i>Pays</i>
<b>2. Grant number: 1216-ZWE-10d-Y</b> <i>Numéro d'allocation</i>
<b>3. Decision Letter number: 1</b> <i>Numéro de la lettre de décision</i>
<b>4. Date of the Partnership Framework Agreement:</b> <i>Date de l'Accord Cadre de Subvention:</i>  <b>Not applicable</b>
<b>5. Programme Title: Health Systems Strengthening (HSS)</b> <i>Titre du programme : Renforcement des systèmes de santé (RSS)</i>
<b>6. HSS terms:</b> <i>Conditions du RSS</i>  The ultimate aim of HSFP support is to ensure increased and sustained immunisation coverage through addressing health systems barriers in Country, as specified in: <ul style="list-style-type: none"><li>• The GAVI HSFP guidelines</li><li>• The GAVI HSFP application form</li><li>• Country's response to the HSFP IRC's request for clarifications.</li></ul> All disbursements under GAVI's HSS cash support will only be made if the following requirements are satisfied: <ul style="list-style-type: none"><li>• Availability of funding;</li><li>• Submission of satisfactory Annual Progress Reports (APRs);</li><li>• Approval of the recommendation by an Independent Review Committee (IRC) for continued support by GAVI after the first year;</li><li>• Compliance with any TAP requirements pursuant to the TAP Policy and under any Aide Memoire concluded between GAVI and the Country;</li><li>• Compliance with GAVI's standard terms and conditions (attached in Appendix [D]); and</li><li>• Compliance with the then-current GAVI requirements relating to financial statements and external audits, including the requirements set out for annual external audit arrangement applicable to all GAVI cash grants as set out in the aide memoire.</li></ul> The HSS cash support shall be subject to GAVI's performance-based funding. Under this, the HSS support will be split into two payments: the programmed payment (based on implementation of the approved HSS grant) and the performance-based payment (based on improvements in immunisation outcomes). This means that in the first year, Country will receive 100% of the approved grant budget (the initial Annual Amount) as an upfront investment. After the first year, 20 percent of the programme budget (subsequent Annual Amounts) will be subject to performance on immunisation outcomes. That is, countries will receive 80% of the programme budget based on implementation of the grant and additional payments will be based on performance on immunisation outcome indicators.  Given that Country's DTP3 coverage was at or above 90% in 2011 based on WHO/UNICEF estimates, Country will be rewarded for sustaining high coverage with: <ul style="list-style-type: none"><li>• 20% of programme budget for maintaining DTP3 coverage at or above 90%</li><li>• 20% of programme budget ensuring that 90% of districts have at or above 80% DTP3 coverage.</li></ul> Country will have the opportunity to receive payments beyond the original approved budget amount, for exceptional performance on the same immunisation outcomes. The performance payments under the performance-based funding shall be used for solely for activities to be implemented in the country's health sector. Performance payments shall not be used to meet GAVI's co-financing requirement.  The implementation framework for performance based funding of GAVI shall apply to the HSS cash support.

**DECISION LETTER FOR HSS CASH SUPPORT**  
*LETTRE DE DÉCISION POUR LE SOUTIEN SOUS FORME D'ESPÈCES*

**7. Programme Duration<sup>1</sup>: 2012–2016**

*Durée du programme:*

**8. Programme Budget (indicative) (subject to the terms of the Partnership Framework Agreement, if applicable):**

*Budget du programme (indicatif) (sous réserve des conditions de l'Accord Cadre de Subvention):*

Note that with PBF, annual disbursements may be more or less than this amount after the first year (see section 6 above).

	2012	2013	2014	2015	2016	Total <sup>2</sup>
<b>Programme Budget (US\$)</b>						
<i>Budget du programme</i>	1,918,714	2,684,014	1,199,249	715,742	281,793	6,799,512

**9. Indicative Annual Amounts (indicative): The following disbursements are subject to the conditions set out in sections 6,10 and 12.**

*Montants annuels indicatifs (indicatif):*

**10.**

	2012
<b>Annual Amount</b>	1,918,714

**11. Documents to be delivered for future disbursements:**

*Documents devant être présentés pour des décaissements futurs:*

The Country shall deliver the following documents by the specified due dates as part of the conditions to approval and disbursements of the future Annual Amounts.

*[Non applicable.] [Le pays devra présenter les documents suivants aux dates précisées dans le cadre des conditions d'approbation et de décaissement des futurs montants annuels.]*

<b>Reports, documents and other deliverables</b> <i>Rapports, documents and autres</i>	<b>Due dates</b> <i>Date limite de réception</i>
Annual Progress Reports (APRs). The APRs shall provide detail on the progress against milestones and targets against baseline data for indicators identified in the proposal, as well the PBF indicators as listed in section 6 above. The APRs should also include a financial report on the use of GAVI HSS funds (which could include a joint pooled funding arrangement report, if appropriate) which has also been endorsed by the Health Sector Coordination Committee (HSCC) or its equivalent, as well as use of performance payments.	<b>15 May 2013</b>

**12. Clarifications: [The Country shall provide the following clarifications to GAVI prior to the disbursement of the Annual Amount in [YEAR]. [GAVI will not release funding until it has received such clarifications.]**

*Éclaircissements : [Le pays devra fournir les éclaircissements suivants à GAVI avant le décaissement du montant annuel en [ANNÉE]. [GAVI ne débloquera pas le financement avant d'avoir reçu les éclaircissements suivants.]*

Clarifications pending as previously communicated. Please see Appendix C point 11 for reference

**13. Other conditions: The following terms and conditions shall apply to HSS support.**

*Autres conditions :*

All cash disbursed under HSS support will not be used for GAVI's co-financing payment requirements.

<sup>1</sup> This is the entire duration of the programme. *Ceci est la durée entière programme.*

<sup>2</sup> This is the total amount endorsed by GAVI for the entire duration of the programme. This should be equal to the total of all sums in the table. *Ceci est le montant total approuvé par GAVI pour la durée entière du programme. Celui-ci doit être équivalent au total de toutes les sommes comprises dans ce tableau.*

**DECISION LETTER FOR HSS CASH SUPPORT**  
*LETTRE DE DÉCISION POUR LE SOUTIEN SOUS FORME D'ESPÈCES*

In case the Country wishes to alter the disbursement schedule over the course of the HSFP programme, this must be highlighted and justified in the APR and will be subject to GAVI approval. It is essential that Country's Health Sector Coordination Committee (or its equivalent) be involved with this process both in its technical process function and its support during implementation and monitoring of the HSFP programme proposal. Utilisation of GAVI support stated in this letter will be subject to performance monitoring.

Signed by,  
*Signé par,*

**On behalf of the GAVI Alliance**  
*Au nom de GAVI Alliance*



Name (Print): Hind Khatib-Othman

*Nom (Majuscules)*

Title: Managing Director, Country Programmes

*Titre*

Date: 17 December 2012

*Date*

### **Update on GAVI's Health System Strengthening (HSS) cash support: Performance based funding instrument**

GAVI's performance based funding (PBF) instrument is designed to incentivize countries to improve immunisation outcomes by strengthening health systems, rewarded by linking the cash support to performance. As approved by the GAVI Board in November 2011, countries approved for HSS grants in 2012 and onwards will be implementing their grants with the PBF instrument. Under the PBF instrument, GAVI's HSS cash support will be split into two different types of payments: a programmed payment, based on implementation of the approved HSS grant, and a performance payment, based on improvements in immunisation outcomes.

In the first year, all countries will receive 100% of the programme budget (approved grant budget) as an upfront investment. After the first year, 20 percent of the programme budget is no longer assured by making progress in implementation, but will be provided (along with the opportunity to obtain even more—see below) subject to performance on immunisation outcomes. That is, countries will receive 80% of the programme budget based on implementation of the grant and additional payments will be based on performance on immunisation outcome indicators. The indicators for determining performance payment are different based on whether a country's DTP3 coverage is at or above 90% (sustained high coverage) or below 90% (coverage in need of improvement) in baseline year (2011) based on WHO/UNICEF estimates. Performance payments will be as follows.

- Countries with DTP3 coverage at or above 90% at baseline will be rewarded for sustaining high coverage with
  - 20% of programme budget for maintaining DTP3 coverage at or above 90%
  - 20% of programme budget ensuring that 90% of districts have at or above 80% DTP3 coverage.
- Countries with DTP3 coverage below 90% at baseline will be rewarded for improving coverage with
  - \$30 per additional child immunised with DTP3, if DTP3 coverage increases
  - \$30 per additional child immunised with first dose of measles containing vaccine, if measles coverage increases.

With the PBF rewards shown above, countries will have the opportunity to receive payments greater than the original approved programme budget, for exceptional performance on these immunisation outcomes (sustaining equitable coverage above 90% or improving coverage with key vaccines).

This PBF instrument offers countries the flexibility to use the reward payments within the health sector, based on the needs of the health sector, without having to provide proposed budgets or activities ahead of time. Requirements for reporting the use of these payments as well as verification for payments will be communicated in early 2013 along with a PBF implementation framework. Performance payments shall be subject to the same annual external audit arrangements applicable to all GAVI cash support, as outlined in the Aide Memoire, and management of these funds is to be performed in compliance with GAVI's Transparency and Accountability Policy.

At this time, there is no action required by countries. Country responsible officers (CROs) from the GAVI Secretariat will be in contact with you about the PBF instrument. Grant-specific HSS intermediate indicators will be decided jointly with countries in 2013, based on the same indicators included with your grant proposal. This is to support improved implementation and monitoring of the HSS grant.

Type of report: Report of the Independent Review Committee

Date reviewed: May, 2012

**Country name:** Zimbabwe

**Type of support requested:** HSS

**Application method:** Common Form

***Country profile/Basic data***

Type of Proposal: New or resubmission	New
Type of application: request template or common form	Common form
Proposal duration	4 years (July 2012-June 2016)
Budget required (USD)	6,799,509.14
GAVI Annual ceiling	1,700,000
National health policy strategy plan (NHPSP) duration	2009-2013 but official letter from the MOH and signed by the Minister (23-04-2012) states that the NHP is extended up to 2015
Country multi-year plan (cMYP) duration	2012-2016
Final NHPSP included	yes
Current cMYP included	yes
Population (year/source)	12,571,000 (JRF 2011)
IMR (year/source)	54/1000 live births (JRF 2011 for year 2010)
DTP3 Coverage (country/UNICEF) year	Country data: 83% (2010) UNICEF data: 76% (last coverage survey WHO/UNICEF 2009 (JRF 2011 for year 2010))

*Title: Towards Universal Coverage for Immunisation Services in Zimbabwe*

**1. History of GAVI HSS support**

Zimbabwe has not previously received GAVI HSS funding.

**2. Composition & functioning of the HSCC**

There does not appear to be an HSCC. Proposal development was led by the CCM, which in 2010 set up a committee to oversee development of applications to the Global Fund and for wider HSS funding. Since 2010 the CCM established a CCM HSS/CSS committee to provide technical support to the HSS (Global Fund) grant and to lead applications for further HSS support. The CCM meeting frequency is intense as there have been 4 meetings in February and March from identifying the focus areas to having the submission endorsed by the stakeholder group. In addition, the CCM HSS

committee held bi-monthly meetings whilst developing the proposal. Members of the team were Ministry of Health and Child Welfare, UNAIDS (CCM HSS Committee Chair), WHO, UNICEF and PLWHIV. CSO representation & involvement on the CCM appears limited, from signature details; there is PLHIV representation, but apparently no other CSO participation.

### **3. Comprehensive Multi Year Plan (cMYP) overview**

The cMYP is a clear, precise overview of the current situation, gap analysis, situational analysis. It is strategic in focus. Specific issues that have been identified for the EPI program are the following: lack of transport, geographical access barrier, and financial barriers (especially to meet transport costs and user fees in some instances). EPI outreach services from District Health Offices to all hard-to-reach (HTR) areas were suspended in the past decade due to many factors including the lack of appropriate means of transport for accessing the outreach points in the HTR areas and inadequate human resources at static facilities. The proposal has identified the need to re-establish outreach services in order to increase utilization of immunization services.

The cMYP is aligned with the HSSP for the period July 2012- June 2016, although not with the health sector strategic plan. ZEPI has the following objectives:

1. Protect more children and women of child bearing age with safe vaccines
2. Accelerate the reduction of morbidity and mortality from vaccine preventable diseases
3. Introduce new and under – utilized vaccines
4. Strengthen EPI surveillance, health information and data management
5. Integrate EPI with other interventions
6. Strengthen advocacy and communication

These are linked with the HSSP objectives which are immunization focused: 1) To strengthen the Cold Chain Capacity, Stock Management and Distribution System at all levels countrywide; 2) To strengthen EPI Data Management at all levels in the context of the existing National Health Information and Surveillance (NHIS) system; and 3) To strengthen EPI outreach services in hard to reach communities countrywide in the context of integrated health service delivery.

The financial analysis is shown in the cMYP. It indicates that UNICEF is the most important source of financing for the program, followed by GAVI. This is because UNICEF is paying for all of the traditional vaccines, cold chain equipment and maintenance, and personnel per diems. UNICEF and GAVI are paying for over 70% of the program costs. It is of concern that the program is so donor-dependent but doesn't discuss financial sustainability and its strategies for become more self-sufficient. It is calculated that the EPI Programme requires between US\$31,030,742 to US\$36,677,592 for the period 2012 to 2016 to meet the running costs of the programme.

### **4. Monitoring and Evaluation/Performance Framework**

The proposal is designed to achieve the following outcomes:

- Increase in the proportion of health facilities that have sound cold chain integrity from 90% to 100%;



- Increase in the proportion of vaccine stores with regular delivery of vaccine orders to 95%;
- Increase in the percentage of health facilities receiving services within 24 hours to address cold chain troubleshooting to 80%;
- Increase in the proportion of health facilities submitting complete, accurate and timely EPI and other NHIS strategic data / information to MOHCW to 100%;
- Increase in DTP3 coverage to 90%.

The performance framework is incomplete. Out of 22 indicators only 4 have baseline data and for all indicators there is no consistent annual targets (some are tracked only for a single year or sporadically). Only 6 indicators have targets for the end of the project on 30<sup>th</sup> June 2016 and no target assumptions. The National M&E plan was not provided even if mentioned in the body of the proposal. Unfortunately it is not clear whether the HSSP indicators are linked to the national M&E framework.

## **5. Linkages to immunisation outcomes**

The proposal is strongly focused on immunization and has clear linkages to immunization outcomes. All three objectives are linked to the immunization program. The first two work towards strengthening the immunization program – cold chain and data management. The third objective is to increase immunization coverage in hard to reach areas.

Thus far, donors including the GFATM, bilateral and multilateral donors have been providing resources through increasingly integrated mechanisms of support for both disease specific programmes (e.g. ESP, MNCH, EPI) and health systems strengthening, particularly the HRH Retention Schemes, drug procurement, HMIS strengthening, transport and infrastructure. However, to date, significant funding gaps remain in the health sector. The supplementary attachment accompanying this application, provides a comprehensive overview of donor financial and programmatic inputs to strengthen HSS.

Although all the HSS pillars were found to be weak, the stakeholders agreed that proposal should focus on the following three pillars which would enhance immunization outcomes: (i) Medical Products, Vaccines and Technologies with emphasis on cold chain management; (ii) Health Information System with particular attention to strengthening data management; and (iii) Health Service Delivery with a focus on outreach services.

This proposal seeks to address the health systems challenges through the following three strategic objectives:

- To strengthen the Cold Chain Capacity, Stock Management and Distribution System at all levels countrywide
- To strengthen EPI Data Management at all levels in the context of the existing National Health Information and Surveillance (NHIS) system
- To strengthen EPI outreach services in hard to reach communities countrywide in the context of integrated health service delivery.

## **6. Action plan for immunisation results**

The proposal narrative demonstrates a good understanding of Zimbabwe's immunization challenges and their success in engaging donor partners to support health systems strengthening interventions. The CCM HSS Committee has been instrumental in putting together this proposal considering national priorities, needs and resource and programmatic gaps.

Activities are used to strengthen the immunization program and other health services through strengthening the cold chain, improving data management and training CHWs in hard to reach areas. There is no justification provided for why these activities have been chosen over other ones. The 2010 EPI coverage survey report considers gender issues in some depth, highlighting the lower rate of immunisation coverage among children whose mothers/caregivers are illiterate, and gender-related barriers to access to routine immunisation and TT2. Goal 1 in the NHS on socio-economic factors explicitly highlights adverse factors hampering women and children's access to quality health care.

One of the key emphases in this proposal is strengthening male participation in Maternal, Neonatal (Newborn) and Child (MNCH) health interventions, including EPI. It is envisaged to encourage couples to adopt mutual responsibilities for MNCH at family and community levels. Gender balance will also be sustained in recruitment and placement of human resources at all levels of health service delivery in the country.

## **7. Feasibility**

The proposal sets out a feasible case for GAVI support. It addresses previously identified HSS challenges that hinder access to immunisation services and more effective use of HMIS. The lead implementer is the Ministry of Health with no sub implementers or explanation as to why there are none given that a significant part of the activities are outreach to hard to reach areas. In order to gauge the full feasibility of the proposal, as complete as possible baseline data should be provided, so that all indicators can be tracked throughout the lifetime of interventions.

## **8. Soundness of the financing plan and its sustainability**

Zimbabwe has provided a budget that covers all SDAs with two major cost drivers: procurement of vehicles and cold chain equipment (46% of budget) together with their associated maintenance, fuel, tyres, insurance and communication equipment and training and community dialogue and outreach (42%). The activities proposed are referenced in the budget adequately.

In making calculations for the budget, Zimbabwe systematically considered the HSS 'Materials Requirements' (Attachment 8) of the country in order to allocate resources.

According to the detailed budget the 10 ton truck for the national level is not costed but associated costs such as fuel, maintenance, communication, tyres and insurance appear in the budget. The 10 ton truck is however listed in the summary budget. This needs to be clarified. The 31 4x4 multipurpose vehicles for districts

for EPI outreach services for hard to reach areas (29) plus an additional 1 provincial supervisory vehicle and one central level supervisory vehicle cost each US\$30,000. Annual insurance has been calculated based on 3.5% of purchase price (US\$1,050) and for the four year of the proposal the total will be US\$130,200. However, the MOH calculated insurance based on a unit cost of US\$45,000 per vehicle overstating the required insurance cost to US\$195,300. The correction needs to be reflected in the proposal. The budget line for 'airtime' for 1,600 Health facilities for year 4 does (US\$57,600) is not cost effective, does not seem to have any relevance, nor is it clear why this activity is important. There needs to be a justification for this expense or deletion.

Zimbabwe's proposal weighs towards cold chain infrastructure investment to include vehicles for supervision, distribution and outreach. The budget lines for vehicles include fuel and tyres for a limited period because the MOH Finance/Treasury will take over recurrent costs.

## **9. Added value**

The proposal sets out how GAVI funding will address a number of key gaps and priorities. As such, there is consideration of added value. If the community-focused activities are successful, this will perhaps represent a significant advance in linking HSS and Community Systems Strengthening – it appears from the proposal that there is currently limited involvement of CSOs and CBOs in specifically immunisation outreach and other activities.

## **10. Consistency across proposal documents**

The proposal is consistent with the National Health Plan and the cMYP and its goal resonates with the Ministry of Health and Government of Zimbabwe's policies.

## **11. Recommendations**

### **Recommendation: Approval with Level II Clarifications**

#### **Clarifications:**

- Provide a completed performance framework with base line data and annual targets.
- Justify reasons to having the Ministry of Health and Child Welfare as a sole implementer given that a significant proportion of the budget is allocated to community outreach in hard to reach areas and civil society organization participation seem limited in the proposal.
- Provide more information on the steps that will be taken (starting in Y1) to support civil society organisations, community health workers and other relevant community health volunteers to deliver and support community outreach services. Given the considerable allocations to these activities (42% of the total budget), more detailed information should be provided as to how they will be monitored and evaluated and also quality assured
- The M&E Plan needs to be provided.
- 46% of the budget is for vehicles and cold chain. Whilst the proposal demonstrated that procurement of these capital goods were needed in the country, the proposal does not provide a transport gap analysis. A supply chain

management inventory is required together with existing vehicle availability and why and where further vehicles are required at all levels of the system. This needs to be provided.

- Clarify whether the budget includes the cost of the 10 ton truck for the national level since its associated costs are included (fuel, maintenance, communication, tyres and insurance).
- The cost of insurance for all vehicles is calculated based on 3.5% of vehicle cost, however, the MOH calculated insurance based on a unit cost of US\$45,000 per vehicles budgeted at US\$30,000 (for 4x4 vehicles) overstating the required insurance cost to US\$195,300 instead of US\$130,200. The US\$65,000 difference needs to be reflected in the budget.
- Justify or delete the budget line for 'airtime' for 1,600 Health facilities for year 4 (US\$57,600) since this activity is not cost effective, relevant and its importance unclear.
- Additional safeguards for resources in light of political instability of further economic crisis.
- The National Health Plan has been extended to December 2015 through a letter sent to GAVI by the Minister, The proposal timeline however goes beyond the extended National Health Plan timeframe. GAVI guidelines stipulate that health systems strengthening proposals need to be within the framework of the national health plan. There needs to be a National Health Plan that covers the proposal period of time and so the IRC seeks clarification as to the length of the NHP extension.

IRC HSFP COUNTRY REPORT  
Level II Clarifications, 1st October 2012

---

Country name: Zimbabwe  
Type of support requested: HSS  
Application method: Common Form

Country profile/Basic data

<b>Proposal duration</b>	<b>4 years (July 2012-June 2016)</b>
<b>Budget required</b>	<b>USD 6,799,509.14</b>
<b>cMYP duration</b>	<b>July 2012-June 2016</b>
<b>National health strategy document included</b>	<b>Yes</b>
<b>National Health Plan duration</b>	<b>2009-2013. Official letter from the MOH and signed by the Minister (23-04-2012) states that the NHP is extended up to 2015.</b>
<b>Population (year)</b>	<b>12,571,000 (JRF 2011)</b>
<b>IMR</b>	<b>54/1000 live births (JRF 2011 for year 2010)</b>
<b>DTP3 coverage (country/UNICEF)</b>	<b>Country data: 83% (2010) UNICEF data: 76% (last coverage survey WHO/UNICEF 2009 (JRF 2011 for year 2010))</b>

IRC Recommendation	Zimbabwe presented clarifications to all the issues raised by the IRC resulting in two issues being clarified. Most of the weaknesses are outstanding, particularly budgetary inconsistencies and overstatements. The CSOs/CBOs and the transport and cold chain proposal components merit further explanation. The performance framework requires additional work to include impact indicators and an M&E framework needs to be provided.
--------------------	--

<b><u>Major and Minor Weaknesses identified by the IRC</u></b>	
<b>Major Weakness 1</b>	
Provide a completed performance framework with base line data and annual targets.	
<b>Applicant's Response 1:</b>	Date: dd- MM-yy
The performance framework was revised and completed by including 22 baseline data and annual targets.	
Supporting Documentation from the applicant relevant to the response	
Annex 1 –	
<b>IRC Comments and/or request for further clarifications 1:</b> <i>(indicate whether the IRC is satisfied with the clarifications/adjustments provided (with or without conditions or matters the IRC wish to draw to the attention of the Secretariat to consider during grant processing) or there are further clarifications/adjustments requested)</i>	Date: 1-10-12
<p>Response: The IRC wishes to thank Zimbabwe for the completed performance framework received. Cross checking figures with the budget however, the IRC noted that on activity 3.1.1, 32 trainers are going to be trained but 35 are budgeted. Similarly, in activity 3.1.1.1 6 trainers are stated to be trained but 8 are budgeted. Please reflect these figures correctly in the budget.</p> <p>The performance framework contains a number of process and output indicators, with no impact indicators being measured. These indicators need to be included in the performance framework.</p>	
<b><u>Major and Minor Weaknesses identified by the IRC</u></b>	
<b>Major Weakness 2</b>	
Justify reasons to having the Ministry of Health and Child Welfare as a sole implementer given that a significant proportion of the budget is allocated to community outreach in hard to reach areas and civil society organization participation seems limited in the proposal.	
<b>Applicant's Response 2:</b>	Date: dd- MM-yy
The Ministry of Health and Child Welfare is not the sole implementer but the lead implementer of the GAVI HSS grant, in line with the provisions of Public Health Act that stipulates stakeholder participation and support, particularly at community level. The MOHCW will be working with other partners and coordinate their efforts at implementation level as described in the proposal. The strategy for outreach activities is that the Civil Society Organizations (CSOs) will mobilize the communities and the district health outreach teams will visit the targeted areas on specific days for immunizations. The CSOs will be trained as trainers on communication and social mobilization on immunization. It is foreseen that through this effort more CSOs would have their capacities developed/strengthened and get engaged in support for immunization and other health services.	

<p><b>Management of funds will be centralized at the MOHCW. Sub grants will be provided to key CSO implementers selected through a transparent competitive process based on agreed criteria e.g. practical presence in identified areas of need, proven capacity to deliver, etc.</b></p>	
<p>Supporting Documentation from the applicant relevant to the response</p>	
<p>Annex 1 –</p>	
<p><b>IRC Comments and/or request for further clarifications 2:</b>  <i>(indicate whether the IRC is satisfied with the clarifications/adjustments provided (with or without conditions or matters the IRC wish to draw to the attention of the Secretariat to consider during grant processing) or there are further clarifications/adjustments requested)</i></p>	<p>Date: 1-10-12</p>
<p>Response: The response is not specific and more details must be provided. The CSO involvement is specified as 32 will be trained on community dialogue. The response requires further clarification, in particular given that section 6.1 (b) in the HSS Submission Form dated July 2012 states that the MOHCW has previously managed outreach and that this is a new area for CSOs. Therefore, more specific information is required on the following issues:</p> <ol style="list-style-type: none"> <li>1. The management structure - is there going to be independent oversight of the community dialogue activity? Or is the MOHCW to have overall management responsibility, as the lead implementer?</li> <li>2. The structure and substance of the community training needs to be clarified, e.g. what are the criteria that will be used to determine which organisations receive the training contract? Which CSOs and CBOs representatives will receive training? Will representatives from all 32 CSOs/CBOs receive training; if not, what will the untrained CSOs/CBOs tasks be? How will the people trained from the CSOs/CBOs, who will become Trainers of Trainers (TOT) be supervised, monitored and evaluated in terms of quality of the training and supervision they will presumably provide to the community health workers. How will those CHWs themselves be supported? How will reporting be managed?</li> <li>3. How will the grant mechanism be managed in terms of financial support to CSOs and CBOs that are not ‘key implementers’? Do reporting structures either exist or will they be developed? Which CSOs and CBOs eligible for sub grants? What are these grants meant to achieve?</li> </ol>	
<p><b>Major Weakness 3</b></p>	
<p><b>Provide more information on the steps that will be taken (starting in Y1) to support civil society organisations, community health workers and other relevant community health volunteers to deliver and support community outreach services. Given the considerable allocations to these activities (42% of the total budget), more detailed information should be provided as to how they will be monitored and evaluated and also quality assured</b></p>	
<p><b>Applicant’s Response 3:</b></p>	<p>Date: dd- MM-yy</p>
<p>Civil Society Organisations (CSOs) will be engaged in the delivery of programmes starting from year 1. Fully fledged participation will start in year 2. In year 1 MOHCW will engage with and sensitize potential CSO implementers; issue an open call for proposal and select key CSOs as sub grantees; train/capacitate all CSOs that are going to be engaged in grant implementation. Throughout grant implementation the District Health Executive (DHE) will provide supportive supervision and mentoring to CSOs involved in programme delivery. The M &amp; E and quality assurance will be performed jointly by the DHE and engaged CSOs. The targets for community outreach and service uptake for</p>	

each district will be set annually by DHE and key CSO implementers with community input. Progress towards achieving the targets will be jointly monitored on a quarterly basis by the DHE and key CSOs. The M & E data and information will feed into the district, provincial and national reporting. The MOHCW provincial and national teams will play an oversight role and perform quality assurance. Health promotion Unit in MOHCW expected to spearhead training of CSOs in ACSM work to advocate parents and guardians to bring children to outreach points for vaccination.

Supporting Documentation from the applicant relevant to the response

Annex 1 –

**IRC Comments and/or request for further clarifications 3:**

*(indicate whether the IRC is satisfied with the clarifications/adjustments provided (with or without conditions or matters the IRC wish to draw to the attention of the Secretariat to consider during grant processing) or there are further clarifications/adjustments requested)*

Date: 1-10-12

The country response is not specific and detailed enough, given the 42% of the overall budget that will be allocated to community-level, CSO-implemented activities. The following issues need further clarification:

1. The revised Performance Framework has the following under output indicator 3.1: *Number of NGOs/CBOs that have capacity to train health workers/CHWs to conduct community dialogues; Number of Health Workers and CHWs have the capacity to conduct community dialogues; Number of hard to reach priority districts that are conducting regular community dialogue on EPI and other priority health services.* All are to achieve 100% by year 4. There are no process or impact indicators for 3.1. This should be rectified, so that action to achieve targets can be tracked year-on-year. The country should consider how such activities might be reflected in coverage rates.

In addition, there is no reference in the Performance Framework to quality of community dialogue.

2. The MOHCW does not have an overall M&E Plan. There is no mention in the country response of any community-level M&E system, or of an M&E framework being developed specifically for the community dialogue activity. Given that this activity will take 42% of the budget, further information is essential.

3. The country response nowhere mentions independent quality assurance: all such activities are to be undertaken by the DHE and key CSO implementers. It is important that independent, at least annual, evaluation of quality assurance be done - among other benefits, this would enable relatively speedy alteration to community dialogue training, outreach, M&E, etc, should any such action be found necessary.

4. Targets: there should also be independent input to the setting of annual targets. The country should also provide further detail on which data will be used to set district-level targets and how these will be monitored and evaluated.

**Major Weakness 4**

The M&E Plan needs to be provided

**Applicant's Response 4:**

Date: dd- MM-yy



Currently the Ministry of Health and Child Welfare does not have an overall national M and E plan. The MOHCW realizes the importance of having a national M & E plan and is in the process of developing one. Meanwhile, based on the National Health Strategy and the National Health Information Strategy, most programmes in the MOHCW have developed and are utilizing specific strategic documents including M & E plans. The EPI uses the cMYP and the National Health Information Strategy to which the indicators in the GAVI HSS proposal are linked. There are also monitoring frameworks and processes in place which the Ministry is using namely; monitoring of the national health strategy indicators, the reviews of the Permanent Secretary's Performance Contract under the Result Based Management framework, the bi-annual Ministry's Performance Review Meetings, Quality Assurance visits to the provinces and districts, cold chain management assessments, EPI coverage surveys and technical supervision.

Supporting Documentation from the applicant relevant to the response

Annex 1 –

**IRC Comments and/or request for further clarifications 4:**

*(indicate whether the IRC is satisfied with the clarifications/adjustments provided (with or without conditions or matters the IRC wish to draw to the attention of the Secretariat to consider during grant processing) or there are further clarifications/adjustments requested)*

Date: 1-10-12

Response: The M&E plan needs to be provided. If an alternative M&E framework other than the one for the MoHCW is being used, this framework should be clearly stated and linked to the proposal as well as shared the IRC at the next iterative process.

**Major Weakness 5**

46% of the budget is for vehicles and cold chain. Whilst the proposal demonstrated that procurement of these capital goods were needed in the country, the proposal does not provide a transport gap analysis. A supply chain management inventory is required together with existing vehicle availability and why and where further vehicles are required at all levels of the system. This needs to be provided.

**Applicant's Response 5:**

Date: dd- MM-yy

The MOHCW regularly produces an inventory of all vehicles and attached is the end of 2011 inventory. The inventory indicates that on average a district has 6 vehicles of which one or two are ambulances, and an average 2 are off road, and the remaining 2 serve all health programmes including those for high disease burden (HIV, TB and Malaria). A significant proportion of the vehicles have surpassed their 5-year lifespan threshold. The EPI programme last received specific vehicles (31 Nissan Hardbody 4X4 Double Cab) in 2008 through GAVI ISS grant and these are nearing time for replacement. For purposes of sustainability of services in the hard-to-reach areas targeted for support by this grant it is proposed to procure high performing, all terrain durable vehicles with capacity to carry more people per trip which are currently are not available at district level.

The country conducted a cold chain assessment end of 2010. The cold chain equipment procurement proposed under this application is in line with the conclusions of the assessment, specifically with the recommendation to procure solar refrigerators in order to reduce running costs.

Supporting Documentation from the applicant relevant to the response	
Annexes: – Vehicle inventory attached and Assessment report	
<b>IRC Comments and/or request for further clarifications 5:</b> <i>(indicate whether the IRC is satisfied with the clarifications/adjustments provided (with or without conditions or matters the IRC wish to draw to the attention of the Secretariat to consider during grant processing) or there are further clarifications/adjustments requested).</i>	Date: 1-10-12
<p>Response: The country must respond to the following issues concerning the IRC:</p> <ol style="list-style-type: none"> <li>a. The 2011 vehicle inventory does not justify the significant transport request. Upon inspection of the inventory, it can be seen that districts do have more than six vehicles, often having at least 6 pooled vehicles plus programme and ambulance vehicles. The IRC noted that some districts have many more than a total of 2 pooled vehicles for example Nyanga has 20 pooled vehicles, Mutasa 9, Mudzi 23, Goromonzu 17 plus ambulances and programme vehicles etc. Some districts have specific EPI vehicles.</li> <li>b. In view of the above and as per the original request, a transport gap analysis needs to be submitted to justify the number of vehicles required for immunization activities. In providing this information, kindly include delivery vehicles in the justification, 8 trucks for district level distribution and the 10 ton (USD \$100,000 dedicated EPI distribution transport) at central level since according to page 15 of the HSFP proposal under activity 1.2.1.1 it is stated that ‘the current situation is that only the Central Vaccine Stores has a truck for vaccine delivery to provinces’. Since this is the case, the 10 ton lorry is not required and should be deleted from the budget together with associated costs.</li> <li>c. Include in the justification frequency of delivery and how is the distribution currently being conducted.</li> <li>d. The cost of the 4X4 multipurpose vehicles is overstated in the budget calculations. The unit cost provided in the assumptions is US\$30,000 but US\$35,000 is used for calculations. The total should therefore be US\$930,000 and not US\$1,085,000, please either justify or reflect this change in the budget.</li> <li>e. Whilst the IRC agree that the 104 battery free solar refrigerators request is in line with the 2010 Zimbabwe cold chain assessment, the 31 generators are not mentioned in the document as a priority requirement. The assessment document does mention however that about 34% of facilities do not have any electricity at all but the generators requested are not for health facilities but intended for districts and some provinces. This needs to be justified or deleted from the proposal request.</li> </ol>	
<b>Major Weakness 6</b>	
Clarify whether the budget includes the cost of the 10 ton truck for the national level since its associated costs are included (fuel, maintenance, communication, tyres and insurance).	

<b>Applicant's Response 6:</b>	Date: dd- MM-yy
This was an omission on budgeting and we have now corrected by including the cost of a Central level 10 tone truck. The cost was derived from budget adjustment for operational costs which will be mobilised locally.	
Supporting Documentation from the applicant relevant to the response	
Annex 1 –	
<b>IRC Comments and/or request for further clarifications 6:</b> <i>(indicate whether the IRC is satisfied with the clarifications/adjustments provided (with or without conditions or matters the IRC wish to draw to the attention of the Secretariat to consider during grant processing) or there are further clarifications/adjustments requested)</i>	Date: 1-10-12
Response: This issue has been clarified.	
<b>Major Weakness 7</b>	
The cost of insurance for all vehicles is calculated based on 3.5% of vehicle cost, however, the MOH calculated insurance based on a unit cost of US\$45,000 per vehicles budgeted at US\$30,000 (for 4x4 vehicles) overstating the required insurance cost to US\$195,300 instead of US\$130,200. The US\$65,000 difference needs to be reflected in the budget.	
<b>Applicant's Response 7:</b>	Date: dd- MM-yy
The cost of insurance for all vehicles (4x4 vehicles) has now been calculated using unit cost of \$30 000 per vehicle	
Supporting Documentation from the applicant relevant to the response	
Annex 1 –	
<b>IRC Comments and/or request for further clarifications 7:</b> <i>(indicate whether the IRC is satisfied with the clarifications/adjustments provided (with or without conditions or matters the IRC wish to draw to the attention of the Secretariat to consider during grant processing) or there are further clarifications/adjustments requested)</i>	Date: 1-10-12
Response: This issue has been clarified.	
<b>Major Weakness 8</b>	
Justify or delete the budget line for 'airtime' for 1,600 Health facilities for year 4 (US\$57,600) since this activity is not cost effective, relevant and its	

importance unclear.	
<b>Applicant's Response 8:</b>	Date: dd- MM-yy
<p>The budget line for airtime supports transmission of information and data from rural facilities to the next level. Until 2014 inclusive, this support is budgeted under Global Fund Round 8 HSS grant. With this support the timeliness and completeness of reporting has improved to average 80% from the then unacceptable of below 50% prior to GF support. It would be catastrophic to lose the momentum built over the few years of this recovery. Therefore it is strongly suggested that GAVI grant continues to support this key activity.</p>	
Supporting Documentation from the applicant relevant to the response	
Annex 1 –	
<b>IRC Comments and/or request for further clarifications 8:</b> <i>(indicate whether the IRC is satisfied with the clarifications/adjustments provided (with or without conditions or matters the IRC wish to draw to the attention of the Secretariat to consider during grant processing) or there are further clarifications/adjustments requested)</i>	Date: 1-10-12
<p>Response: The airtime required beyond 2014 should be identified within Government budget lines or other partners. The IRC believes this activity is disconnected to this HSFP proposal and should not be funded. Please remove from the budget.</p>	
<b>Major Weakness 9</b>	
Additional safeguards for resources in light of political instability of further economic crisis.	
<b>Applicant's Response 9:</b>	Date: dd- MM-yy
<p>With the establishment of the Government of National Unity, Zimbabwe has stabilized both politically and economically, and the environment that created the risks warranting the imposition of additional safeguard measures has improved significantly. However, if additional safeguard measures for resources are required, the grant could be disbursed through WHO or other international partner appropriately involved in HSS/EPI. The mechanisms of disbursing to MOHCW that exist and have proven effective in Zimbabwe include:</p> <ul style="list-style-type: none"> <li>• WHO acting as the grant manager for GAVI new vaccine introduction grant.</li> <li>• UNDP working as the Principal Recipient for HIV, TB, Malaria and HSS GF grants.</li> <li>• UNICEF managing the resources of the multi-donor Health Transition Fund (HTF)</li> </ul> <p>The country is prepared to work with GAVI in exploring safeguard to secure approved and disbursed grants where risks exist or are envisaged.</p>	
Supporting Documentation from the applicant relevant to the response	
Annex 1 –	

<b>IRC Comments and/or request for further clarifications 9:</b> <i>(indicate whether the IRC is satisfied with the clarifications/adjustments provided (with or without conditions or matters the IRC wish to draw to the attention of the Secretariat to consider during grant processing) or there are further clarifications/adjustments requested)</i>	Date: 1-10-12
<p>Response: The IRC welcomes Zimbabwe’s willingness to work with the GAVI Secretariat to find safeguards to secure financial resources provided by GAVI. This issue is clarified and the IRC delegates to the Secretariat in pursuing a mechanism for mutual agreement.</p>	
<p><b><u>Major and Minor Weaknesses identified by the IRC</u></b>  Please add lines as necessary for each iteration.</p>	
<p><b>Major Weakness 10</b></p>	
<p>The National Health Plan has been extended to December 2015 through a letter sent to GAVI by the Minister, The proposal timeline however goes beyond the extended National Health Plan timeframe. GAVI guidelines stipulate that health systems strengthening proposals need to be within the framework of the national health plan. There needs to be a National Health Plan that covers the proposal period of time and so the IRC seeks clarification as to the length of the NHP extension.</p>	
<p><b>Applicant’s Response 10:</b></p>	Date: dd- MM-yy
<p>The National Health Strategy was extended by 2 years to 2015 so that it falls in line with the MDGs timeframe. The midterm review of the extended National Health Strategy (NHS) (2009 - 2015) planned for 2013 will launch and inform the development of a new NHS that will cover the period starting from 2016. The priorities in the new strategy with respect to immunization will be congruent with the provisions of the current cMYP (2012-2016).</p>	
<p>Supporting Documentation from the applicant relevant to the response</p>	
<p>Annex 1 –</p>	
<b>IRC Comments and/or request for further clarifications 10:</b> <i>(indicate whether the IRC is satisfied with the clarifications/adjustments provided (with or without conditions or matters the IRC wish to draw to the attention of the Secretariat to consider during grant processing) or there are further clarifications/adjustments requested)</i>	Date: 1-10-12
<p>[GAVI Secretariat comment: this GAVI policy is under consideration at the moment. No further action required from Zimbabwe at the moment]</p>	

## APPENDIX D

### **GAVI Alliance Terms and Conditions**

Countries will be expected to sign and agree to the following GAVI Alliance terms and conditions in the application forms, which may also be included in a grant agreement to be agreed upon between GAVI and the country:

#### ***FUNDING USED SOLELY FOR APPROVED PROGRAMMES***

The applicant country ("Country") confirms that all funding provided by the GAVI Alliance for this application will be used and applied for the sole purpose of fulfilling the programme(s) described in this application. Any significant change from the approved programme(s) must be reviewed and approved in advance by the GAVI Alliance. All funding decisions for this application are made at the discretion of the GAVI Alliance Board and are subject to IRC processes and the availability of funds.

#### ***AMENDMENT TO THIS PROPOSAL***

The Country will notify the GAVI Alliance in its Annual Progress Report if it wishes to propose any change to the programme(s) description in this application. The GAVI Alliance will document any change approved by the GAVI Alliance, and this application will be amended.

#### ***RETURN OF FUNDS***

The Country agrees to reimburse to the GAVI Alliance, all funding amounts that are not used for the programme(s) described in this application. The country's reimbursement must be in US dollars and be provided, unless otherwise decided by the GAVI Alliance, within sixty (60) days after the Country receives the GAVI Alliance's request for a reimbursement and be paid to the account or accounts as directed by the GAVI Alliance.

#### ***SUSPENSION/ TERMINATION***

The GAVI Alliance may suspend all or part of its funding to the Country if it has reason to suspect that funds have been used for purpose other than for the programmes described in this application, or any GAVI Alliance-approved amendment to this application. The GAVI Alliance retains the right to terminate its support to the Country for the programmes described in this application if a misuse of GAVI Alliance funds is confirmed.

#### ***ANTICORRUPTION***

The Country confirms that funds provided by the GAVI Alliance shall not be offered by the Country to any third person, nor will the Country seek in connection with this application any gift, payment or benefit directly or indirectly that could be construed as an illegal or corrupt practice.

#### ***AUDITS AND RECORDS***

The Country will conduct annual financial audits, and share these with the GAVI Alliance, as requested. The GAVI Alliance reserves the right, on its own or through an agent, to perform audits or other financial management assessment to ensure the accountability of funds disbursed to the Country.

The Country will maintain accurate accounting records documenting how GAVI Alliance funds are used. The Country will maintain its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of GAVI Alliance funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against the GAVI Alliance in connection with any audit.

**CONFIRMATION OF LEGAL VALIDITY**

The Country and the signatories for the government confirm that this application is accurate and correct and forms a legally binding obligation on the Country, under the Country's law, to perform the programmes described in this application.

**CONFIRMATION OF COMPLIANCE WITH THE GAVI ALLIANCE TRANSPARANCY AND ACCOUNTABILITY POLICY**

The Country confirms that it is familiar with the GAVI Alliance Transparency and Accountability Policy (TAP) and will comply with its requirements.

**ARBITRATION**

Any dispute between the Country and the GAVI Alliance arising out of or relating to this application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either the GAVI Alliance or the Country. The arbitration will be conducted in accordance with the then-current UNCITRAL Arbitration Rules. The parties agree to be bound by the arbitration award, as the final adjudication of any such dispute. The place of arbitration will be Geneva, Switzerland. The language of the arbitration will be English.

For any dispute for which the amount at issue is US\$ 100,000 or less, there will be one arbitrator appointed by the GAVI Alliance. For any dispute for which the amount at issue is greater than US \$100,000 there will be three arbitrators appointed as follows: The GAVI Alliance and the Country will each appoint one arbitrator, and the two arbitrators so appointed will jointly appoint a third arbitrator who shall be the chairperson.

The GAVI Alliance will not be liable to the country for any claim or loss relating to the programmes described in this application, including without limitation, any financial loss, reliance claims, any harm to property, or personal injury or death. Country is solely responsible for all aspects of managing and implementing the programmes described in this application.

**USE OF COMMERCIAL BANK ACCOUNTS**

The eligible country government is responsible for undertaking the necessary due diligence on all commercial banks used to manage GAVI cash-based support, including HSS, ISS, CSO and vaccine introduction grants. The undersigned representative of the government confirms that the government will take all responsibility for replenishing GAVI cash support lost due to bank insolvency, fraud or any other unforeseen event.