EPI Mozambique
Gavi
National & international partners

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Gavi 2020

Multi-Stakeholder Dialogue

Immunisation planning in light of COVID-19

Mozambique

Prepared for Gavi, DNSP, ICC
Distribution: Gavi, MISAU, ICC, EPI partners

Contents

Abbreviations / acronyms

3PL	third-party logistics
4PL	fourth-party logistics
APE	community health worker
bOPV	bivalent oral poliovirus vaccine
CCEOP	Cold Chain Equipment Optimisation Platform
CHAI	Clinton Health Access Initiative
CMAM	Central Medicine Stores
cMYP	Country multi-year plan
DAF	Department of Administration and Finance
DeProS	Health Promotion Department
DHIS2	District Health Information System
DHS	Demographic and Health Survey
DNSP	National Directorate of Public Health
DPC	Directorate of Planning and Cooperation
DPM	provincial medicines stores
DPS	provincial health directorates
DQA	data quality self-assessments
DQIS	Data Quality for Intelligent Systems
DTP-HepB-Hib	diphtheria, tetanus, pertussis-hepatitis B-Haemophilus influenzae type B conjugate vaccine (absorbed)
DTP	diphtheria, pertussis and tetanus
EIR	electronic immunisation register
EPI	Expanded Programme on Immunisation
eVIDR	Integrated Disease Surveillance and Response (IDSR)
FESP	EPI Electronic Supervision Tool
FIC	fully immunised children
FVP	fixed vaccination posts
GFA	(the Gavi-contracted monitoring agent)
GFF	Global Financing Facility
GIS	geographic information system
GMR	Grant Management Requirements
GPF	Grant Performance Framework
HCD	human centred design
HPV	human papillomavirus
HSS	health systems strengthening
ICC	Interagency Coordination Committee
ICG	International Coordinating Group
ICRH	International Centre for Reproductive Health
IDP	internally displaced people
IGM	Immunoglobin M (antibodies)
IPV	inactivated polio vaccine
ISS	integrated supportive supervision
JSI	John Snow Inc.
KPI	key performance indicators
LMC	leadership, management and coordination
LMIS	logistics management information system
LWG	Logistics working group
M&E	monitoring and evaluation
MA	monitoring agent
MoH	Ministry of Health
MR	measles rubella
MSD	multi-stakeholder dialogue
NGO	non-governmental organisation
NITAG	National Immunisation Technical Advisory Group
ODP	operational deployment plan
OPS	operations
PBF	performance-based financing
PEF	Partners Engagement Framework
PHC	primary health care
PPE	personal protective equipment
PPR	EPI Readiness and Recovery Plan
PSG	presentation switch grant
Q	Quarter
RED/REC	reach every district / reach every community
SC	supply chain
SD	(UNICEF) Supply Division
SELV	electronic vaccine logistics system
SMT	stock management tool
SoA	Statement
SOPs	standard operating procedures
TA	technical assistance
TCA	Targeted Country Assistance
TMP	preventive medicine technician
ToR	terms of reference
UGB	Asset Management Units
UGEA	MoH Procurement Management Unit
USD	United States Dollars
VAN	visibility analytics network
VAT	value added tax
VIG	vaccine introduction grant
WB	World Bank

Introduction

2020 has been marked by the unprecedented crisis caused by COVID-19. Though the longer-term trajectory of the pandemic remains uncertain, evidence shows that immunisation services in Gavi-supported countries have been disrupted. Millions of people are expected to miss out on immunisation, likely leading to a resurgence of VPDs, further exacerbating existing inequities and putting the most marginalised and poorest communities at greater risk.

In Mozambique, existing inequities, access to and availability of health care have been exacerbated by large internal displacements due to armed conflict as well as the enduring aftermath of 2019's cyclones (Idai and Kenneth) and destroyed infrastructure (including health facilities). A recent report estimates 1.4% of the population is currently displaced as a result of the armed attacks in Cabo Delgado, Manica and Sofala provinces[1]. Only a minority of affected families are in accommodation centres, with the majority relying on shelter provided by relatives.

Gavi supported Mozambique's Expanded Programme on Immunisation (EPI) in the reallocation of existing HSS and TCA support to respond to immediate needs presented by the COVID-19 pandemic. The Gavi Alliance and EPI are fully committed to restoring immunisation services that were scaled-back and otherwise affected during the pandemic response.

Multi-stakeholder engagement remains key to Gavi's portfolio management approach. It is particularly critical in 2020 as a forum for engagement on how the Gavi Alliance partners and other stakeholders can support countries as they deal with the different phases of the COVID-19 pandemic and seek to maintain and restore primary health care (PHC), including immunisation services that have been disrupted.

The 2020 multi-stakeholder dialogue exercise

Recognising the difficult operating environment and the rapidly evolving landscape currently faced by countries, and to ensure that Gavi's continuing support to the EPI programme is aligned with realities, in lieu of the traditional Joint Appraisal, in 2020 Mozambique has conducted a multi-stakeholder dialogue (MSD). The MSD reviewed the immunisation programme performance in 2019, the impact of the COVID-19 pandemic on immunisation and involved discussion in-country and with external partners on the need for maintaining and restoring immunisation services in the context of PHC and planning for short-term catch-up activities. The need for a roadmap for further re-allocation/planning has also been discussed.

EPI has tailored this 2020 MSD exercise to the country context, taking into account current constraints in terms of travel, meetings, and workload. The process involved preparatory work on data for the review, multiple exchanges in-country and two virtual meetings with external partners. This report and appendices present the conclusions of the MSD.

The 2020 multi-stakeholder dialogue report is structured as follows:

- **Section 1:** Country situation: overview of performance of vaccine support, HSS grant implementation, PEF-TCA and other Gavi support, up to end of 2019/early 2020; pre-COVID-19.
- **Section 2:** Update on impact of COVID-19 immunisation service delivery and immunisation coverage (in 2020) and status of the implementation of the COVID-19 recovery plan (if relevant).
- **Section 3:** Discussion on priorities, immediate catch-up needs, related action plan, estimated budget and technical assistance needs. Roadmap for further analysis and re-allocation/planning.

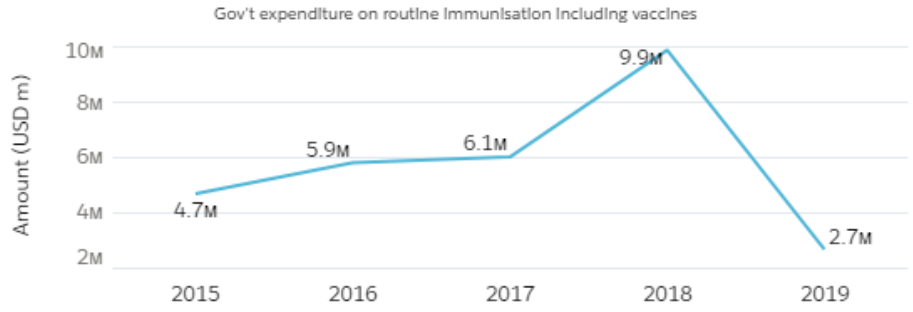
[1] The number of internally displaced people in Mozambique has grown by about 2,700% in two years. CIP. October 2020

Section 1

[This section is pre-filled by the Gavi Secretariat] The main sources are the JRF data and GPF data provided by the country.

1 Country situation pre-COVID-19, based on information received by Gavi

Indicator Name	Year	Source	Value
GNI per capita	2019	World Bank	480
Nurses/Midwives per 1000 population	2018	WHO - GHO	6.9
Population	2020	UNPD	31,255,435
Surviving Infants	2020	UNPD	1,095,851
Under-5 mortality (per 1000)	2018	UNICEF	73



1.1 Overview of performance of vaccine support (end of 2019/early 2020; pre-COVID-19)

Vaccine	Introduction Date	2018 Coverage (%)	2019 Coverage (%)	2019 Target	2020 Target
PENTA	11-2008	88	88	94	96
PNEU...	04-2013	80	80	90	90
ROTA	09-2015	80	88	94	96
IPV	11-2015	64	85	80	80
MEASLES	11-2015	87	87	94	96
MR	05-2018	-	-	-	-

Vaccine Name	Type	Sub-Type	Status	CP Date ↑	Phase
HPV	Routine	-	Approved	2021-10-01	NA
HPV	Campaign	MAC	Approved	2022-04-04	NA
TYPHOID	Campaign	-	Forecasted	2022-07-01	NA
MR	Campaign	Follow-up	Forecasted	2022-12-31	NA
TYPHOID	Routine	-	Forecasted	2023-07-01	NA
MR	Campaign	Follow-up	Forecasted	2026-12-31	NA
MR	Campaign	Follow-up	Forecasted	2030-12-31	NA

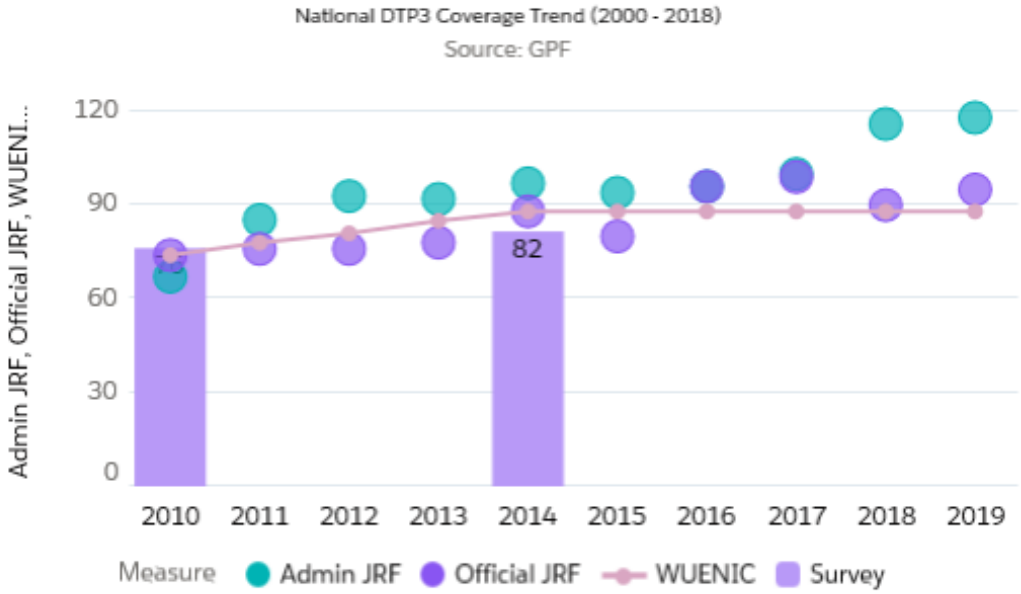
1.1.1 Performance against Alliance KPIs

Indicator	Source Name	Year	Value	Previous Value	Trend
Measles containing vaccine (second dose) coverage at the national level (MCV2)	WUENIC	2019	85	59	▲
Pentavalent 3 coverage at the national level (Penta 3)	WUENIC	2019	88	88	→
Drop-out rate between Penta1 and Penta3	WUENIC	2019	5.4	5.4	→
Difference in Penta3 coverage between children of urban and rural residences	Survey	2018	11	0	▼
Difference in Penta3 coverage between the highest and lowest wealth quintiles	Survey	2018	0	0	→
Penta3 coverage difference between the children of educated and uneducated mothers/care-takers	Survey	2018	20	0	▼
EVM	EVM	2019	71	68	▲
# of Underimmunised Children	Calculated	2019	128800.44	126127.92	▼

0 = no survey conducted / no information available

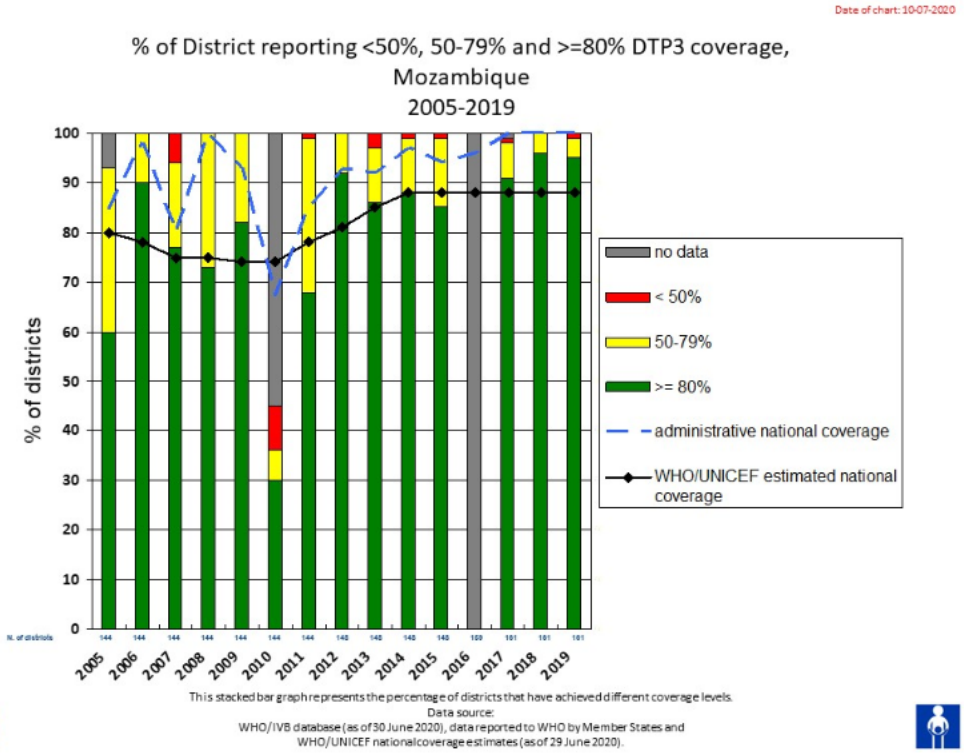
- The country acknowledges the quality of administrative data challenges programme decision-making. In October 2020, district level coverage surveys initiated; these will occur in 14 districts across seven provinces; the Programme is pleased a DHS is planned for 2021.
- Work to improve data quality includes:
    - Review and validation of the methodology to estimate target group population (new district coefficients)
    - RED/REC microplanning for improved identification of communities and underserved children (denominator) and the provision of vaccinations to more children (numerator)
    - Allocation of qualified resources specifically for monitoring and evaluation (M&E) in the provincial health directorates (DPS) for data analysis and feedback to districts and health facilities
    - Data quality self-assessments (DQA)
    - Central and district meetings to discuss and analyse data with feedback provided to DPS and districts
    - Support supervision
- A suggested method to triangulate performance indicator information is to report absolute number of vaccinated children together with coverage (%). Unless there are unexpected population movements in a district the number of vaccinated children should increase steadily as a result of growing birth cohorts.
- A significant proportion of districts report DPT3 over 100% - EPI developed a new methodology for calculating numerators and denominators, however this was not uniformly rolled out across the provinces as it has not been validated for use by the Directorate of Planning and Cooperation (DPC).
- Gavi is requested to advocate with the Minister of Health and National Directors on the denominator/numerator issue. This situation is not exclusive to EPI, with both WB/GFF and the Global Fund expressing concerns in the past, therefore interagency advocacy is an option.

1.1.2 Trends and district equity



1.2 Overview of HSS grant implementation (end of 2019/early 2020; pre-COVID-19)

1.2.1 HSS implementation summary (as of 30 June 2020)



*Structured based on grant objectives or GPF indicators **(graph prepopulated by the CMM team**)*

HSS financial summary table to 30 September 2020

	In (US$)				
Recipient	Grant Amount	Funds Disbursed	Expenditure	% Grant execution***	Cash balance
MISAU		20,158,209	15,315,160	76%	4,843,049
WHO		979,089	889,048	91%	90,041
UNICEF		1,425,115	1,372,403**	96%	52,712
UNICEF SD		5,964,375	4,979,890	83%	984,485
CHAI		326,431	-	0%	326,431
Total	**30,680,876***	**28,853,220***	**22,556,501**	**74%**	**6,296,718**

* Inclusive of US$ 2,980,000 support to COVID-19 request

**As per the SoA of SC 181148 and SC 160565 as of 9 September 2020.

***The % of grant execution is Expenditure/Funds disbursed

	Process Indicators			Intermediate Results		
	Indicator name	Value	Rel. % change	Indicator name	Value	Rel. % change
OBJ-1				Percentage of districts implementing at least 80% of outreach plans in high priority provinces (Nampula, Zambezia, Tete and Manica)	79	↓, -10%
				Percentage of districts implementing at least 80% of outreach plans in other provinces	78	↓, -2%
				Percentage of districts with updated micro-plans to raise immunization coverage in high priority provinces	76	↑, 129%
				Proportion of health facilities with fixed vaccination post with at least one functional motorbike (transport availability)	NA	NA
OBJ-2	Percentage of maintenance request that have been responded in a given year	88	↑, 33%	Proportion of HF with functional prequalified CC refrigerators	NA	NA
	Percentage of vaccines delivery performed at provincial level as compared to planned (vaccine Distribution - central, to provincial, level)	65	↑, 35%			
OBJ-3	Number of HW training performed (all levels included)	21	↑, 5%	Percentage of MCH/EPI HF integrated supervisions performed as per planned	0	NA
	Number of integrated Supportive Supervision from central level to provincial level	6	NA			
	Number of integrated Supportive Supervision from district level to health facilities level	622	↑, 8%			
	Number of integrated Supportive Supervision from provincial level to district	567	↓, -28%			
OBJ-4	Number of HF BES (Boletim Epidemiológico Semanal - Weekly Epidemiological Report) received (Integrated Surveillance of Epidemic Prone Diseases - SUB SUB ACTIVITY4.1.2)	84750	↑, 2%	Percentage of Districts with Complete reporting	72	↓, -4%
	Number of planned studies implemented:	0	↓, -100%	Percentage of Districts with data verification rate of at least 80% through DQ	68	↓, -14%
OBJ-5	Number of NGOs supporting EPI programs	8	↑, 60%			
	Proportion of districts with community radio social mobilisation activities performed	71	↓, -14%			

Relative % change refers to the percentage increase/decrease of the reported value from the year prior.
Value cell color is green if target has been >= 90% met, yellow if 70-90% met, and red < 70% met.

1.3 Overview of other Gavi, such as VIGs, OPS, PBF, switch grants, transition grants etc. (as applicable)

				In US$			
	Start Date	End Date	Recipient	Grant Value	Disbursed	Expenditure	Cash balance
PBF	2018	2020	MOH	1.489.620	102,023	95,897	6,126
			UNICEF		147,976*	779	147,197
			WHO		230,000	230,000	0
OPS MR	2018	2018	MISAU	7,879,866	7,879,866	7,862,591	17,275
PSG – Pneumo	2018	2018	MISAU	271,286	271,286	224,843	46,443

*As per the SoA of SC 181148 as of 9 September 2020.

Residual grant balances have been programmed as follows:

- *OPS MR* – $14,000 to cover HPV demand generation costs in 2021 in support of introduction of the HPV vaccine.
- *PSG – Pneumo* – $45,272 is currently being used to support HSS costs related to the vaccination coverage survey being implemented in five priority provinces.
- Cash balances of $3275 (OPS MR) and $971 (PSG Pneumo) are being programmed for the HSS grant.

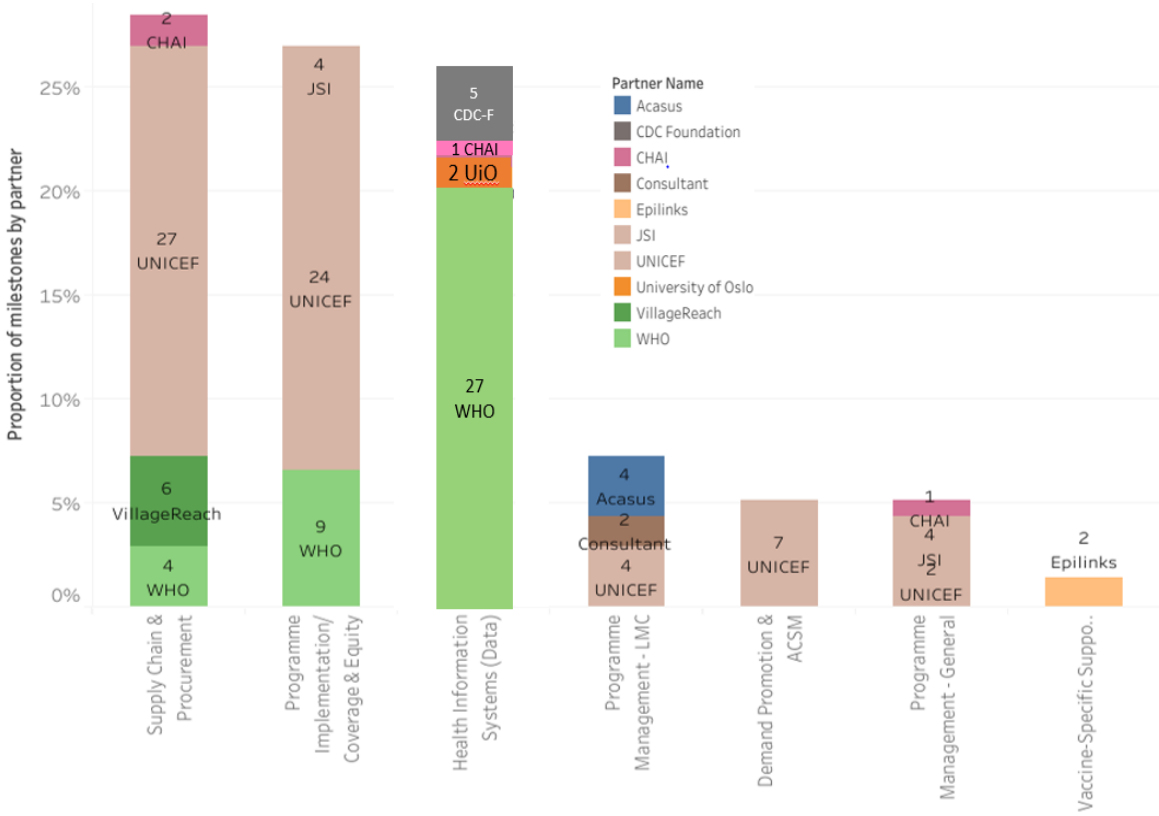
1.4 Compliance, absorption and other fiduciary risk matters

- Financial absorption for end of the health systems strengthening (HSS) grant before end of 2020 appears a challenge in current context. Therefore, the country requests extension of HSS until June 2021 in order to use up existing balance and fully implement the 2020 plan (delayed by COVID-19) before HSS2 starts (Gavi is expected to approve the HSS2 grant in early quarter (Q) 1 2021 at the latest).
- As per the last financial report for Q3, budget execution to date is 53%; Q4 forecast execution is expected to be approximately 93% of HSS 2020 funds available in the country (HSS 2020 first tranche and non-HSS grant balance). Although these funds are sufficient to cover most programme activities until December 2020, it is critical for the country to receive the HSS 2020 2nd tranche before the end of 2020 to be able to:
    - Finalise UGEA (the MoH Procurement Management Unit) 2020 procurement processes initiated under the HSS grant (committed expenditures). Processes are expected to conclude by end Q4 2020 or early Q1 2021 (see Appendix 1: Summary of UGEA procurement processes in progress).
    - To ensure continuity of HSS 2020 planning during the transition between HSS and HSS2 (those activities delayed due to COVID-19 and now reprogrammed for Q1/Q2 2021 prior to initiation of HSS2).
- All financial reports and audit reports are compliant. Audit report timeline changed effective for 2020 grant year and will impact 2019 audit deadline of 31 December 2020. Due to COVID-19 the 2019 and 2020 external audit reports will be provided in the course of Q2 2021.

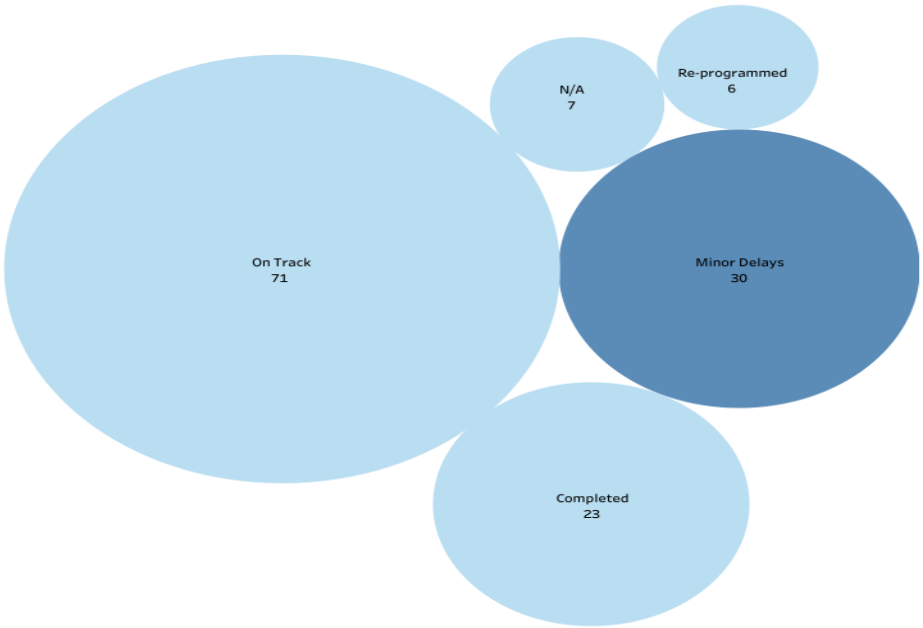
- Additional flexibility was granted for reimbursement of State funds back to the Programme (VAT reimbursement of USD 788 K was pushed to end of December 2020 instead of the initially agreed date of June 2020). MoH proposed a reimbursement schedule for other remaining funds (USD 633,795) to be returned to Gavi in September which was accepted by Gavi in October 2020. The revised schedule now completes repayment by 30 September 2021. The Minister's commitment remains valid.
- The monitoring agent (MA), GFA, commenced in August 2020 for an initial one-year period; it is too early to comment on performance as the annual workplan has only recently been agreed (October 2020).
    - The MA's plan has been discussed and approved between EPI and GFA and discussed with Gavi early September. Currently information is being gathered in relation to past audits to inform development of the terms of reference (ToR) to monitor what will be done at provincial level. Four provinces have been selected based on recurring audit recommendations, geographic location and volume of transactions. Inclusion of a fifth province has been discussed – to be approved by GFA.
    - EPI and GFA worked closely to develop the Grant Management Requirements (GMR) and Audit Recommendation monitoring matrix currently being reviewed by Gavi. The processes and mechanisms for communication collaboration have been clarified to avoid extra reporting workload on EPI. EPI has fully engaged with the MA, sharing relevant information and synchronising work processes, on the condition the MA proactively seeks information to report. Close collaboration with the HSS team and its routine work are key to support identification of relevant EPI staff and engage more informally to allow continuous information flow.
    - EPI also acknowledges the support to date regarding the review of the Administrative Court audit ToR.
- The GMR came into force in October 2019. The monitoring of their implementation is also part of the MA's tasks.
- EPI has complied on time with programmatic reporting requirements against the Grant Performance Framework (GPF), which are up to date on the Gavi portal.

1.5 Overview of PEF TCA progress

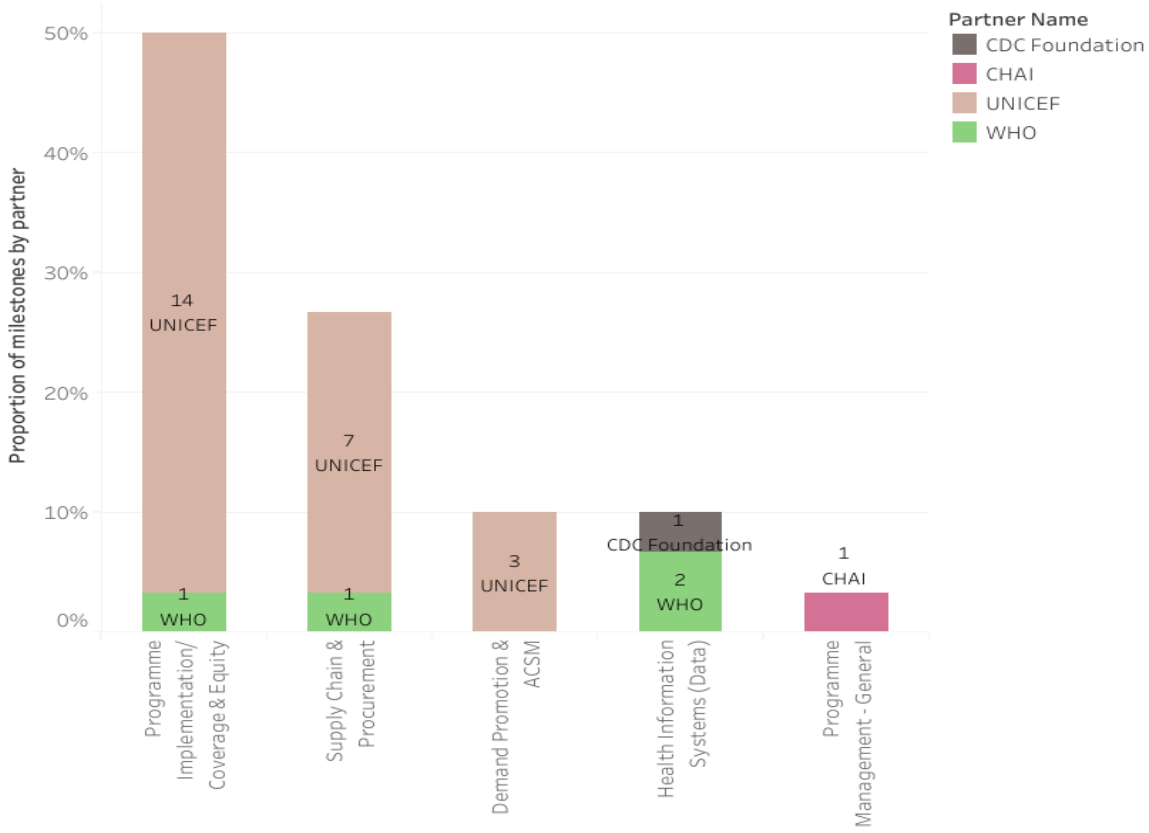
1) Total number of milestones (137) per programmatic area per partner from June 2019- June 2020:



2) Total milestone reporting from June 2019- June 2020, as per milestone status:



3) Total number of delayed and reprogrammed milestones, per partner, per programmatic area from June 2019 - June 2020



The figures above show the total number of milestones between June 2019 and June 2020, and cover milestones from three reporting periods, namely June 2019, November 2019 and June 2020. This is because the MSD aims to review 2019 TCA performance, which had milestones for all these three reporting periods in the 2019 TCA plan.

Although UNICEF 2020 TCA has a total of 23 milestones, of which 8 have been either reprogrammed or suffered minor delays, over the three reporting periods the total number of milestones is 64, spread across the areas of supply chain (27), coverage & equity (24), leadership, management and coordination (4), demand promotion (7), programme management-general (2).

A total of 22% (30/137) milestones have been reported as having minor delays during June 2019-June 2020. These belong predominantly to the coverage and equity, as well as supply chain programmatic areas.

There are no milestones with major delays for Mozambique during June 2019-June 2020.

Additional comments – as relevant – on implementation of the TCA plan (e.g. progress in key areas, challenges, constraints, reallocations, no-cost extensions). **It should be noted, all TCA partners collaborated actively with EPI at central level to address significant, emerging needs** e.g. to develop the EPI Readiness and Recovery Plan (PPR), including aspects such as analysing the impact of COVID-19 on immunisation services. These groups also developed country content for this MSD report.

In 2019, Gavi worked with partners to develop a capacity-building framework, including indicators, to include in the 2020 OneTA Plan. Key considerations to consider during 2020 TCA planning of capacity building activities were:

- Follow prioritisation of HSS-funded activities for under-immunised and focus provinces
- Balance trained staff across central, provincial, district and HF level
- Consult with members of beneficiaries to ensure tailored capacity building approach
- Document pre-post knowledge of capacity building participants
- Use post-capacity building recommendations for future capacity building efforts
- Identify a minimum of quality indicators to be used by all implementing partners, ideally linked to GPF indicators
- Coordinate closely during planning, implementation and monitoring of all capacity building activities (see capacity building framework for further facilitation).

Planning for development of the 2021 OneTA Plan will require assessment of the extent to which these considerations were observed and potential for consolidating in 2021.

Organisation	Progress	Challenges & Constraints
CHAI	**Epidemiological Surveillance System** • July 2020 - Installation of the electronic health surveillance system for Covid-19 in 238 health units. • Expansion to other provinces is scheduled **Integration - Supply Chain Medicines** • CHAI, in agreement with CMAM and EPI, formalised supplier purchase orders to better equip the regional warehouse cold stores in the north. • Through the LWG, in coordination with EPI and CMAM, integration of medicines and vaccines in the central warehouse (Zimpeto) is already under discussion; CHAI will monitor the process and indicate if there is a need for additional work to improve CMAM's existing cold room. **Outsourced Maintenance** • Third-party maintenance contracts signed between CHAI, Contracted Service Providers and MoH/DNSP (EPI), with these three-party agreements: • PLM - For preventive and corrective maintenance of electrical installations and generator sets. • Liquid Logic - For cold systems maintenance	**Epidemiological Surveillance System** • Integrated Disease Surveillance and Response (eVIDR) training requires greater interaction between trainers and trainees, and given the current recommendations (physical distance), alternative measures are required to ensure safe implementation. • Depending on the evolution of the pandemic, eVIDR's oversight activities should be adjusted. Nonetheless, technical support is always given to health facilities. **Outsourced Maintenance** • CHAI, in coordination with EPI, discussed first steps to align the process with UGEA requirements to initiate development of ToR and

		launch public tenders as per MoH norms. • Coordinate with DPC-MoH to submit VAT certificate requests to suppliers in a timely manner. • Work with all suppliers receiving GAVI funds to agree the VAT regularisation mechanism. • Strengthen communication with the central and provincial EPI, in coordination with service providers, to ensure quality monitoring of preventative and corrective cold chain equipment maintenance.
VillageReach TCA was extended for an additional 3 months.	**Training** • EPI and technicians from the provincial medicines stores (DPM), including 3PL and 4PL (Bollore and Agility), from Nampula, Sofala, Inhambane, Tete and Zambézia provinces were trained in standard operating procedures (SOPs) for handling and distributing vaccines. (26 agents / supervisors in Nampula, 18 in Tete, 24 in Zambézia). • SELV V3 face-to-face training was given to central MISAU, Maputo Province, Maputo City, Gaza, Inhambane, Niassa and Sofala in replacement of the SMT. Remote training was conducted for Tete. • LWG training on the use of SELV v3 in all 11 provinces (at provincial level) to replace SMT. • SELV v3 remote and face-to-face training (in 4 priority provinces) is scheduled for September. **PELF - integration** • Integrated distribution, from provincial warehouse to health facility, is being implemented in Zambézia, Tete, Sofala and Inhambane. Vaccines, medicines and other products are delivered on a monthly basis through 3PL. • An M&E Plan has been developed for integrated distribution of vaccines with other essential supply chain drugs. • The Integration Committee's ToR were reviewed and updated to include reporting to the Medicines Working Group. However, due to the emergency period and the restrictions imposed by the Government of Mozambique, and the priority given to responding to the Covid-19 pandemic, the group has not met. • VillageReach is working to integrate the Vaccines and Medicines Dashboard (AVIDO Panel), a single	**Impact of COVID-19** • Because of Covid-19 the country's focus is on emergency response to the pandemic. • Activities that require physical presence, such as training and workshops are experiencing significant delays, or changes in the implementation methodology. Many of the activities planned in the VillageReach TCA require workshops and training. For example, the EIR Readiness Assessment Workshop; training and expansion of SELV v3; VAN training; meetings of the Logistics Technical Group. etc. • Agenda conflicts both with MoH, DPS and partners as all are involved in COVID-19-specific activities, leading to changes in the timetable for implementing training, workshops and TA visits. • Due to some local challenges, the integration of the vaccine in the remaining province (Nampula) has been

	dashboard that combines vaccine related key performance indicators (KPI), as well as other medicines. **Transition of VAN management** • Skill Development Assessment Tool. • The electronic immunisation register (EIR) readiness Assessment initiated and an EIR working group created (EPI, DPC-DIS, VillageReach, Zenysis, Acasus) to conduct the EIR Readiness Assessment and Implementation Plans. **Other** • To ensure vaccine conservation, i.e., avoid multiple opening and closing of cold boxes during transport and to guarantee the potency of the vaccine, additional smaller cold boxes were purchased by VillageReach to provide individual packs to each health facility to facilitate handling of 3PL deliveries during distribution. • SELV v3 is already in use and stock data are available for all trained provinces and central MoH (with the exception of Inhambane and Maputo Province). We already have visibility of inventory data in provincial and central warehouses.	postponed and rescheduled to start in September.
WHO Zero cost extensions for activities planned to end in June 2020	**Supervision** • Integrated supervision of EPI and surveillance in the 4 priority provinces - activity started in July 2020 due to travel restrictions imposed under COVID-19. Two health facilities were visited in 4 districts of each province in the country. This activity was carried out together with Department of Epidemiology technicians. • Two health facilities were visited in 4 districts in each province - next joint supervision with EPI staff is planned for September and November **Urban study** • Protocol designed for the study of urban immunisation in Tete and Manica using UNICEF-WHO standard tools and strategies developed to address inequalities in urban areas. The study is planned to start in November	• Overall: Delays to implementation of activities taking into account the COVID-19 protective measures **Training affected** • Train EPI staff at district level on data analysis and utilization for local decision-making using DQS, in Nampula and Zambézia - activity replanned for October 2020 • Training in GIS and ISS tools – activity replanned in coordination with AFRO / IST for November 2020, (provided international flights resume) • Training of EPI District Managers to use the ODK platform for integrated supervision in Nampula and Zambézia - activity replanned for October 2020 • Conduct quarterly data review and periodic review (desk review) using data triangulation - analysis for the third quarter analysis to take place at the beginning of the fourth quarter • Training in GIS: provided international flights resume - a plan B is being analysed in order to continue the activity
John Snow Inc. - JSI	**RED/REC** • Providing assistance for the implementation of the RED / REC strategy in the provinces of Sofala,	**RED/REC affected activities** • Finalise the development of a guide for the main RED / REC indicators to integrate in DHIS2

Zero-cost extension may be required at end 2020	Manica and Nampula, including support to improving data quality to EPI technicians in collaboration with other partners • Completed the training of health professionals in RED / RED micro-planning **Data strengthening** • District specific coefficients developed to estimate target groups in each health facility catchment area • Training provided to central level data managers in data analysis and triangulation; impact assessment of COVID-19 on routine immunization services	• Non availability of transport • Lack of funds for fuel purchase in health facilities, affecting planned outreach • High turnover of health professionals trained in RED/REC micro-planning, affecting the consistency of RED / REC implementation • Provide continued support to integrated supportive supervision for RED / REC implementation among priority districts in Nampula, Sofala and Manica **Data strengthening** • Obtain birth data from 2017 census to finalize the validation of district coefficients and plan the training and rollout of the coefficients
UNICEF	**RED/REC** • Funded by CIDA, UNICEF completed expansion of RED/REC microplanning to the last 12 districts in Nampula and to five in Sofala in August. UNICEF will also support Sofala microplanning in a further five districts with CIDA funds and another five districts with HSS GAVI funds. • To address the issue of equity in immunization, with Gavi funding to UNICEF globally, the RED/REC Strategy Digitalisation Proposal was developed to use GIS with a geospatial component for mapping populations and geographic areas with least access. The proposal has been accepted by MoH and initial activities are in progress. **Logistics / supply chain** • Participates and ongoing technical assistance to the NLWG, both in terms of reception and distribution of vaccines as well as the entire immunisation supply chain: supported repair of vehicles for the transport of medicines from central to provincial level; support to assembly and placement of motorbike registrations; rental of private cold rooms for vaccine storage. • Annual forecasts for GAVI vaccines for 2020 took place in November 2019. Despite COVID-19, vaccines are being delivered; UNICEF has been organising delivery via charter flights to ensure continuity of services. • Support to EPI logistics monthly updates of the VIVA system. Vaccine stock analysis is performed and shared with the EPI Manager and Gavi to minimise stock shortages. The country has received bOPV, Penta and IPV vaccines. • Recruitment of a logistical immunisation officer to support the MoH logistics team in progress.	**Impact of COVID-19** • Operationalisation of the communication plan remains challenging as it requires implementation of a human-centred design workshop – meaning physical presence of participants which is not possible due to COVID-19. However, some activities are underway, such as promotion of vaccine services using community radio, multimedia audio mobile units and health committees. Prior to limitations on the number of people allowed to congregate, religious leaders, theatre groups and mobile multimedia units were encouraging parents and caregivers to take their children for vaccination and to adhere to the vaccine schedule. • Operationalisation of the communication strategy with community actors in Nampula and Zambézia has been reprogrammed for January 2020 as it is based on human centred

	• CCEOP project activities are underway: 1) first meeting with local suppliers has been held; 2) ODP has been finalised; 3) first consignment of refrigerators arrived July & August 2020 and the last part is expected in September 2020; 4) allocation has begun to Maputo City and Maputo Province; 5) the entire cold chain inventory has been carried out with support from UNICEF and a joint supervision plan with MoH has been drawn up to monitor the installation of CCEOP equipment. • Effective vaccine management plan costing **HSS** • HSS 2020, HSS 2021 and HSS2 planning – submitted to Gavi • Development of PSR annexes and the revised PSR 2021-2025 budget; support to development of EPI response to GAVI's 3rd round of comments on the HSS2 PSR budget • Preparation of the proposal for reallocation of GAVI funds in response to COVID-19 in the country • Analysis of the effect of COVID-19 on EPI service delivery • Development and coordination of the EPI Readiness and Recovery Plan (PPR) • Development of the new methodology for HSS 2021 district planning of HSS2021 based on the UNICEF bottleneck analysis methodology and support to the training and planning process in priority provinces and districts • Update of the EPI organisational structure of Mozambique: Organisation chart and Terms of Reference for EPI staff; to be finalised and approved by EPI management • Review and finalisation of One-TA Plan 2020-2021 • Preparation of the HSS2020 M&E plan • Organisation and participation in the Gavi MSD **Communication** • Activities such as interactive dialogues with religious leaders, multimedia mobile unit and community theatre have reached approximately 500.000 people in Zambézia and Nampula provinces, during February and March 2020, creating a positive environment that supports social vaccine acceptance and increase vaccination intent among caregivers. • Production of various communication materials for the COVID-19 response & to increase uptake of immunization during the pandemic **Other**: • Support to Nampula and Cabo Delgado provinces to control measles outbreaks in Nampula, Zambézia and Cabo Delgado.	design and requires the physical presence of the participants. • Covid-19 related preventive measures have deeply affected social interactions, hampering UNICEF efforts to increase demand and uptake of immunisation services. • RED/REC expansion should have been achieved in June. • Delays to receipt of vaccines in-country due to delayed flights, leading to stockouts of some vaccines.

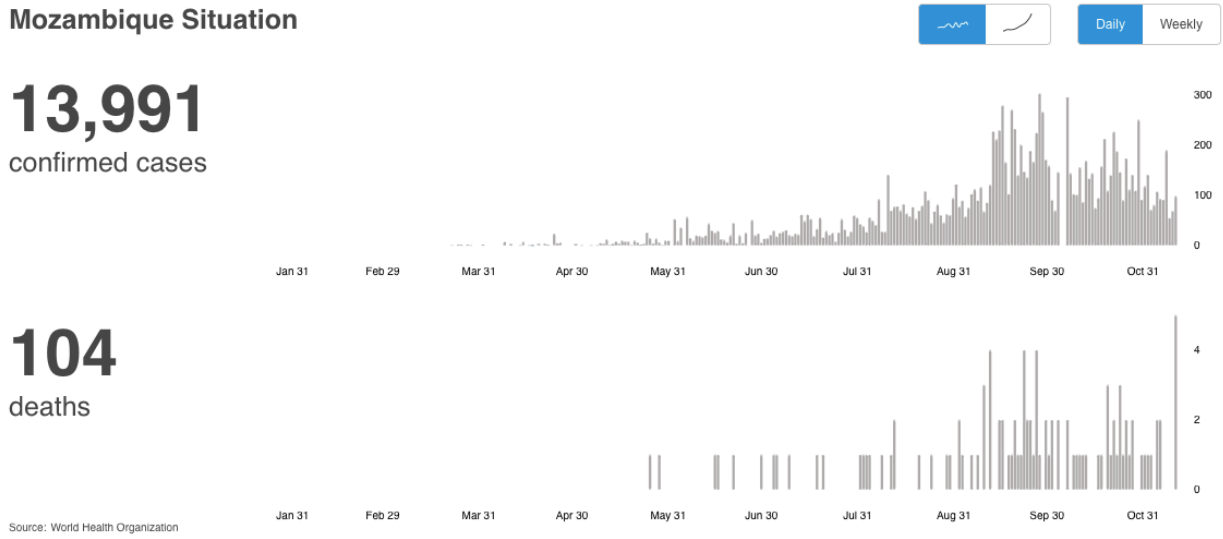
	• UNICEF secured additional funds for intensified outreach in Cabo Delgado, with a focus on accommodation centres.	
Acasus	**<u>Planning & management processes</u>** • Final action plan to address recurring and topical issues based on survey results and programme evaluations (EPI Action Plan on recurring and current issues_V1.1_300120_EN) agreed with EPI and partners; plan used to inform annual planning. • Support to developing country request for reallocation of HSS to the COVID-19 response plan. • Detailed action plan for Zambézia based on provincial supervision reports (FESP; Nampula removed from this activity due to delayed rollout of FESP. Plan shared with the provincial EPI team and approximately 60% of issues identified resolved by August. • Support to preparation of the PPR • Support to analysis of the impact of COVID-19 on routine immunisation • Expansion of FESP to all districts in Nampula province • Improvement materials and plan designed for workshop on data usage – preparation for data training for central level EPI and 30 more provincial managers • Development of outreach improvement plans for two provinces • Support to EPI management team to develop and implement procedures, processes and tools to guide annual planning exercises (e.g., JA, annual review and EPI planning meeting); district and national planning processes supported (2020) and multi-stakeholder dialogue process ongoing	**Impact of COVID-19** • Affected timing and ability to conduct visits to the provinces • The second semester has been loaded with scheduling of many competing activities for both the EPI team and partners • Scheduling of the data workshop, which involved local recruitment (due to international travel restrictions)

Section 2

2 COVID-19 impact on immunisation (in 2020): current situation

2.1 COVID-19 cases and deaths (as of 12 November 2020)

In **Mozambique**, from **Jan 3** to **4:41pm CET, 12 November 2020**, there have been **13,991 confirmed cases** of COVID-19 with **104 deaths**.



https://covid19.who.int/region/afro/country/mz

Mozambique opted not to model country scenarios regarding the COVID-19 pandemic, nor was a peak estimated. This decision was taken partially due to resource constraints, recognition of the complexity of the exercise based on the experiences of other countries and the absence of WHO guidelines.

A series of prevalence surveys have, however, been implemented in major cities across the country (Beira, Lichinga, Nampula, Pemba, Quelimane and Maputo City, as well as Maputo province. These surveys have identified and mapped areas of greatest transmission as well as most affected age groups and professions (transporters, market traders and health professionals). In Pemba displaced populations were among the most affected and, in Nampula, refugee camps.

The country has been testing for COVID-19; in the first week of November, the positivity rate was 7%, over 84% of diagnosed cases have recovered and 99 people have died from the virus.

2.1.1 Progress against indicators and targets achievement

Vaccine Programme	Source (2019)	Intermediate results Indicator	Reported actuals	Rel. % change
PNEUMO	Admin (JRF)	Number of surviving infants who received the first recommended dose of PCV vaccine (PCV1)	1,256,124	11%
	Admin (JRF)	Number of surviving infants who received the third recommended dose of PCV vaccine (PCV3)	1,124,578	9%
PENTA	Admin (JRF)	Number of surviving infants who received the first recommended dose of pentavalent vaccine (Penta1)	1,260,442	3%
	Admin (JRF)	Number of surviving infants who received the third recommended dose of pentavalent vaccine (Penta3)	1,179,936	2%
MCV	Admin (JRF)	Number of children in the target population who received the second recommended dose of measles containing vaccine (routine) (MCV 2)	832,598	11%
	Admin (JRF)	Number of surviving infants who received the first recommended dose of measles containing vaccine (MCV1)	1,160,134	1%
IPV	Admin (JRF)	Number of surviving infants who received the first recommended dose of IPV	962,124	24%

Disease Surveillance and Incidence

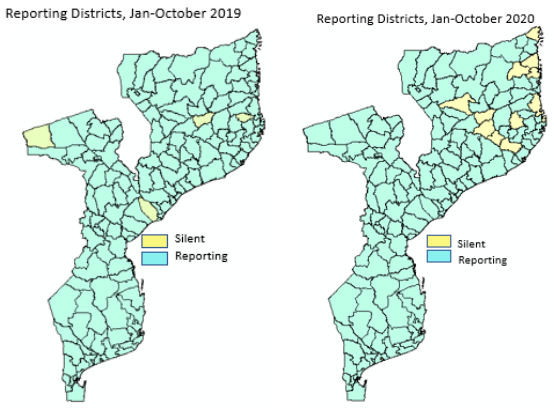
[Information from CCM team and/or https://www.who.int/immunisation/monitoring_surveillance/data/en/]

2.1.2 Impact of COVID-19 on disease surveillance and cases

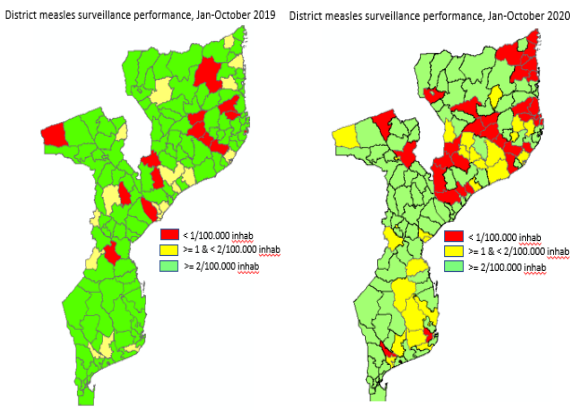
Below is a brief description of the impact of COVID-19 on the sensitivity and specificity of vaccine preventable disease surveillance.

In 2019, 154 (95.7%) of the country's 161 districts reported at least one suspected measles case compared to 148 (92%) districts in the same period in 2020. In both years, for the period under consideration, >90% of districts reported at least one suspected measles case. However, while in 2019 73.29% of districts reached the minimum performance of at least 2/100,000 population, in 2020 only 56.52% reached this rate, indicating a reduction in district performance in 2020 as compared to 2019 (see figures below).

Reporting and silent districts, Jan-Oct 2019 & 2020



District measles surveillance performance, Jan-Oct 2019 & 2020



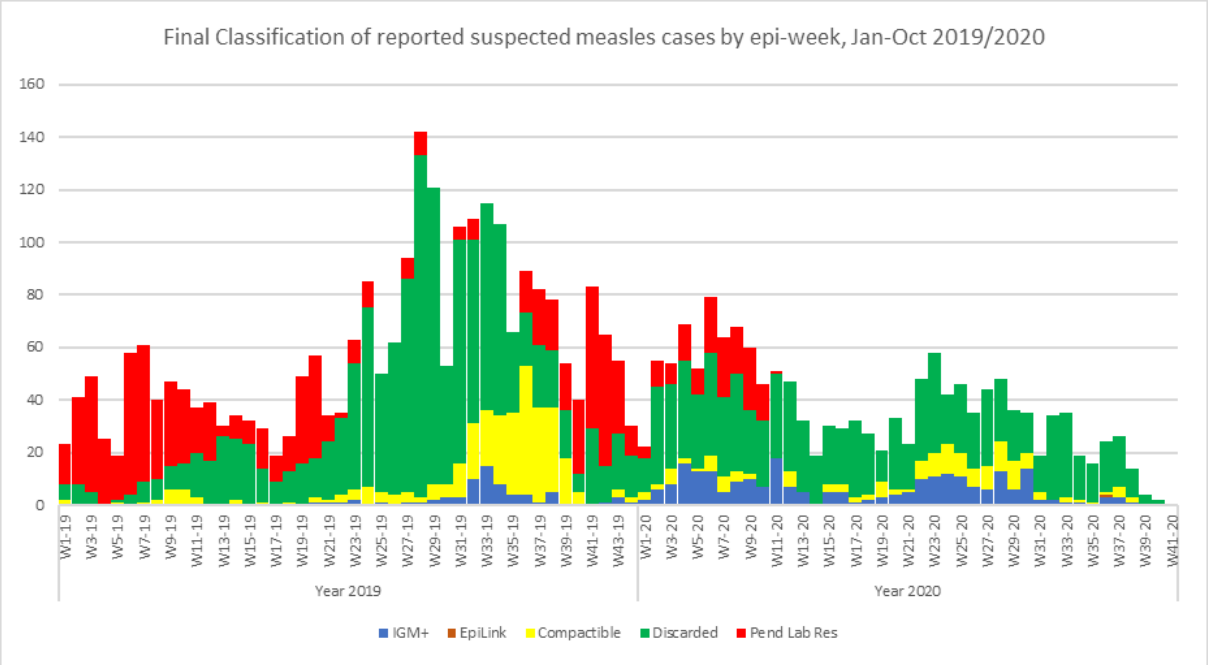
In 2019, as of 31 October, 2,577 suspected measles cases were reported. The final classification of reported cases indicates 53.5% (1,378) were discarded, 2.6% were confirmed IGM+ and 12.6% compatible. The remaining 807 cases lacked laboratory results due to the reagent stockouts the country has been facing for some time.

Over the same period in 2020, 1,498 suspected measles cases were reported. The final classification of reported cases indicates 16.6% were confirmed (16.5% by laboratory, 0.1% by Epi-link). It is noted the number of suspected measles cases reported reduced by 58%, whereas there was a 13.8% increase in cases compared to the same period in 2019 (see table below). This could indicate measles incidence increased in 2020 compared to 2019, at least in the period under review. Considering the reduction in surveillance performance, probably also impacted by COVID-19, the situation may be worse than is presented here.

Final classification of suspected measles cases reported from January to October 2019 and 2020

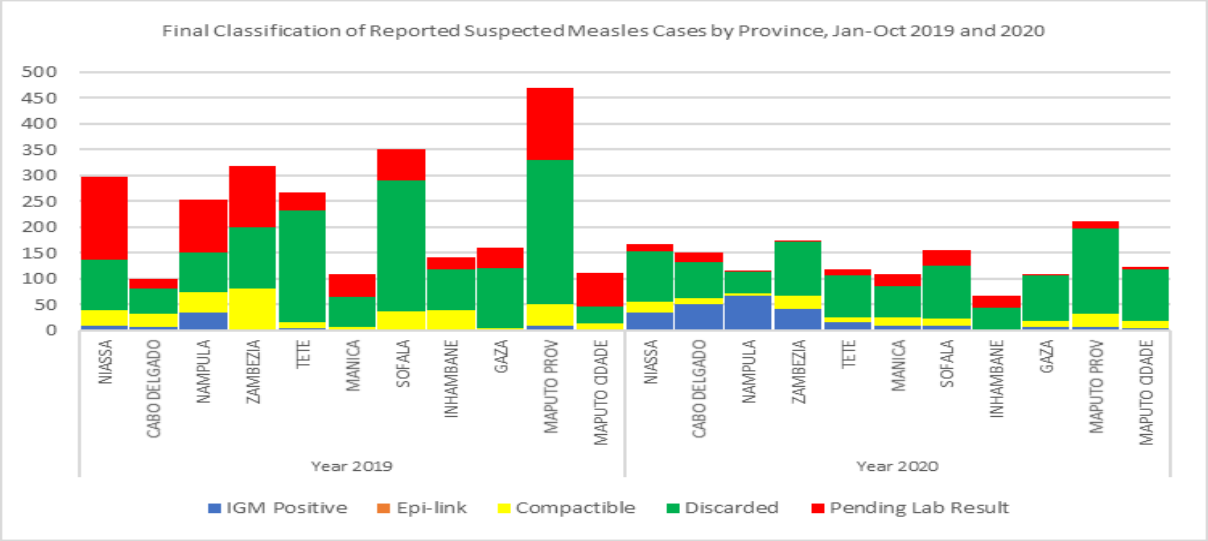
Final Classification	2019		2020	
	#	%	#	%
Laboratory confirmed	68	2.6%	247	16.5%
Confirmed by Epi-link	0	0.0%	1	0.1%
Compatible / clin no spec	324	12.6%	151	10.1%
Discarded - IGM negative	1,378	53.5%	952	63.6%
Pending Lab Results	807	31.3%	147	9.8%
TOTAL	***2,577***	100.0%	***1,498***	100.0%

The figure below shows IGM+ measles cases have been occurring since Q3 of 2019 and have increased over the last 15 consecutive months.



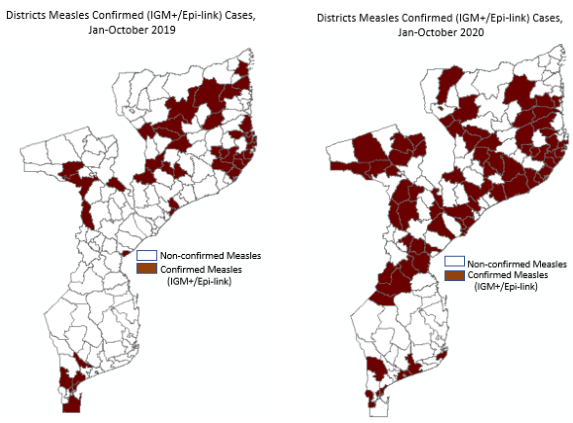
The distribution of cases by province shows Niassa, Cabo Delgado, Nampula, Zambézia and Tete have the highest IGM positivity rates. In effect, the number of positive measles cases in 2020 has doubled / tripled in the northern and central regions of the country compared to the same period in 2019 and has spread to Manica and Sofala provinces.

In the southern region, the number of positive measles cases has remained stable when comparing the two years, with some spread to Gaza province and Maputo city in 2020. This distribution shows that from 2019 to 2020 the number of positive measles cases has been increasing and spreading to a greater geographic area.

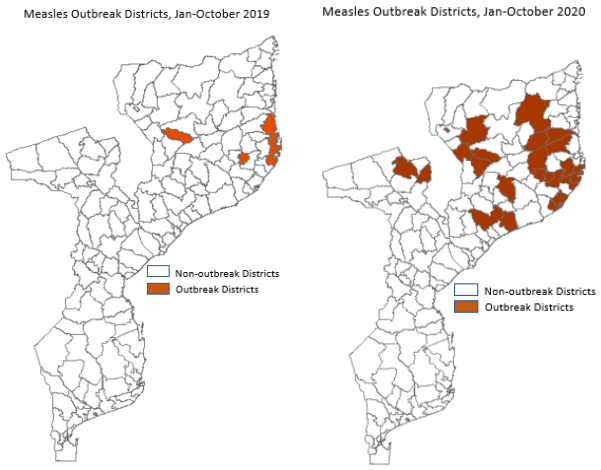


In 2019, of the 154 reporting districts, 40 had at least one positive measles case (IGM+ and Epi-link); only five met the measles outbreak definition criteria (at least 3 IGM+ within a four-week interval). In 2020, of the 146 reporting districts, 76 had at least one positive measles case (IGM+ and Epi-link), 27 of which had at least 3 IGM+ over a four-week interval. This means, in 2020, the number of districts with confirmed measles cases almost doubled, whilst the number of districts with measles outbreaks was five times greater than in 2019 (see figure below) despite a reduction in district surveillance performance in 2020 compared to 2019, as shown previously. Districts with outbreaks in 2020 are located in northern (Niassa, Cabo-Delgado and Nampula) and central provinces (Zambézia and Tete). It is important to note that the districts with measles outbreaks in 2019 are not the same as those with outbreaks in 2020, indicating measles cases have not only increased, but have also spread across the country, as observed earlier.

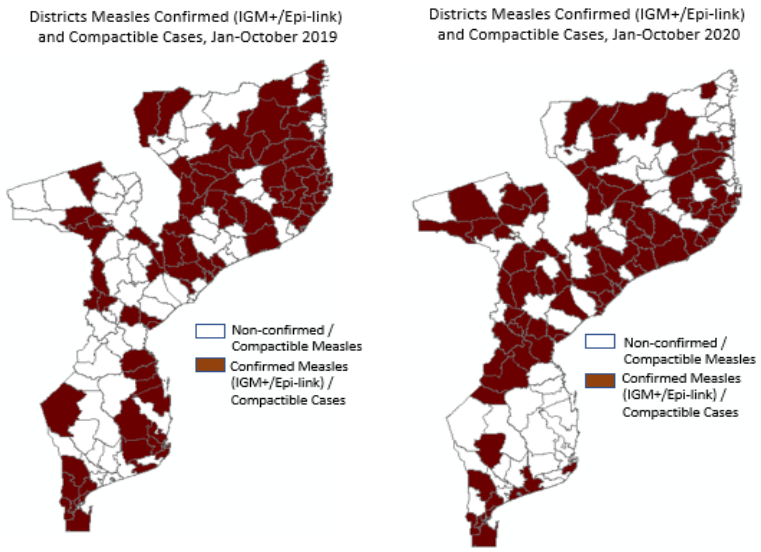
Districts with confirmed measles cases (IGM+/Epi-link), Jan-Out 2019 & 2020



Districts with confirmed outbreaks, Jan-Out 2020 and 2020



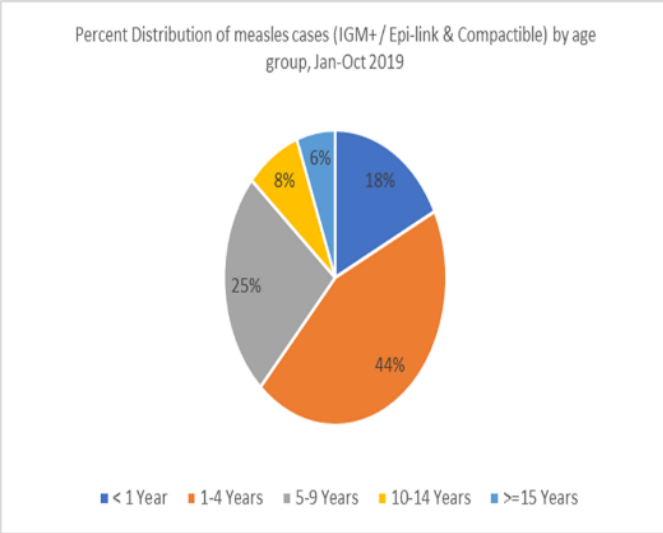
If compatible cases are to be considered in the analysis, jointly with confirmed cases, 95 and 97 out of the 161 districts have had at least one measles case in 2019 and 2020 respectively (see figure below). Compatible cases are an indication of weaknesses in surveillance performance and the possibility of these being confirmed measles cases cannot be ruled out.

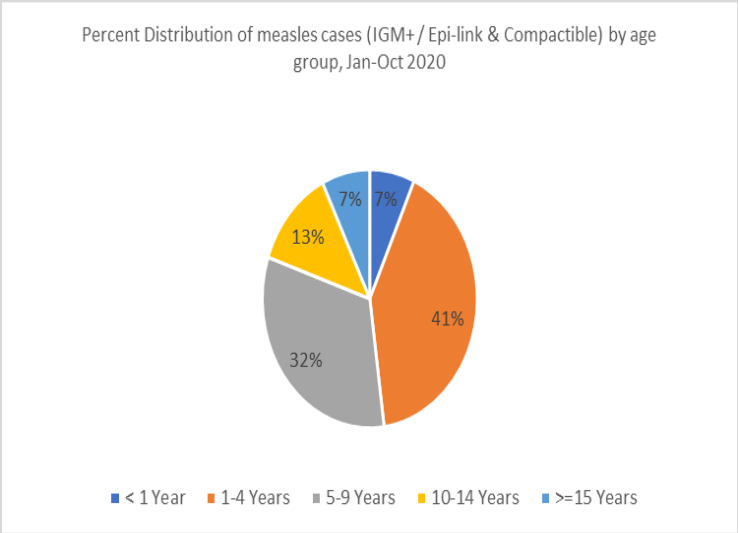


Of the 25 districts that met the outbreak definition at some point in time as of October 2020, eight met this condition in the last three months (July/August to September) and appear to have had sustained transition from April/May to July/September. These districts are: Namuno (19 cases, May-September), Montepuez (12 cases, May-July), Chiúre (3 cases, June-September) all in Cabo Delgado

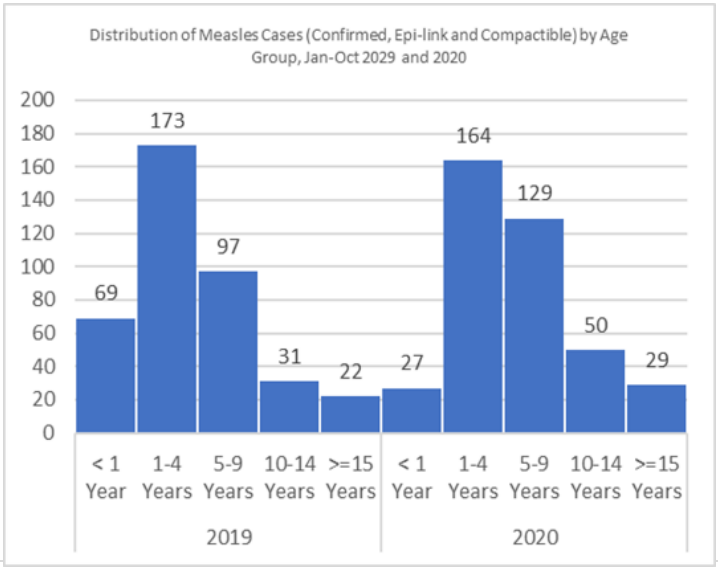
province; Cuamba (19 cases from April-July), Lichinga (3 cases, March-July), both in Niassa province; Alto-Molocué (17 cases in January-March and May-August), Mocuba (7 cases, July-September), both in Zambézia province; and Caia (5 cases, Abril-July), in Sofala province.

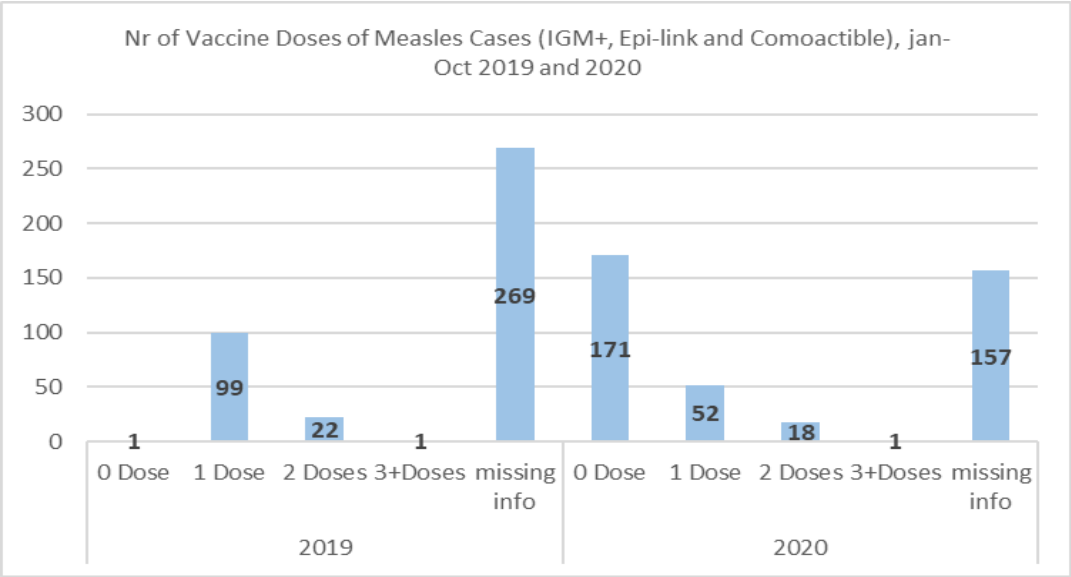
Distribution by age group in 2019, indicates that out of 392 measles cases (IGM+, Epi-link and compatible), 44% occur in children 1-4 years and 25% in those aged 5-9 years. The trend is similar in 2020, with 399 measles cases, of which 41% and 32% of cases occur in the same respective age groups (see figures below).





In addition, only 23 (5.9%) and 19 (4.8%) of children received at least two measles doses that warranty protection against measles. Furthermore, there's high percentage of zero vaccine dose in 2020 (42.9%). These data might be an indication routine immunisation has been missing a considerable number of children over the last two of years, despite the consistently high reported coverage. Meanwhile, 68.6% and 39.3% of measles cases (IGM+, Epi-link and Compatible) are missing vaccination status information and consequently additional important information on routine immunisation performance is missing.





Of the 1,498 suspected cases reported in 2020, as of October, 1,495 specimen samples reached the laboratory, of which 1,454 (97.3%) presented adequate conditions for testing. Of these, only 239 (16.4%) blood samples reached the laboratory within three days following collection, while 176 (12.1%) arrived within four to seven days. Ideally, it is expected specimens reach the national laboratory within three days of collection, or within seven days at the latest. This means only 28.5% of samples reached the laboratory within acceptable time limits. Two main reasons were advanced by provinces for this situation:

1. Reduction in availability of flights to/from provinces as a result of COVID-19. This situation might be mitigated with the 'new normal', as more regular flights resume;
2. Samples are retained at provincial level if there is no investigation form with the sample or if it is missing relevant data. Most such samples are those sent directly from the health facility to provincial level, bypassing the district, as a result, the district surveillance officer has no opportunity to check forms for correctness and completeness.

In addition, a considerable percentage of samples are pending laboratory results (146), reflecting additional delay in communicating results to surveillance units or delayed entry of laboratory results in the database, and 136 have yet to be tested due to stockouts of testing kits. It is noted that when the laboratory resumes activities following stockout of kits, it first tests the most recently received samples. Both delays in reaching the laboratory and in testing as a result of stockouts represent 19.4% (282/12,454 in good condition) of the delayed response.

This delay in getting samples tested for any of the abovementioned reasons results in delayed outbreak detection and response. Furthermore, it is problematic to Epi-link and subsequent line listing as these start when the district meets the outbreak criteria. Indeed, in 2020, the country has systematically missed the timely detection of measles outbreaks in several districts, some of which responded with sub-NIDs in the applicable health catchment areas months after the outbreak has started and eventually ended. Considering the high transmissibility of measles, late responses even through campaigns, have little or no impact in controlling the disease. It is believed the 2018 measles rubella (MR) campaign to reach children under 15 years might have prevented the explosive cases, probably due to some level of community protective immunity.

Findings from the ISS tool used in supervision visits indicate the following:

- Of the 94 health facilities visited in July/August 2020, 36% are of very high /high priority. However, there is no evidence these health facilities are regularly visited by a surveillance focal person in search of potential missed reporting cases. Indeed, central supervisors identified 23% to 31% of suspected measles cases were not reported from January to July 2020 in several districts.
- In 23% of health facilities, the last supportive supervisory visit was conducted over 6 months previously.
- 24% of staff responsible for integrated disease surveillance at health facility level had no training on reporting (eVIDR) and 6% had received refresher training more than 2 years ago.
- In general, districts and health facilities are not conducting active case detection and we found no evidence health facilities communicate regularly with community focal points to check for occurrence of diseases / events of public health concern.

In summary the key issues highlighted by the analysis are:

1. The decline in measles surveillance performance as shown by the reduced number of suspected cases reported in 2020 compared to 2019 and reduced proportion of districts meeting surveillance indicators.
2. Increase numbers of reported laboratory confirmed measles cases and districts reporting laboratory confirmed outbreaks in 2020 compared to 2019, despite the poor surveillance. This raises concerns that perhaps the magnitude of outbreaks is not being captured against a background of poor surveillance performance.
3. Increase in confirmed measles cases in 2020, indicating an increase in the number of measles susceptible children, especially under five years of age, in Mozambique
4. Delay in transportation and testing of measles samples, which also speaks to the delay in detection and reporting of measles outbreaks.

Action points

From the analysis above it can be concluded that in order to improve surveillance performance the country needs to address the following issues:

1. Conduct training of health facility staff in charge of eVIDR, train community surveillance focal points and intensify active case detection. Means of verification of regular contact with community focal points needs to be established, for whom zero reporting should also be established.
2. Supportive supervision and spot checks to be conducted on a regular basis by central/province level to districts. The district eVIDR focal person should also do the same to health facilities. Resources should be allocated for this to be effective. Consider the use of the MSD platform to address concerns over measles surveillance performance, using innovative strategies.
3. Address the different causes of delays in getting the samples tested and communicating laboratory results, to allow for timely detection and response to outbreaks.

4. Use currently available IT to conduct regular data harmonisation meetings between the surveillance unit, central level and laboratory.
5. The district surveillance focal person should check all case investigation forms for completeness before samples are shipped to the province. As much as possible, health facilities should avoid sending samples directly to the province and bypassing district level.
6. Conduct a measles risk assessment, including a measles susceptibility profile, for all districts and identify strategies to close immunity gaps in high-risk districts.
7. Consider submitting an application to Gavi in 2021 (in the January or May window) for an MR follow-up campaign in Q1 2022 (at the earliest). *Note, Gavi advises, given the build-up of susceptibles as demonstrated by the different data points, the country should consider prioritising this application for January 2021. Delaying the application to May 2021 means the earliest possible date for the campaign would be Q3/Q4 2022.*

2.2 Impact of COVID-19 on immunisation

2.2.1 Briefly describe the impact that COVID-19 has had on your ability to effectively deliver immunisation services, including:

- *Constraints on routine immunisation services (e.g. are health workers still carrying out immunisation services? What barriers do health workers face?)*

Through Presidential Decree No. 11/2020, the National State of Emergency was declared on 31 March. As a result, a rotating work regime was instituted in the public sector to allow physical distancing in office spaces - although this was not intended for frontline health workers, some health facilities failed to realise this and in these cases service provision slowed down.

With the implementation of measures to contain the spread of COVID-19, some preventative medicine health professionals were redirected to carry out COVID-19 surveillance activities and strengthen implementation of COVID-19 prevention protocols in the country.

EPI and partners performed an exercise to evaluate short term effects of the pandemic on immunisation performance in order to inform design and adaptation of its operational, readiness and response plans (Appendix 2). The tables below detail results for the different indicators over the period May and June 2020 during the State of Emergency, compared to the same period in 2019.

Tabala 1a. Resumo dos resultados do desempenho do PAV, no âmbito de COVID-19 em Moçambique

Avaliação dos efeitos de COVID-19 no PAV em Moçambique			Linha de Base: Pré-COVID19 (Abril e Maio 2019)			Período COVID19: Abril e Maio 2020			Razão das prevalências*		
Variáveis			N	n	%	N	n	%	Valor %*	(95% IC)	*Valor de P*
Demanda e oferta de serviços	Consultas de CCS	<12 meses	1,597,903	844,252	53%	1,091,139	668,976	61%	**16%**	**(15 - 16)**	**<0.001**
		12 - <24 meses	1,597,903	447,433	28%	1,091,139	271,294	25%	**-11%**	**(11 - 12)**	**<0.001**
		24 - <60 meses	1,597,903	306,218	19%	1,091,139	150,869	14%	**-28%**	**(27 - 29)**	**<0.001**
		0 - 59 meses	**5,074,998**	**1,597,903**	**31%**	**5,204,540**	**1,091,139**	**21%**	**-34%**	**(32 - 34)**	**<0.001**
	Brigadas Móveis Planificadas e Implementadas¥		2,508	1,977	79%	510	120	23.5%	**-70%**	**(65 - 75)**	**<0.001**
	Contribuição da Brigada Móvel na vacinação	Pentavalente (DTP/Hep.B/Hib)	594,524	69,686	12%	524,694	13,553	3%	**-78%**	**(77 - 79)**	**<0.001**
		Sarampo+Rubeola (MR)	315,568	55,956	18%	279,363	11,256	4%	**-77%**	**(77 - 79)**	**<0.001**
	Crianças vacinadas com Pentavalente (DTP/Hep.B/Hib)		179,910	193,993	108%	180,400	169,000	94%	**-13%**	**(11 - 14)**	**<0.001**
	Crianças completamente vacinas (CCV)		179,910	170,776	95%	180,400	154,397	86%	**-10%**	**(12 - 13)**	**<0.001**
	Crianças faltosas ou desistência *(drop out)* para completar a vacinação	Pentavalente (DTP/Hep.B/Hib)	208,284	14,291	7%	185,162	16,162	9%	**27%**	**(25 - 30)**	**<0.001**
		Sarampo+Rubeola (MR)	180,400	46,110	26%	161,922	44,481	27%	**7%**	**(5 - 8)**	**<0.001**

*¥ Apenas são dados das Províncias prioritárias implementação de Ed/REC: Manica, Sofala, Zambezia, Tete e Nampula. * Valor Atribuível a possíveis efeitos de COVID19*
PAV= Programa Alargado de VAcinação. IC=Intervalo de Confiança. Boldado, indica valor de P<0.05

Tabela 1.b. Resumo dos resultados do desempenho do PAV, no âmbito de COVID-19 em Moçambique (Continuação)

Avaliação dos efeitos de COVID-19 no PAV em Moçambique			Linha de Base: Pré-COVID19 (Abril e Maio 2019)			Período COVID19: Abril e Maio 2020			Razão das prevalências*		
Variáveis			N	n	%	N	n	%	Valor %*	(95% IC)	*Valor de P*
Logística	Unidades Sanitárias que Reportaram Roptura de stocks da Pentavalente durante as visitas de distribuição de vacinas		1,278	69	5%	1,205	72	6%	11%	(8 - 53)	*0.384*
Qualidade dos Serviços	Completude de reporte de dados de vacinação no SIS-MA		3,252	3,179	98%	3,252	3,155	97%	**-1%**	**(>0.1 - 1.0)**	**0.031**
	US visitas para logística de vacinas *(distribuição e reporte de stocks de vacinas)*		2,464	1,278	52%	2,464	1,205	49%	**-6%**	**(1 - 11)**	**0.019**
	Completude de reporte de dados de logística de vacinas no SELV		2,464	1,952	79%	2,464	1,543	63%	**-21%**	**(12 - 24)**	**<0.001**
	Reuniões Provinciais monitoria e discussão de planos e dados de PAV		33	21	64%	33	15	45%	-29%	(45 - 113)	*0.07*
Vigilância DPV	Casos de Sarampo	Nr médio mensal de casos suspeitos	29,318,301	727	2.5	30,066,664	819	2.7	10%	(9 - 12)	*0.032*
		Nr médio de casos de Sarampo IgM+	29,318,301	3	0.01	30,066,664	132	0.44	**4.2**	**(1.4 - 13.5)**	**<0.001**
	Número medio mensal de casos de pólio (Paralisia Flácida Aguda) na população < de 15 anos de idade		13,520,579	55	0.41	13,774,024	23	0.17	**-59%**	**(33 - 75)**	**<0.001**

*¥ Apenas dados das Províncias prioritárias implementação de RED/REC: Manica, Sofala, Zambezia, Tete e Nampula. * Valor Atribuível a possíveis efeitos de COVID19*

PAV= Programa Alargado de Vacinação. DPV= Doenças Preveníveis por Vacinas. SELV= Sistema Eletrónico de Logistica de Vacinas. IC=Intervalo de Confiança. Bolado, indica valor de P<0.05

The evaluation revealed a 34% reduction in demand for 'healthy child consultations' (*criança sadia* – providing integrated maternal and child health, immunisation and nutrition services to children under five years old) during the period. Among children under five, the proportion of children under one year old increased significantly, at the expense of the reduction in children over one year old, the majority of whom are not of vaccination age. This can be explained by the spacing of consultations for children >1 year or mothers' fear of COVID-19 transmission and compliance with the recommendations of the State of Emergency when bringing children >1 year to be weighed. The need to better understand the causes of reduced demand to allow adjustment to and strengthen communication so as to improve uptake of immunisation led to EPI's rapid demand assessment described below.

The 70% reduction in outreach performance in the five HSS priority provinces, where RED/REC is implemented with Gavi funds, was due to the suspension of outreach and other community activities. As mentioned above, these activities were suspended as a result of the State of Emergency. This finding supported EPI advocate within MoH for a review of these recommendations. As part of the operationalisation of the State of Emergency, MoH prepared the **COVID-19 National Pandemic Readiness and Response Plan (March 2020)** (Appendix 3), with specific guidelines to guarantee continuity of essential health services whilst strictly observing individual protection of health professionals and clients to reduce COVID-19 transmission. Guidelines affecting EPI activities include:

- Scheduling of appointments.
- Suspension of collective health talks
- Cancellation of outreach in order to reduce crowding of people in the community.
- Avoiding encounters with the community.
- Avoiding group meetings at health facilities and in districts.
- Allocating TMP (preventive medicine personnel) to COVID-19 testing, handling of samples, home follow-up of those infected and under quarantine as well as strengthening implementation of COVID-19 prevention protocols.

At both fixed vaccination posts (FVP) and through outreach, the COVID-19 impact evaluation also found the number of children reached or vaccinated with DTP3 reduced significantly in the two months during which emergency measures were in force, thus reducing the number of fully immunised children (FIC) in the community. A reduction was also noted for MR1 and MR2 by 11% (100 to 90%) and 15% (95 to 86%) respectively - data not included in the tables). This is of concern because a reduction in the number of children vaccinated increases susceptibility to outbreaks of vaccine-preventable diseases. This informed PPR planning to strengthen routine strategies (intensified outreach) for service provision and to strengthen demand through communication.

These and other aspects have affected the normal functioning of EPI, both in terms of supply and demand for services at FVP as well as through outreach services, for example:

- Fear and insecurity on the part of some TMP to carry out activities.
- Technical staff in the workplace in rotating shifts to comply with physical distancing measures.
- Temporary restrictions (March to June) on availability of vaccination services by suspending outreach to the community.
- Temporary interruption (March and April) of health talks that required people to gather in health facilities and communities.
- Temporary interruption (March and April) of the monthly face-to-face data discussion meetings in the districts

All of these factors, plus the impact on the community described below, contributed to reduced supply and demand for vaccination services and resulted in a new way of working. This in turn implied the need to reorganise service delivery at all levels and to strengthen communication and social mobilisation activities.

- *Impact of the pandemic that may have exacerbated gender related barriers to immunisation experienced by caregivers, adolescents and/or health workers.*

Regarding children, an analysis of DHIS2 data indicates no significant differentiation by sex relative to vaccinations administered compared to the same period in 2019 (Appendix 4).

The possible impact of the pandemic on gender barriers related to health professionals has not been investigated.

The pandemic's impact on immunisation in relation to barriers has also not been studied, although a number of organisations have initiated/completed COVID-19 impact studies:

- In October, ICRH-Mozambique and the Faculty of Medicine of Eduardo Mondlane University initiated an online survey (I-SHARE study) being conducted in over 30 countries to understand how COVID-19 prevention measures, such as school closures, working from home and others, are affecting sexual behaviour, violence, and access to sexual and reproductive health services[2].
- Media coverage has reported on the increased challenge girls faced due to COVID-19:
  - Risk of early marriage as a result of poverty and family pressure, despite marriage having recently been made illegal for under 18-year olds[3].
  - Less time to study whilst schools are closed as domestic chores take precedence[4].
- Key messages from a June 2020 UNICEF COVID-19 policy note[5] included:
  - Access to healthcare may reduce further as the system responds to the pandemic, increasing the existing vulnerability of children needing immunisation.
  - School closures and lost learning are expected to particularly impact girls, who may not return to classes.
  - Child marriage (pre-COVID-19 already at 48%) and transactional sex may also increase.
  - Increased domestic violence, as has been found in other countries.

A number of recent studies / policy documents have investigated this issue at a global level; it is feasible the following issues are also relevant to Mozambique:

- A United Nations policy brief recognises the pandemic has highlighted and exacerbated existing inequalities and discusses the following impact on women[6]:
  - How the pandemic has compounded the economic impacts on already more economically vulnerable women and girls, providing recommendations
  - Impact on women's health as family resources may be reallocated away from health

[2] https://ishare.web.unc.edu/mozambique/
[3] E.g. https://www.dw.com/pt-002/mo%C3%A7ambique-pandemia-da-covid-19-aumenta-risco-de-casamentos-prematuros/a-54743776
[4] https://clubofmozambique.com/news/covid-19-pandemic-pushing-mozambican-girls-into-premature-marriage-173859/
[5] The Impacts of COVID-19 on Children in Mozambique. COVID-19 Policy Note. UNICEF Mozambique Social Policy, Evaluation, and Research unit. June 2020 PN-01
[6] The Impact of COVID-19 on Women. United Nations. 9 April 2020

- Increased responsibility for care of children (not in school), the elderly/infirm and sick
- The need to ensure public health messages on COVID-19 and other health issues reach women and girls, particularly in remote / underserved areas as well as camps for refugees and internally displaced people. Messages should be culturally appropriate and accessible, including in low literacy contexts
- The need to attend to the impact on female health workers, ensuring PPE (sized appropriately), hygiene and sanitation e.g. sanitary pads, soap, hand sanitizers, etc.) and to protect against gender-based violence.
- Ensure PHC services continue, ensuring infection control measures and access to HIV treatment.

The policy document concludes '*Putting women and girls at the centre of economies will fundamentally drive better and more sustainable development outcomes for all, support a more rapid recovery, and place us back on a footing to achieve the Sustainable Development Goals*'.

- Plan International and UNESCO have warned adolescent girls will be disproportionately affected by increased school drop-out, which will worsen education gender inequities and increase the risks of sexual exploitation, early pregnancy and early and forced marriage[7].

➢ *Impact on uptake, demand and community engagement (including impact of rumours or misinformation)*

In the community, information about the new and unknown disease created a lot of fear and uncertainty. One of the main messages under the State of Emergency was "*Stay at home*". Unfortunately, this message was interpreted as a ban on going to health facilities, significantly affecting demand for vaccination services, particularly in April.

To combat rumours, within the scope of the MoH National Plan for COVID-19 Pandemic Readiness and Response, awareness activities reached the entire population. Through various channels, the population was advised to comply with the vaccination schedule whilst observing preventative measures. In addition, regular COVID-19 status press conferences have stressed continuity of health services and delivered messages encouraging continued vaccination. Alternative means of disseminating information, based on digital systems, have been increasingly used, several digital posters were created and shared via WhatsApp and Facebook, increasing the range of information provided on continuing to vaccinate in the context of COVID-19. EPI's regular participation in television and radio programmes was intensified during this period, providing an opportunity to clarify and combat rumours and fake news.

Financing of the MoH National Plan had considerable, early support from Gavi (see 2.4) for the risk communication and community engagement component (in addition to personal protective equipment or PPE). Bureaucratic issues have, however, delayed use of these funds, so some interventions originally planned for using Gavi funds proceeded with support from other partners. Currently ongoing are training activities with community actors, interventions in markets, programmes on community radios, message sharing via mobile audio units, message sharing via social networks and collection of feedback via digital platforms (social listening).

[7] https://en.unesco.org/news/covid-19-school-closures-around-world-will-hit-girls-hardest and Halting lives: The impact of COVID-19 on girls and young women. Plan International. 2020.

These activities and others will be reinforced by implementation of the **National Community Response Strategy to COVID-19** (Appendix 5) and the **Service Continuity Plan** (Appendix 6) and through a variety of platforms, including community actors and the media.

Following the evaluation on the impact of COVID-19 on immunisation presented above, EPI performed a **Rapid Assessment on the Reasons for Reduced Demand for Vaccination Services in the context of COVID-19** (Appendix 7). This rapid assessment aimed to gain a holistic understanding of the reasons behind the reduced demand by conducting a series of consultations with mothers, caregivers, community leaders and health workers. The assessment was carried out in districts identified as having the lowest immunisation coverage rates.

Figure 1: Main findings regarding compliance with the vaccination schedule: perspective of mothers, fathers and caregivers

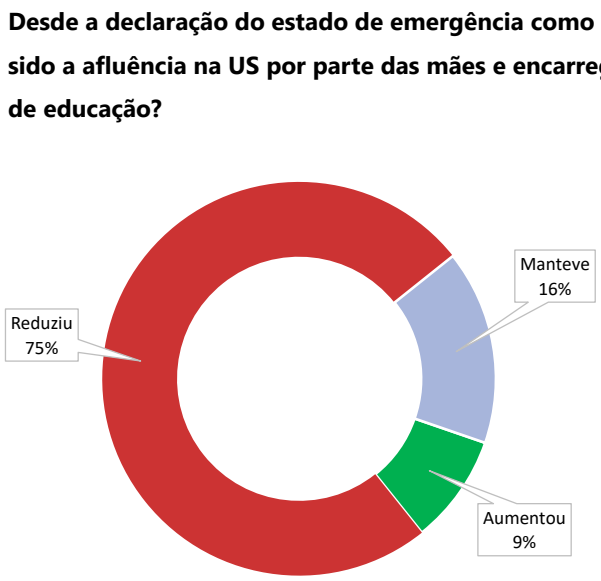
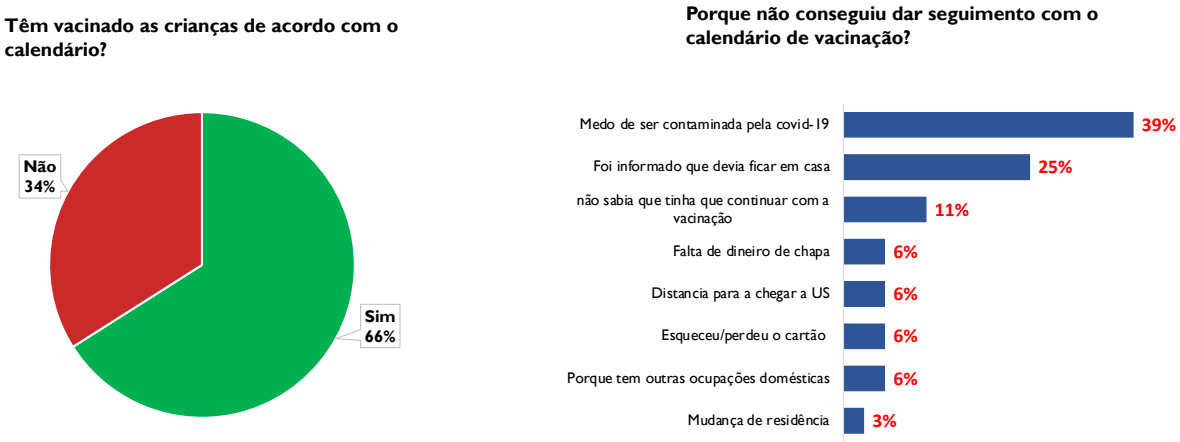


Figure 2: Main findings regarding compliance with the vaccination schedule: perspective of health workers



Community leaders consulted (neighbourhood secretaries and community health workers, known as APEs) suggested, in order to guarantee the continuation of vaccination services even during the duration of the pandemic:

- It is necessary to develop a clear message in order to mobilise mothers
- Conduct outreach
- Reactivate health committees
- Continue to give health talks informing mothers about the importance of vaccination
- Door-to-door mobilisation
- Fast service so there is no crowding in the health facilities
- Involve both men and women in vaccination. Men who take the children to the health facility should be the first to be attended so they are more motivated.

➢ *Impact on any planned new vaccine introductions or campaigns*

In response to the emergency situation resulting from the cholera outbreak in Cabo Delgado, a cholera vaccination campaign (supported by ICG for vaccines) was planned for some districts of the province in Q1 2020. In view of the increase in the number of COVID-19 cases reported in the province, together with the ongoing insurgency, the campaign was postponed and implemented from 21 to 25 September (1st round) and 12 to 18 October (2nd round) in Pemba city, Ancuabe, Ibo, Macomia, Metuge and Palma, achieving 94% coverage at provincial level. A technical report is available in Appendix 18.

The introduction of HPV is currently scheduled for the second half of 2021 (postponed due to COVID-19 from April 2021) through intensified outreach in schools and communities. No other introduction campaign was planned for new vaccines. In the meantime, EPI continues to work with EpiLinks to develop the demand generation plan for HPV introduction.

➢ *Impact on vaccine stocks (e.g. restocking of vaccines and related supplies, risk of expiry, updating dose requirements, reallocating stocks internally within the country/districts to ensure equity of supply)*

The table below shows the availability of vaccines at central level in June 2020 (data source is SELV). It shows central level had stockouts of bOPV and DTP-HepB-Hib vaccines and predicted IPV stockouts. Despite stockouts at central level, provinces had sufficient vaccines for use until September and to ensure distribution to districts and health facilities

Regarding the reception of vaccines.

- Delays due to closure of airspace and consequent limitation of flights:
    - The national deposit registered a delay in the arrival of DTP-HepB-Hib which culminated in a 26-day stockout after spending 114 days below the minimum stock.
    - Regarding bOPV, there was a stockout for approximately 120 days following 84 days below the minimum stock.
- All other vaccine shipments arrived on time in May and June 2020, with no interruptions caused by global COVID-19 blockages.
- The central warehouse also kept its plans updated – for distribution and of provincial stocks. There were no stock issues at provincial level; it remained consistent in the first quarter (before COVID-19) and during the second quarter of 2020.

Vaccine	Stock level	Needs for next 6 months	Usage time	ETA	Comments
BCG	1,774,000	1,649,000	Dec 2020	No date	
bOPV	0	3,664,200	0	No date	Dependent on international flights in the context of COVID-19
DTP-HepB-Hib	0	1,954,400	0	No date	Dependent on international flights in the context of COVID-19
Rotavírus	995,350	1,234,400	Nov 2020	No date	
PCV-13	1,485,200	1,851,400	Nov 2020	No date	
IPV	315,000	651,800	Sep 2020	No date	
MR	1,759,000	1,563,600	Mar 2021	No date	
TT	2,597,500	1,628,800	Apr 2021	No date	

The vaccine supply chain has been affected on a medium scale because of international and national flight limitations, causing delays in the supply of bOPV and DTP-HepB-Hib vaccines to the country, and creating uncertainties regarding their resupply. Supplies eventually arrived in July. In the country, the distribution of vaccines has been restricted due to breakdowns in dedicated transport at central level (not COVID-19 related). However, provincial level, despite limitations re means of transport, has not registered any distribution constraints.

Due to the delay in international shipment of vaccines for the fourth quarter of 2019, the country received a large quantity of PCV13 vaccine, which unexpectedly increased available stock (excess stock). In order to guarantee conservation of this vaccine, space equipped with cold rooms suitable for the storage of this vaccine was rented from the private sector with financial support from Gavi via UNICEF. The monitoring of vaccine levels and replenishment, at all levels of service provision, will be an important activity of EPI's PPR.

On the other hand, emergency procedures have been activated to guarantee stocks of vaccines and vaccination supplies needed by the provinces and direct delivery distributions mostly continued, despite national restrictions in force.

Constraints noted in the EPI assessment of the impact of COVID-19 on immunisation services (Appendix 7) include:

- A significant reduction in the number of health facilities visited during the initial COVID-19 response period. This was reflected in reduced completeness of SELV data and in stock flows reported by the facilities visited. The impact of this may be more noticeable in upcoming months – which will contribute to reduced uptake of vaccination services.
- Potential stockouts in unvisited health facilities.

To minimise COVID-19-related impact on vaccine stocks, these were frontloaded. As a result, no vaccine stockouts are expected at the end of the year. MR vaccines are on the way and bOPV is expected in October.

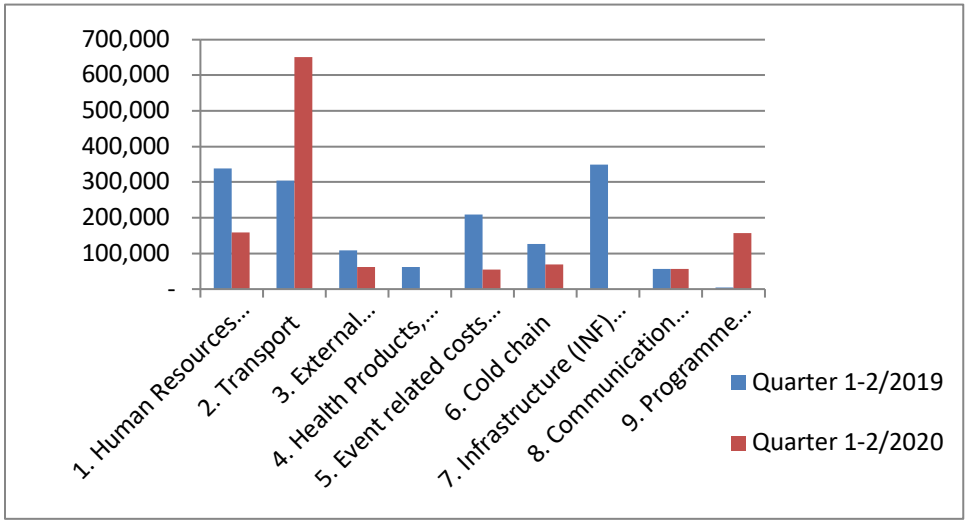
➢ *Impact on health and immunisation (incl. vaccines) financing (e.g. repercussions on the health/ immunisation/ vaccine budget; delays in budget disbursements relating to immunisation activities; intention of other donors to make additional funding available for health/ immunisation/ vaccines)*

The impact of COVID-19 on health financing and the national agenda to achieve universal health coverage has yet to be analysed. Overall, COVID-19 did not have a significant impact on the funding of immunization activities by either Gavi or the Government as they made efforts to secure funding for essential activities. However, year 2021 funding may reflect better the impact of the pandemic on government funding as distortion to economic activities and possibly government revenue will only manifest in the budget going forward.

- Health care workers' salaries have not been cut.
- The payment plan for vaccine co-financing sent to Finance has not changed.
- Payment was made for traditional vaccines. Stockouts were caused by delays in shipping vaccines due to the closure of airspace under restrictive measures related to COVID-19.
- The delays in budgetary disbursements related to activities were unrelated to COVID-19; the processes were sent in electronic format to the Ministry of Economy and Finance and the orders were processed in the same process. Delays affected supervision and outreach in the first quarter (pre-COVID-19); from the second quarter (during COVID-19) it was possible to use the remainder of other Gavi funds as a loan to allow EPI operations to proceed.
- There was no need to request intervention from other donors to provide additional funding.
- However, there was a need to request postponement of the date on which reimbursement to Gavi was paid in order to prioritize COVID-19 response activities and continuity of services.

➢ *What has been the impact on the implementation of Gavi support (vaccines, HSIS, TCA, other), including financial absorption, stock management etc.?*

Implementation of HSS activities such as supervision, outreach and training were affected, mainly in the second quarter. The table below shows this resulted in decreased percentage execution of funds due to the restrictions adopted by the country and health worker concerns related to performing their activities (Appendix 8). Additionally, due to the delay in disbursement by Gavi, there was a need to use the balances of other grants existing in the country to implement priority activities.



On the other hand, after Gavi's disbursement, as the decentralization process underway in the country resulted in the need to create new Asset Management Units (UGB) in some provinces, the transfer of funds to the provinces was delayed by 30 days. It was therefore only in July that some provinces received HSS / 2020 funds, with the exception of Nampula which received them in August.

Procurement activities through UGEA were paralysed for two months, given the Administrative Court was not receiving processes due to the State of Emergency. Since then, it has not responded with the same flexibility, mainly due to staff shortages as they are working on rotating shifts.

On the other hand, the Programme's technical support partners (TCA) were also affected, with time available to provide technical support to the programme reduced due to the need to participate in different technical groups for coordinating the response to the COVID-19 pandemic. Also, Programme partners were restricted visiting the districts to provide supervision and technical support, with virtual working initiated for part of the work. For affected activities, refer to 1.5, 2.4 and 2.5.

2.3 Already agreed budget reallocations of HSS grant for COVID-19 response

[Please complete table to reflect any budget reallocations already approved – example below]

MOH requested on 30 March 2020 the reallocation within HSS of USD 2.968 m towards the COVID-19 response. Gavi approved this request within an additional HSS amount on 7 April. Further, on 24 June, Gavi approved the reallocation of funds within the already approved amount. The funds were disbursed to UNICEF SD (Activity 2) and MoH (Activity 1) on 9 June and 30 June 2020 respectively.

	COVID-19 activity (national response plan)	Amount (additional to already approved HSS) US$	Status of implementation
Activity 1	Advocacy and communication activities	1,011,030	Ongoing, execution rate on 03.12.2020 is 2%, however all tender processes are with UGEA pending finalisation of procurement activities (included in Appendix 1).
Activity 2	Infection prevention and Control (PPE)	1,968,030	100% financial execution rate (17.09.2020) 100% of PPE delivered in-country to CMAM, Maputo (01.10.2020)
Total		**2,980,000**	

EPI has requested Gavi agree to the inclusion of reporting on HSS COVID-19 execution within the quarterly HSS financial report; the Q3 2020 report is due in November 2020.

It should be noted, the PPE procurement process has been coordinated by CMAM and multiple donors have provided PPE to support Mozambique meet its requirements. PPE are tracked into CMAM but lose their 'donor' identity on leaving the warehouses for distribution. At all levels, EPI supervision by all levels includes verification of PPE in stores and in use by health workers during visits in order to ensure it is available at health facilities to protect staff and encourage confidence by parents and caregivers to bring their children for vaccination.

2.4 Already agreed modifications in Technical Assistance

Partner	TCA Modification	Further details
Acasus	No Cost Extension with additional deliverables for Covid-19 related activities	Contract extended till 30 March 2021. New COVID-19 recovery related deliverables include: 1) Support development of justification for HSS fund reallocation to national COVID-19 response 2) Contribute to drafting of readiness and recovery plan for resuming immunization activities post COVID-19 3) Contribute to analysis of the impact of Covid-19 on routine immunization.
VillageReach	No-cost extension for 2 months granted with no changes in deliverables	Contract extended till 30 June 2020.

2.5 Unspent funds and savings from Gavi support, available for re-allocation

Due to the pandemic, there was a delay in performing some activities as well as cancellation of others, which meant that, even though we did not receive the global disbursement of the budget approved for 2020, we were able to reallocate to activities not covered by the disbursed funds (Appendix 9 Reallocations Table). In the case of some activities, the funds were reallocated because their implementation would not be effective in 2020; they may be implemented in the first quarter of 2021 following disbursement of the remaining values, for example, demand activities, as well as some trainings that were cancelled due to restrictive measures.

As for activities where savings have been made (part of the budget for some events, e.g. Joint Assessment (JA), central planning, ICC, payment of the northern HSS advisor, etc.), the funds may be allocated to other activities considered as priority over the course of the year for improved Programme performance. These savings are shown in the table below.

Possible Savings	Amount
Joint Assessment	$ 30,358.70
Workshop for presentation and approval of the EPI M&E plan	$ 180.79
External audit of the HSS grant by the Administrative Court	$ 65,966.46
RED / REC annual review meeting - national level	$ 48,869.56
Training in DQS / VAN	$ 33,081.84
DQS / VAN data analysis meeting at provincial level	$ 139,781.97
Mass media EPI Communication Strategy	$ 23,551.81
Implementation of the EPI Communication Plan in the five priority provinces	$ 50,000.00
Pharmacovigilance - printing the AEFI form and promotional material	$ 26,634.38
	$ 418,425.51

2.6 Displaced populations in Cabo Delgado

Mozambique is currently experiencing an insurgency that has displaced nearly 450,000 people from parts of Cabo Delgado province. The Provincial Government, in coordination with MoH and other Ministries, are developing a response plan in order to address emerging needs of these populations, with particular focus on health.

The humanitarian situation in Cabo Delgado province has significantly deteriorated since April 2019 when it was battered by cyclone Kenneth; the situation has been exacerbated following further consecutive climatic shocks, insecurity and violence, leading to largescale displacement of people, disruption of livelihoods and lack of access to basic services. Over the past months, insurgent attacks have increased in scale and scope, with the coastal districts of Moçimboa da Praia, Macomia and Quissanga hardest hit. Displacement has risen rapidly over the last month as violence has escalated, with more than 250,000 people now estimated to be internally displaced in the province, according to the latest reports; over 400,000 are reported displaced overall. Most of the recently displaced persons have fled to neighbouring Nampula, and Niassa Provinces.

The intensification of violent attacks in October / November, including on the capitals of Moçimboa da Praia, Quissanga, Muidumbe and Macomia districts, have forced many humanitarian actors to temporarily withdraw to Pemba (the provincial capital) and Maputo from vital hub locations, reducing their ability to assess and respond to rising needs. At the same time, road transport has proven challenging in the province as roads and infrastructure are in poor condition and remain susceptible to weather conditions. From 16-23 October, at least 7,402 new internally displaced people (IDPs) arrived by boat to Pemba according to IOM/DTM. On 22 October alone, 24 boats carrying 2,700 people arrived in Pemba. The IDPs, mostly women and children, are coming from Quissanga, Macomia, and Ibo districts, fleeing conflict, violence and insecurity, including armed attacks on Matemo island in Ibo district.

This humanitarian emergency is rapidly escalating, impacting access to PHC services, including routine immunisation. Affected populations are at risk of elevated morbidity and mortality from vaccine preventable and other infectious diseases through the creation or exacerbation of factors associated with disease transmission such as mass population movements, overcrowding, malnutrition, and poor water and sanitation conditions. IDPs are particularly susceptible to communicable disease outbreaks due to malnutrition that can further increase vulnerability.

Vaccination is one of the most basic and critical health interventions for protecting vulnerable populations during emergencies. A cholera outbreak and campaign have already occurred and there is high risk of measles and polio outbreaks.

In the view of the above situation, under the coordination of WHO Country Office, supported by UNICEF and WHO AFRO, Cabo Delgado Health Authority has developed a Vaccination in Humanitarian Emergency Plan (draft attached in Appendix 10). The province's Emergency Coordination Task Force will manage technical planning, risk mapping and resource mobilisation, working with MoH and stakeholders. UNICEF and WHO are providing technical and financial support to this Plan, which will be implemented by the DPS, Provincial Health Services (SPS) and MoH. The initial plan only focused on covering Cabo Delgado, however, as the escalating situation is resulting in IDP in other provinces, the aim is now to extend the intervention to Nampula, Niassa, Sofala and Manica provinces – as a result, there remains a considerable financial gap.

The objective of the Plan is to provide protection to high-risk populations along likely transmission routes, limiting the probability of occurrence of measles and polio cases due to low immunisation

coverage, population movement associated with a background of malnutrition and micronutrient deficiencies. Vaccination is being proposed as an additional outbreak prevention and control tool for vulnerable communities living in poor sanitary conditions of high population density. Measles and polio vaccinations will be combined with on-going prevention and case management activities.

Analysis is required to identify the need to extend the district prioritisation undertaken for HSS2 to include more districts of Cabo Delgado.

2.7 Decentralisation

Following national elections, in 2020 Mozambique began implementing a new decentralisation process which involves creation of Secretariat Services to support the new provincial position of Secretary of State; each province has an elected Governor. Now, in addition to the DPS, there are Provincial Health Services. The functionality of these two bodies is based on a Decree however, there was a limited understanding of roles and responsibilities, as well as reporting mechanisms. In the first week of October, a seminar chaired by the Minister of Health was held involving MoH, Ministry of Public Administration and provincial representatives to clarify the terms of reference for each body.

According to the decree on decentralisation, it is understood the DPS is responsible for PHC activities and implementation, whereas the Provincial Health Services are responsible for hospital care, health product management and logistics (i.e., for immunisation, vaccines and vaccine materials) in addition to providing oversight of the implementation of PHC. However, limited clarity on how these roles are to be performed and with what resources, as well as their coordination mechanism, has affected implementation in the first semester of the year.

Section 3

3 Discussions on priorities, action plan and technical assistance needs

This section provides an outline of Mozambique's plans to reinforce/re-establish routine immunisation activities and catch-up on missed children in the context of the country's epidemic response/recovery plans while taking into account the guidance provided by the Alliance. Details are provided in the following subsections.

From the MSD perspective, it is understood short/medium term plans encompass approximately three to 12 months and medium/long term plans approximately six to 18 months. The country's PPR, components of which are described in Sections 2 and 3, was developed to address gaps in routine immunisation coverage as a result of the pandemic and is considered the country's short/medium term plan in response to COVID-19. However, it should be noted EPI considers the methods described in the PPR relevant for the duration of the affected period (length unknown), to be applied periodically as required and identified through data analysis.

3.1 PPR – Mozambique's short/medium term plan (3-12 months)

In 2020, EPI entered the fifth and final year of its first Health Systems Strengthening (HSS) grant from Gavi. The principal objectives for 2020 were to:

1. Finalise training activities started in the previous year (VAN, DQS, MLM, CIP; supply chain maintenance, etc.);
2. Strengthen the Programme's management capacity (planning and leadership);
3. Harmonise existing data platforms and strengthen data quality and use;
4. Improve EPI supply chain management and logistics capabilities with a view to integration with CMAM

In 2020, EPI had also planned an ambitious project to modernise and expand its cold chain through the CCEOP, financed by Gavi and supported by its technical and implementation partners. The Programme also planned formative research to inform the communication strategy for the introduction of the new HPV vaccine in 2021. Although delayed, these activities are ongoing.

Despite COVID-19, it was agreed these should remain the objectives for the year, however, their implementation was reviewed and reprioritised, resulting in the focus on activities described in PPR and its corresponding action plan. It should be noted that, in addition to COVID-19, implementation of planned supervisory, training and outreach activities in the first quarter of 2020 was limited due to lack of funds (delays in the availability of remaining 2019 values and in the Gavi funds approval and disbursement process).

Mozambique reacted quickly to the identified reduced demand for and provision of immunisation services, developing in May 2020 and implementing its PPR from March to September. The PPR methodology (data analysis to identify areas requiring immunisation catch-up) remains operational for the medium term and guided the annual planning exercise for 2021.

2021 Annual Plan – Mozambique's medium/long term plan:

Development of the EPI 2021 annual plan involved reflection on the PPR as well as review and prioritisation (in light of emerging needs related to the pandemic) of the upcoming HSS2 grant (to initiate mid 2021), HSS 2020 no-cost extension/transition planning (for quarters 1 and 2 of 2020) and the Programme's other long-term plans, including the Effective Vaccine Management Improvement plan, CCEOP and cMYP. The EPI 2021 annual plan has been developed to respond to perceived immediate needs, established priorities for the period and broader MoH planning in order to contribute to overall efforts to build back better. It is currently being finalised.

As indicated, the methods developed to identify and respond to immunisation coverage gaps detailed in the PPR will be applied to meet emerging needs for intensified action to recover children lost to immunisation. In addition, EPI is taking up the WHO suggestion to consult the NITAG for advice on reviewing its policy for dropouts to potentially include children older than the current target group of 23 months (up to 36 months or even under five years of age). This would involve EPI analysis of potential number of children and required doses (at least for vaccines with most frequent outbreaks).

3.2 Short/medium-term activities to maintain/restore routine immunisation

3.2.1 COVID-19 recovery plan

MoH developed the **National COVID-19 Pandemic Readiness and Recovery Plan** in March 2020. This document supported the MoH and EPI adapt to the new reality and the mobilisation of funds with Mozambique's main health cooperation partners. Based on this plan and its initial budget, Gavi reallocated approximately $3m of HSS funds to support the national response (see Section 2.4).

In June 2020, EPI developed the **Vaccination Readiness and Response Plan in the Context of COVID-19** or **PPR** to safeguard immunisation and reduce the risk of outbreaks of vaccine preventable diseases. The PPR, described in more detail below, responded to emerging WHO guidance on maintaining, suspending and resuming routine immunisation during the pandemic. MoH and EPI were committed to safeguarding public health; services were resumed once health workers had been informed of safe practices and preventative measures, in order to protect them, children and their caregivers.

The PPR strategy developed is considered equitable, efficient and sustainable – ongoing EPI programming will include regularly revisiting key aspects both to respond to the evolving COVID-19 context as well as to rebuild better. The EPI Technical Group (central level) will be responsible for adjusting the plan throughout its implementation, as necessary, to reflect operational changes or depending on the evolution of the pandemic and the performance of the Programme. The PPR represents EPI's short / medium term plan and is expected to influence longer term planning; Appendices 11 and 12 present the PPR work plan and budget.

In September 2020, MoH finalized the **Services Continuity Plan in the context of COVID-19** (Appendix 6), an indication of the highest priority given to ensuring continued provision of PHC and immunisation services. The Services Continuity Plan recognises the COVID-19 response requires integrated and coordinated actions by health facilities and the communities in their direct catchment area. In relation to immunisation, the following are included in the plan:

- Ensuring availability of vaccination services in health facilities
- Implementing the RED/REC strategy, expanding it to Nampula and Sofala provinces
- Ensuring outreach implementation (hard-to-reach places, where dropout rates are high, etc.)
- Strengthening communication and education on the importance of vaccination
- Intensifying surveillance of vaccine-preventable diseases
- Distributing and managing vaccines and vaccination materials
- Maintaining the cold chain

3.2.2 Immunisation services: strategies implemented at service delivery points to re-activate immunisation services and address immunisation gaps resulting from COVID-19

➢ *Are any additional strategies/delivery mechanisms planned (e.g. updated demand strategies, community outreach, PIRIs, new campaigns, etc.)?*

The PPR was developed on the basis of sustaining routine immunisation services delivered through fixed vaccination points (in health facilities) and integrated outreach to communities, adapting these to recover missed children. The PPR offers a guide to immunisation health professionals faced with the challenge of sustaining coverage and reaching zero-dose or under-vaccinated children in the context of COVID-19. The PPR's main strategic focus is the **intensification of integrated outreach** to reach missed children (previously and due to COVID-19), from hard-to-reach / missed communities.

EPI analysis of COVID-19's impact on immunisation (Appendix 2) indicated a 70% reduction in outreach performance at national level and a 34% reduction in healthy child consultations. A significant reduction in the number of children seeking vaccination services across the country was noted, associated with the increase in positive measles cases reported in various districts of the country (see section 2.3). **Using key DHIS2 immunisation data, EPI identified 87 districts** (Appendix 13) **across the country with high immunisation dropouts.** Of these districts, 43 (68%) overlap with the 63 districts prioritised in the PSR. These results were shared with the EPI Technical Group and contributed to development of the rapid evaluation on demand described in this report.

DHIS2 data used to identify & prioritise 87 districts for intensified outreach

- ***low MR2 coverage***
- ***MR vaccine dropout rate***
- ***confirmed measles cases***

EPI distributed a national circular, in May, confirming the resumption of routine immunisation services, including outreach and sharing the 87 prioritised districts with provincial, district and health facilities. This circular also provided details on the organisation of intensified outreach in the context of COVID-19 in order to enact measures to prevent transmission and ensure personal protection and safety, as per WHO guidelines.

Intensified outreach, integrated with nutrition and MCH services, to recover dropouts was carried out in 66 of the 87 PPR priority districts (76%) over two weeks in August 2020; implementation did not take place in Nampula and Maputo provinces because the transfer of funds was negatively impacted by the decentralisation process. EPI is now monitoring these data in order to repeat the strategy should any further downward trend be spotted over the course of the pandemic.

In resuming immunisation services, EPI supplemented these intensified outreach initiatives with routine integrated outreach, supervision (to and within all provinces) and targeted social mobilisation messages. These efforts complement MoH service continuity and communication planning.

Fixed posts

Routine vaccination in fixed vaccination posts remains EPI's primary strategy for coverage and recovery of unvaccinated children. Vaccination activities at health facilities was not interrupted, however, in March and April attendance for vaccination dropped as a result of initial COVID-19 messaging ('Stay at Home'). A concerted effort, including public awareness campaigns on the availability of immunisation (and other) services and the importance of vaccination, helped return attendance to normal in subsequent months.

The PPR also involved development of SOPs in coordination with other primary health services to reinforce infection prevention and control and PPE good practice at health facility level.

Communication and social mobilisation are the basis for the success of any vaccination activity, not just at fixed vaccination posts, but also at community level. Intensified communication has shown positive results in increasing demand and recovering lost or missing children, with vaccination coverage showing an upward trend in fully immunised children of approximately 5% on average per month from May to August.

To inform messaging, EPI conducted a rapid evaluation to identify key drivers of reduced uptake of services (see Section 2.3). Once MoH had authorised the resumption of routine outreach, efforts focused on improving community uptake of PHC and immunisation services. Communication included explaining how to reduce infection risk, educating on the importance of children who missed vaccinations to catch-up and complete scheduled vaccinations, even during the pandemic. A combination of media was used (television talk shows, radio, local leadership, individual or small group talks at health facilities and in the community etc.).

EPI messaging was also included in the MoH COVID-19 Digital Communication Strategy; this included using social media to fact check information on vaccinations and emphasise the importance of fulfilling the vaccine schedule during the pandemic. Digital communications include the *ÂloVida* and *Pensa* interactive platforms where questions submitted by the public are answered as well as the MoH Facebook and WhatsApp services. The MoH Facebook page has had over 30,000 followers over this period.

Communication is equally critical to creating demand in population concentrations during intensive outreach in the 87 PPR prioritised districts, including observation of recommended protective measures (physical distancing, wearing masks, hygiene).

- *If so, how are these measures incorporated into broader PHC considerations and are they in line with WHO guidelines?*

The PPR took into consideration WHO guidelines (including updates) for immunisation in the context of COVID. The measures adopted by EPI are incorporated in guaranteeing the continuity of essential services and health programmes, such as Maternal Child and Adolescent Health, Nutrition, Malaria, HIV, Mental Health, Noncommunicable Diseases, either through preventive or curative actions at community level.

➢ *What plans exist regarding risk communication and community engagement in the response?*

In addition to the communication strategies developed within the scope of the response to COVID-19 by MoH and EPI, the **National Strategy for Community Response to COVID-19** (Appendix 5) was recently approved. Development of this strategy involved multiple sectors of the Government of Mozambique, at its different levels. The following specific actions have been identified for EPI:

- Disseminate the importance of vaccination and the new approach to EPI service delivery at health facilities during COVID-19
- Mobilise mothers and / or caregivers of children under the age of 5 for vaccination and nutrition activities, with a focus on observing the vaccination calendar to prevent outbreaks of diseases with high epidemic potential, such as measles, rubella, polio, diarrhoea and acute respiratory infections
- Guarantee the continuity of active searches and referral of children with incomplete vaccination (dropouts from vaccination services) at community level, obeying all the principles and measures issued by MoH, for the containment of COVID-19
- Offer EPI services in the community, in addition to the fixed vaccination posts, such as mobile services or outreach, ensuring personal protective equipment measures according to MoH rules.

The MoH COVID communication plan is currently being updated; in Appendix 14 we share the version under review.

➢ *What lessons learned and/or innovative approaches to immunisation service delivery that were used to cope with the epidemic are worth broader adoption and scaling-up?*

Lessons learned through the implementation of the PPR that are worth broader adoption and escalation include:

- **Coordination**
    - Early in the national response to COVID-19, EPI coordination suffered as physical distancing requirements led to the suspension of in-person meetings, 15-day rotation of public sector staff between the office and home and the need to facilitate working from home and moving online. However, mobilising around the PPR led to the creation of new working groups with specific and clear terms of reference and timelines. This focused attention and honed virtual practices of partners and EPI teams and resulted in the PPR achieving its objectives to schedule. The success of this initiative included high levels of motivation, clear EPI team leadership and equitable technical support to programmatic areas, ensuring ownership of the plan. The same method was adopted to draft this MSD report.
    - The EPI team, at all levels, quickly adapted to virtual meetings and communication to ensure coordination continued despite challenges with connectivity, technology and costs of airtime. Routines were established and observed, and efficiency increased as a result. This shift online has led to improved coordination even when EPI central management are in the field, which can be of benefit to the programme in the future. However, for this to be effective and equitable for EPI staff, use of a free software e.g.

GoogleMeet should be promoted and investment is required to ensure everyone has access to computers (with audio/visual capability), modems, airtime, headphones etc. Such investment can lead to improved access to e.g. training materials, real time document development etc.

- Review of the EPI organisational structure was accelerated during this period and included updating of the organigram, staff job descriptions and working group terms of reference. Working groups are: Logistics, Service Delivery, M&E, Communication, Finance and Resource Mobilisation.

- **Communication**
  - Use of digital communication platforms (through the National COVID-19 Pandemic Readiness and Recovery Plan) to disseminate messages supporting continued demand for vaccinations through the MoH Facebook page and via WhatsApp. Continued use of such platforms for promoting healthy behaviours, social listening and community engagement to create demand for immunisation services will be pursued with the MoH communication department, DEPROS.
- **Evidence for decision making**
  - Despite its issues, it is possible to use administrative data to inform programmatic decisions. These data made it possible to identify hard-to-reach populations and children who had missed vaccinations previously and due to COVID-19.
  - EPI and partners were able to use operational data to understand the effects of COVID-19 on routine immunisation.
  - Supervision of outreach by central level and partners identified positive aspects that could be adopted by all and gaps to be improved.
  - Some districts were prioritised for immunisation recovery (PPR), however they are not PSR priority districts; there may be a need to revise the criteria for the next interventions.
  - There is a need to develop a separate registration mechanism to record these vaccine doses administered through intensified outreach.
- **Community engagement**
  - Timely provision of the right information on implementation of integrated outreach, including the services to be provided and COVID-19 preventative measures required, to community leaders was critical to creating demand at vaccination sites and ensuring infection prevention and control measures etc.
- **Miscellaneous**
  - It is possible to engage in supervision and provide training virtually.

3.2.3 Equity approach: plans to ensure underserved and missed communities, including zero-dose children, are prioritised within the country's recovery plan

➢ *Does the plan consider any additional cohort of children or any new communities that might have missed immunisation due to COVID-19 and have strategies to address them?*

In the short term, the PPR criteria for identifying hard to reach communities meant district micro-planning and the financing of intensified outreach focused on those most underserved communities

with poor coverage indicators at district level. The 87 priority districts identified through the PPR addressed equity issues by reaching underserved and missed communities (zero dose children) – whether due to COVID-19 or otherwise. It enabled intensive outreach planning to focus on hard-to-reach areas. In addition, populations displaced due to the 2019 cyclones (Idai and Kenneth), insurgency in Cabo Delgado and opposition attacks in central Mozambique, were also reached with immunisation services integrated with other PHC services.

In the medium to long term, district prioritisation criteria may more evolve to align with the criteria used to identify HSS2 priority districts. Once at-risk populations and priority districts have been identified, supportive supervision and technical assistance can focus on improving district EPI management team activity planning and management and allocation of HSS2 capacity building and operational activity funds can be targeted.

Quarterly review of data will monitor dropouts and zero-dose children in order to include them in routine immunisation, whether through intensified outreach to hard-to-reach communities or strengthen communication to connect those living within health facility catchment areas.

As a result of the humanitarian emergency described above (Section 2.7), MoH is developing a response which will include implementing Cabo Delgado's Vaccination in Humanitarian Emergency Plan and a 'Health Week' which will focus on Cabo Delgado, Nampula, Niassa, Sofala and Manica provinces – for which EPI would like to reallocate some HSS funds (2020 budget).

The M&E working group is also updating the district prioritisation exercise which, in addition to reviewing criteria will agree on the need to consider Cabo Delgado as a special case requiring particular, targeted interventions.

- *Does the plan consider disproportionate impacts of the pandemic on women and girls or other vulnerable groups (including migrant, disabled, HIV+, LGBTQI communities) and propose gender responsive/transformative strategies to mitigate them?*

EPI has been and continues to encourage involvement of fathers in immunisation through messaging and prioritising children brought by their fathers for vaccination. The organisation of vaccination service delivery has also been modified to minimise waiting times and crowding as well as allow for physical distancing.

Given domestic violence has experienced an increase in other countries, as part of the national response to COVID-19, the Ministry of the Interior and MoH, in partnership with telecommunications companies, have established functional national helplines available 24/7 as a means for women and girls to safely report gender violence, offering scaled back or remote services where possible[8].

EPI planning does not currently specifically contemplate the disproportionate impacts on women / girls e.g. as a result of economic hardship / costs to reach clinics etc. However, the PPR's intensification of outreach attempts to ensure those children who have missed vaccinations and remote communities are reached, in order to reduce these issues to the extent currently within EPI capacity.

See also section 2.3.1.

[8] https://data.undp.org/gendertracker/?country=mozambique; accessed 1 October 2020

- *Does the plan consider new or strengthened partnerships to reach underserved communities, including CSOs?*

There are currently at least 300 active types of community actors in Mozambique, of which 6,673 are community health workers (APEs); 1,300 first aiders; 79,860 health committee activists; 19,455 members of health facility co-management committees; 7,231 traditional midwives (PTs); and 109,642 traditional medicine practitioners (PMTs). There are also other community agents for health (ACSs), vital statistics, social security, in addition to 1,422 agents from local emergency committees. Mozambique also has 110,432 teachers, 9,500 adult literacy teachers and agricultural extension workers.

Existing community actors have been trained in their respective areas and implement different actions, and their geographical distribution, between rural and urban areas, is not uniform. For example, predominant in rural areas are APEs, traditional midwives, traditional medicine practitioners, literacy teachers and extension workers, whereas in peri-urban and urban areas, first aiders are more common.

The **National Community Response Strategy to COVID-19** (Appendix 5) aims to guide and ensure an effective and coordinated community-based response, formalising informal health support at community level. At the same time, it aims to strengthen collaboration, at all levels, between government sectors, health partners and communities, allowing the community health system in Mozambique to be strengthened and endure beyond the pandemic.

EPI intends to support implementation of this strategy at national level and prioritizes this approach given the limited capacity and geographic scope of CSOs would require an unrealistic level of management and monitoring by EPI. **CSO involvement to strengthen the community component of the vaccination program in order to map underserved populations, locate dropouts and promote vaccination would require partnering (TCA) with a national / international NGO experienced in working with and strengthening CSOs, preferably already working in the health field.** A number of NGOs work directly with CSOs in this way and it may be possible to integrate immunisation into their activities e.g. through Global Fund grant recipients. A mapping exercise will be required to identify and explore possible options.

Support to the strategy may include ensuring APE (community health worker) responsibilities involve community surveillance and tracking of zero dose/under immunised children; integration of EPI community registers and communication tools to ensure the importance of immunisation is understood and children are immunised.

In the medium term, aligned with Gavi strategy 5.0, there are opportunities to discuss and define how defined EPI TCA requirements can be met by national actors at central and subnational level. Through a global initiative, UNICEF is supporting countries to develop a new technical assistance (TA) delivery system to improve the health supply chain with the principal objectives of:

- strengthening local markets to provide required TA, identifying actors (academic institution, training centre, private company, NGOs), organising hubs and supporting contractual relationships
- ensuring skills transfer and capacity development of civil servants working in the health supply chain

EPI in Mozambique recently engaged with this initiative, which aligns with expressed needs in outsourcing of services and capacity building of the supply chain workforce. This process will be jointly

led with CMAM over two years, starting with a key actors workshop in Q4 2020 and a market shaping study, including landscape analysis early 2021. This innovative approach applied to the supply chain could identify local partners that may actively support the supply chain at health facility and community level. in the long term, the initiative could be replicated for different programmatic areas.

- *What are the gaps in immunisation data and information that will limit the ability to identify missed children, track reaching those children, and monitor the effect of recovery strategies/service delivery mechanisms?*

Gaps identified include:

1. **Inaccurate estimates of target population size (denominator)**, with coverage therefore not reflecting missing children. This can be addressed by:
   - Using tailormade district coefficients to improve target population estimates by area. This strategy is in progress in Mozambique and will be scaled up for the medium term.
   - Using absolute numbers of vaccinated children, with increased rates used to update progress towards targets and monitoring goals.
2. **Facility to track children for immunisation is complicated**:
   - Children to not have an ID number to facilitate registration and tracking and duplication of registration due to complicated registers or children attending different health facilities
     EPI with VillageReach has initiated the preliminary stages of an electronic immunisation register (EIR) readiness assessment in October 2020. In the short to medium term this may result in an EIR pilot and in the long term the scale up of an agreed EIR.
   - Reference points in registers are frequently not filled in and/or geographical references are inadequate.

     RED/REC includes community integration in outreach planning and monitoring to optimise its potential.

     In the medium term, UNICEF plans to pilot digitisation of population maps vis-à-vis health facilities to support optimised outreach. The pilot is planned for 2021 to take place in a total of three to four districts in Zambézia and Manica provinces. Should this prove successful, it may be scaled up from 2022.

   - Health worker workload, skills and practices limit proactive identification and tracking of missed children.

     The PPR has shown the relevance of developing skills and practices at subnational level to use administrative data to identify missed children.

Explainer: new district coefficients
Health facilities now use the gross birth rate of their district and not the national average of the gross birth rate.
- Rough realistic targets support vaccinators understand their performance and use data for action.
- Pressure to achieve unrealistic targets relieved, improving accuracy and reducing falsified numerator data.
- Helps improved planning of inputs and vaccines and avoidance of waste or vaccine stockouts
- Helps understanding of local dynamics of target group population and vaccinator as dynamic and not dependent on central level estimations

Through DQIS, EPI has been implementing an integrated strategy to address data quality and data management since 2018; scale up to cover the whole country is included in HSS2.

At national level, geographical scope and financial priority will be defined based on a harmonised model to rank district performance. Criteria will integrate drop-out rate on quarterly basis as was the case in the short-term recovery plan (PPR).

3. **Lack of information on demand** for immunisation to better inform service delivery and focus of demand strategy. HSS2 includes regular demand and user satisfaction assessments and Premise data on demand, providing visibility of indicative (not representative) information and trends is just becoming available to the country. The results of a recently completed JSI multi-country study, which used a human centred design approach to assess opportunities for strengthening service experience to improve immunisation demand will also inform strategy. Considerations include:
    - Build capacity of health staff (health professional training, in-service training, and capacity exchange) in interpersonal communication and use of data for decision-making skills; as well as adaptive management skills for health managers
    - Implement capacity exchange program where health professionals with a certain set of skills and experience shift from one health facility to another for a period of time for capacity transfer to other colleagues
    - Conduct implementation research on health worker service experience so as to better understand and motivate health professionals to ensure retention of staff in the system
    - Support the functioning of health and co-management committees so they can be better leveraged to ensure community participation in the planning of health programs as well as the monitoring and accountability of health providers
    - Develop job aid on Key Principles to Strengthen Immunization Service Delivery Experience for health workers that can be used at the district and health facility levels to reinforce client confidence in the health system and promote health seeking behaviours.
4. **Lack of information on vaccine consumption at all levels** to strengthen supply management and reduce stockouts; this is particularly important due to internal population displacements. SELV does not currently provide this information. SELV will be integrated with CMAM's SIGLUS tool, a last mile logistics management information system (LMIS) introduced in 2018 being scaled-up to national level over the next two years. In the medium to long term, live aggregated stock management data and the EIR will support improved supply chain efficiency and data triangulation, facilitating monitoring and reporting. EIR will also be capable of tracking zero dose children.

➢ *Does the recovery plan include activities to improve known gaps in immunisation data?*

- The intention is to repeat the PPR exercise to **prioritise districts with high dropouts on a quarterly basis.** The continued monitoring of programme performance trends opens space to redefine activities and strategies to fill known as well as emerging gaps. This intervention demonstrates the effort made to resolve gaps in immunisation data and contributed in August to an average coverage of 49% for MR2 (8,757 children vaccinated) and an MR1-MR2 dropout rate of 18% in target districts.

- **Regularly repeat rapid demand assessments**, as implemented by EPI in the PPR, to identify the real reasons for reduced uptake of vaccination services to inform the design of recovery strategies based on evidence.
- **Distribute vaccines and related materials to health facilities is based on consumption levels** not only on the target group estimates e.g. a health facility with a low target group yet high coverage is provided vaccines aligned with monthly consumption.
- **Digitisation using GIS to estimate populations** using geo-spatial techniques and digital mapping of health areas is included going forward.

3.2.4 Gavi immunisation financing:

This section describes the Gavi-funded programme for which data is readily accessible. Disbursement of the first tranche of HSS 2020 funds ($3.4m) and reprogramming of the non-HSS grant balance, means most EPI routine activities have been secured until Q3 2020. HSS 2020 funds were also used for outreach intensification (PPR) as funds for outreach activities had not been fully used in the first semester of 2020. HSS funds reallocated to support the national COVID-19 response allowed additional immunisation communication activities and funded PPE procurement (see 2.4).

Local procurement processes for non-cold chain items have been launched, however delays in UGEA may impact payment. EPI, the Financial Advisor and MA are actively working to control and accelerate these processes, with an estimated $112,285 due to be paid by the Department of Administration and Finance (DAF) at central level between Q4 2020 and Q1 2021. There will be a need for Gavi to disburse the remaining 2020 value to ensure payment of procurement processes currently in UGEA and the transfer of funds to UNICEF, as requested.

Identified medium/long term funding gaps include:

- **Operational funds for non-priority provinces and districts**. Gavi has stated HSS2 funds can only be used to support operational activities in priority areas – EPI was not prepared for this major change from the current HSS grant guidelines which has significant impact on the programme given the scarcity of health resources, its status as a Gavi Phase 1 country and the economic crisis now exacerbated by the global COVID-19 pandemic, which also threatens expected income from oil and other natural resources. Development of the EPI advocacy and resource mobilisation strategy has been included in this document for TCA, however its development is currently planned for 2022 under the HSS2 grant.
  EPI calls for Gavi to review this situation and ensure support for routine immunisation operational costs given the limitations of the State budget and to ensure hard won gains, thanks to Gavi financing, to strengthen the health system and immunisation across the country are not lost. To avoid a critical situation, EPI proposes a more progressive redirection of Gavi funds over the next five years, together with support to development and implementation of the proposed advocacy and resource mobilisation strategy.
  EPI recently requested Gavi authorisation to direct re-imbursement of VAT ($788k; as per Gavi Audit findings) to partially fund core EPI activities, including operational costs, for the first semester of 2021, with the expectation the second tranche of HSS 2020 funds will complete requirements for funding of core activities across the country.
- **Demand generation and planning for HPV vaccine introduction in 2021**: these activities will be at least partly funding from unspent cash grants reallocated in 2020. Financial gap will only

be identified in 2021 following completion of the HPV demand strategy and budget. The HPV vaccine introduction will now only target the single age cohort (9-year-old girls) as international stock levels are insufficient to meet multi-age cohort requirements. As a result, only the vaccine introduction grant (VIG-HPV) is available, and no funds can be used from the operational costs grant (OP COSTS HPV) associated with the multi-age cohort. Hence the allocation of unspent cash grants to support demand activities. *Gavi advises it is possible to reallocate VIG-HPV and any such request should be submitted in Q1 2021.*

- **Co-financing**: to date, the country has disbursed in full all its 2020 co-financing obligations.
- **COVAX vaccine procurement, cold chain and logistics extension, demand creation and AEFI surveillance:** Mozambique's National Development Deployment and Vaccination Plan is expected by early 2021, will clearly identify funding gaps. Financial concerns include creating demand and acceptability for the COVID-19 vaccine among a new target group, strengthening the AEFI surveillance system and adapting the cold chain and logistics to accommodate the new vaccine and delivery mechanisms. Please see section 3.4.4 below for more details on COVAX

3.3 What support is required from Gavi for the planned short/medium-term response efforts?

3.3.1 Key technical assistance needs to be funded through PEF TCA

EPI pre-identified TCA requirements during the PSR development in 2019; these requirements were reviewed early 2020 to advance some TCA ahead of HSS2, and again during the MSD in consideration of the impact of COVID-19 on the Programme. These reflections will inform discussion and development of the One TA Plan, the final version of which is to be submitted to Gavi by 10 February 2021. **The content of this section is therefore indicative and will be further reviewed during development of the One TA Plan 2021**.

New vaccine introduction

1. **Covax**: technical support to ensure country planning and readiness for introduction of the COVID-19 vaccine e.g. to create demand and acceptability for the vaccine, strengthen the AEFI surveillance system, adapt the cold chain and logistics and develop new delivery mechanisms.
2. **HPV**: introduction planning and implementation requires support e.g. product confirmation and ordering, develop implementation plan, implement communication strategy, develop communication tools (as needed), crisis response planning, training planning, assess cold chain capacity and vaccine distribution process, stakeholder engagement planning etc.
3. **MR and IPV2**: technical support to prepare and complete applications, develop and manage implementation plans and a post-campaign coverage survey.

Finance:

1. Development of an EPI advocacy and resource mobilisation strategy, as planned in HSS2.

Service delivery:

1. Technical support to address the Penta 1-MCV1 dropout rate.
2. Expand the RED/REC approach to HSS2 priority districts in Niassa, Cabo Delgado and Maputo provinces (PSR), requiring TCA for initial training and supportive supervision (medium/long

term). The PSR prioritised a total of 19 districts outside the priority provinces: Cabo Delgado (7), Niassa (6), Inhambane (1), Gaza (1), Maputo Province (2) and Maputo City (2).

3. Strengthen **routine** liaison with community actors to locate underserved populations and children at risk of vaccination through the National Strategy for Community Response to COVID-19:
    a) Provinces with RED/REC through community focal points, using existing tools
    b) Provinces without RED/REC:
        i. Create instruments (possibly from RED/REC)
        ii. Map APEs and identify capacity building needs
        iii. Identify other community actors: community or religious leaders, mentoring mothers, etc.
4. Digitisation and use of GIS population tracking to optimise service delivery planning, identify missed communities and support improved population estimates in health facility catchment areas. The pilot is planned to initiate in 3-4 districts of Manica and Zambézia provinces in 2021.

Supply chain & logistics

1. Continued support to improve vaccine management and visibility, is critical to EPI and was a gap at subnational level for the PPR. Existing TCA to rollout of SELV (e-LMIS) V3 will rapidly improve capacity.
2. Continued support to private sector management of the last mile supply chain has been included in HSS2.
3. Development of a new TA system delivery focussed on reshaping the supply chain TA delivery model.
4. Continued support to strengthen cold chain and logistics management within the EPI supply team at central level.
5. Development and implementation of a plan to transition supply chain and logistics responsibilities from EPI to CMAM (integration plan)
6. Review and updating of cold chain and vaccine management SOPs, aligned with integration plan
7. Development and implementation of a supply chain capacity building plan for central level (EPI/CMAM), focused on logistics leadership and planning, and contract management.
8. Development and implementation of a supply chain capacity building plan for intermediate level (warehouse and distribution management) focused on vaccine / medical supplies and cold chain management and adapted to high human resource turnover and the existing LMIS.
9. Development and implementation of a supply chain capacity building plan for operational level (comprehensive medical supply management at health facility level), adapted to high human resource turnover and the existing LMIS.
10. Support the integration of a single LMIS for the vaccines and medicines supply chain.
11. Development of effective maintenance and repair systems for facility-level cold chain equipment and strengthening of cold chain technician capacity to monitor maintenance system performance.
12. ICT skills transfer for CMAM and EPI personnel to identify secure, low cost hosting and management for the LMIS database.
13. Development of vaccine waste management strategy

Data

1. Support to developing an information system (integrated with existing information systems) to capture data from intensified routine immunisation activities.
2. Support to piloting of EIR, as per readiness assessment results

Training

1. Development of training materials and other tools, as recommended in the (still to be developed) EPI capacity building strategy, to support new approaches to learning for health workers, particularly those in more remote locations.

Community involvement:

1. Support to planning and contributing to materials development for rollout of the National Community Response Strategy to COVID-19 (Appendix 5). This strategy will help mobilise support from local partners e.g. health committees ensuring greater involvement of communities in planning and supporting equitable restoration and sustainability of immunisation services.
2. Partnering with large NGOs building capability of CSOs in order to include activities in support of increased immunisation uptake in underserved communities.

Gender and socio-economic barriers to immunisation:

MoH and EPI are conscious of the importance of framing activities through the lens of gender and wealth. These barriers are understood to exist, however, their impact on access to immunisation has not been assessed. In addition, the impact of COVID-19 on gender-related barriers is unknown. Consequently, developing and implementing approaches to addressing these issues have not been developed.

The PSR situation analysis identified the following in relation to estimates from the WHO Health Equity Assessment Toolkit (figure at end of discussion on trends):

- **Trends in vaccination coverage by wealth status**
  - In 2003, coverage among the poorest for BCG was below 60% and among the richest above 95%. By 2011 all groups had coverage above 80%, with the highest increase seen amongst the poor. Immunisation coverage increases the higher the wealth quintile. In 2003 only 45% of children aged 12-23 months in the lowest quintile received all vaccinations at the time of the survey compared to 53% in 2015. In 2015, a significant improvement between wealth quintiles was noted, however coverage in the upper three quintiles (86%-95%) remained higher compared to the lowest two (72%). The discrepancy between FIC in the richest and poorest quintiles is gradually reducing, from 50% in the poorest quintile to 80% in the richest (2011) to 53% and 85% respectively in 2015. The highest quintile has seen a reduction between 2003 and 2015, particularly for DPT3, polio and FIC.
- **Trends in vaccination coverage by education:**
  - All surveys have shown immunisation coverage increases the higher the education level of the mother/caregiver. Between 2003 and 2015 immunisation coverage improved among those with no education, with DPT3 coverage between women with least education and those with the highest schooling ranging from 59% to 98.6% in 2003 and 73.1% to 92.6% in 2015. FIC increased from 53.2% in 2003 to 57% in 2015. Comparing 2011 and 2015, there were improvements at primary level (77% to 83%) and secondary level (86% to 93%), but little change among those with no education (72% to 73%).
- **Trends in vaccination coverage by gender:**
  - The UNDP Gender Development Index measures gender equality of countries by looking at gender gaps in human development achievements, accounting for disparities between women and men in health, knowledge and living standards. In 2017, Mozambique was ranked 124 of

164 countries – potentially impacting the immunisation programme. The CEA 2019 explored gender barriers to immunisation – detailed in Section 3.4, priority issue 5. Difference in immunisation coverage by gender is shown by the FIC coverage of 68.1% in boys versus 63.5% in girls in 2015 (IMASIDA, 2015).

- **Trends in vaccination coverage by urban/rural residence:**
  - Although differences in access to vaccination services depending on urban/rural residence have been reducing, those living in urban areas have greater access. In 2015, coverage was just under 90% in urban areas compared to nearly 79% in rural areas. EPI is concerned to conduct a study to assess challenges in access faced by the urban poor with a view to addressing these and comparing them with challenges faced by rural communities. In 2003, 56% of children aged 12-23 months in the rural areas received all vaccinations at the time of the survey compared to 62% in 2015, for urban areas the difference was 80% in 2003 and 78% in 2015.

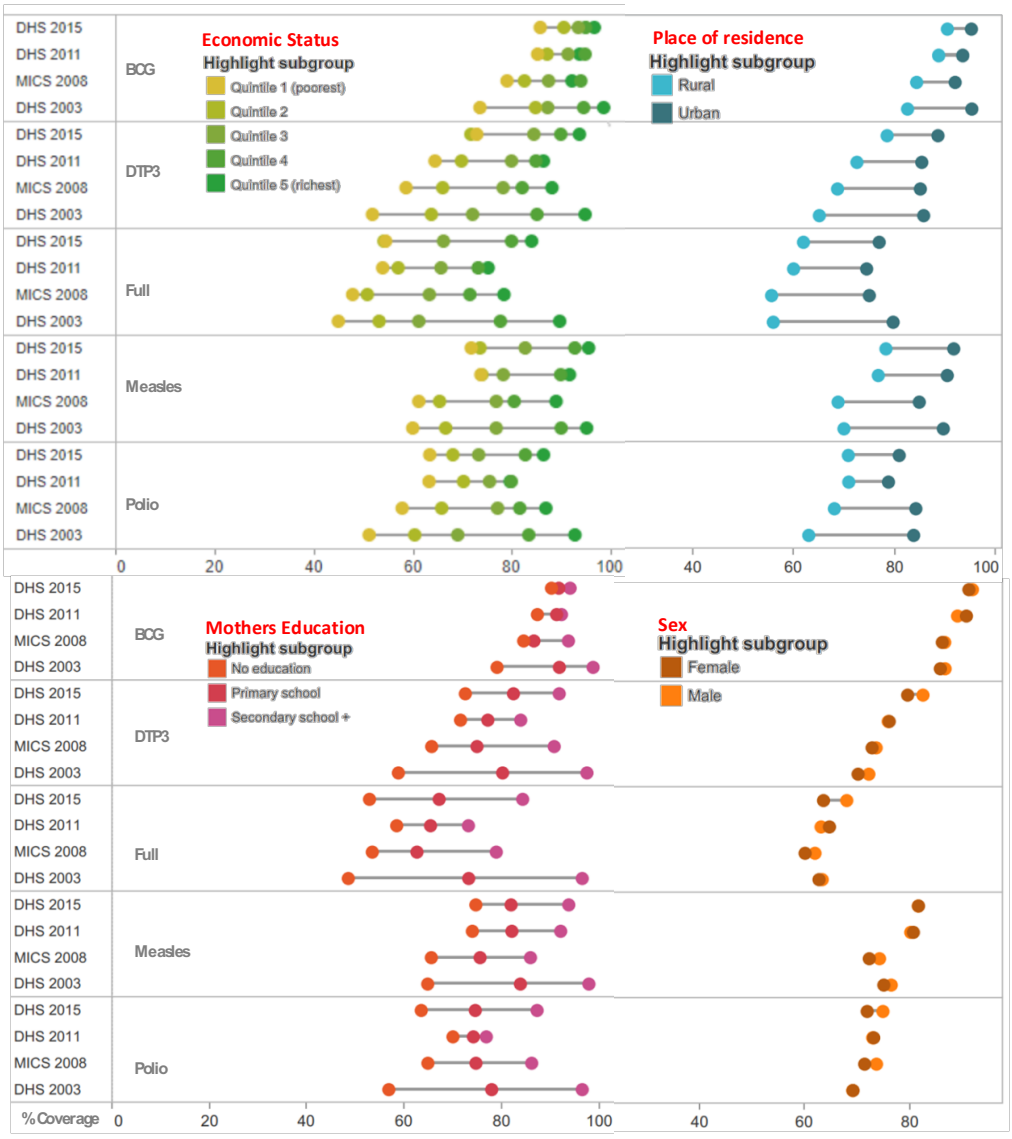


Figure 3: Estimates for wealth status, education, gender and place of residence

3.3.2 Anticipated additional HSS flexibilities or support required

Flexibility related to the external audit by the Administrative Court and disbursement of the remaining funds for the 2020 plan.

Regarding the Administrative Court:

- Due to the pandemic, the Administrative Court suspended the 2019 external audit, which is one of the requirements for the next year's disbursement. In view of this, Gavi has agreed to EPI's request for an exemption from the need to submit the report of the Administrative Court as a condition for approval and disbursement of the **2021 annual plan and the HSS2 Year 1 plan later this year**. Further:
  - MoH and Gavi agree to perform the 2019 HSS and 2020 HSS audits together in Q1-Q2 2021, with both reports to be delivered by 30 June 2021. **An official request to this end has been sent by DAF to the Administrative Court for approval**.
  - The Administrative Court recently informed MoH the audit will be performed remotely.
  - Gavi has agreed to an exemption from the need to submit the report of the Administrative Court as a condition for disbursement this year.
  - EPI will obtain a letter from the Administrative Court stating when the respective 2019 and 2020 reports will be submitted to Gavi, as this is a disbursement requirement.

Regarding disbursement of the remaining HSS funds (2020 budget):

- No-cost extension for completion of HSS to Q2 2021.
- Streamlining disbursement of the remaining 2020 funds pending compliance with Gavi requirements (*budget execution, post-audit payment plan, financial and audit reporting*).
  - As mentioned in Section 1.4 Financial Absorption, it is likely *budget execution* reported in the quarterly financial report will not meet Gavi execution requirements by end 2020 as engaged expenditures (pending processes in UGEA) are not reflected. If taken into consideration, total engaged expenditures will take EPI above Gavi's execution requirement. EPI requests Gavi take these committed values into account to allow disbursement of the second tranche of HSS 2020 funds and honouring of procurement processes.
  - EPI is advocating at the highest level of MoH to guarantee timely reimbursement of the *post-audit payment plan*, recognising this would be a condition for disbursement.
  - EPI will deliver *financial reports* on time.
  - *Audit reporting*, as agreed in the point above on the Administrative Court, should be waived in this instance.
- Support in the processing of cases at UGEA / Administrative Court and processes in the Planning and Cooperation / Finance Department
  - The workload of the Financial and HSS Advisors and MA does not allow for proper procurement process follow-up and UGEA strengthening. For this reason, EPI requests additional HR to work as the EPI focal point in UGEA – similar to the arrangement within DAF.
- Exceptional authorisation for the balance of 2020 HSS funds to be allocated to meet operational costs outside of the HSS2 priority districts and authorised reallocation to cover core EPI activities during the transition between HSS1 and HSS2 (Q1 and Q2 2021) grants.

- Guidance is requested regarding the HSS 2 Y1 plan and budget fiscal year as HSS2 is now planned to initiate in July 2021. EPI requests alignment with the country's fiscal year i.e. to end Year 1 by December 2021.
- Gavi's support in expediting any forthcoming request for reallocations of funds or inclusion of a new activity that may be considered a priority for EPI performance given the evolution of the pandemic, using savings from cancelled activities or those that were restricted under COVID-19.

3.3.3 Adjustments to planned new vaccine introductions or campaigns in light of the current situation?

HPV:

- The HPV vaccine introduction is planned for October 2021. It is not yet known whether the introduction of a COVID-19 vaccine may impact on this date.
- Gavi will disburse the VIG for a single cohort (i.e. $2.40/girl or a total of US 1,082,311) six to nine months prior to the planned introduction. The operational costs grant (i.e. $0.65/girl) will be disbursed at the time of multi-age cohort immunisation, with no visibility on when this might happen because of global supply issues.
- As a result, EPI has funds (VIG) for vaccine distribution, vaccination card. Production, supervision, HR costs and quarterly monitoring meetings at all levels.
- The lack of earmarked funding for planning and demand generation activities will influence the country's ability to introduce HPV vaccine as currently planned. We have requested above some flexibility in relation to the use of allocated HPV funding and TCA to support focused HPV introduction planning (particularly in a context where a COVID-19 vaccine is also likely to be introduced). This planning, plus the HPV communication strategy may identify options for such reallocation of Gavi HPV funds and/or support additional resource mobilisation as required.

Measles: In relation to the measles outbreaks in Nampula, there was a need to conduct a blocking vaccination campaign. Due to the COVID-19 situation, the blocking campaign was carried out using a door-to-door vaccination strategy and was funded by UNICEF, USAID/FHI360 and Transform Nutrition (Appendix 19).

Cholera: As part of the control of cholera outbreaks in Cabo Delgado province, a cholera vaccination campaign was carried out from 21 to 25 September 2020, where a mixed vaccination strategy was used (Appendix 18).

3.3.4 Future applications for new vaccine support & product/presentation switch in the next 6-24 months

The country plans to apply for new vaccine support in order to introduce the second dose of IPV and transition from TT to TD:

- **Introduction of IPV2** - the IPV2 introduction plan was postponed to 2022 due to constraints related to COVID-19 and taking into account that in 2021 the introduction of HPV is already planned, in addition to being the start of HSS2. It is recognised EPI will need submit an application to Gavi in 2021.

- **Transition from TT to Td** - the transition plan was developed, however its implementation was postponed due to COVID-19.
- **MR Follow-up Campaign:** Mozambique is forecasted to conduct MR follow-up in 2022 and plans to submit an application in early 2021. Section 2.2 provides clear motives for a campaign, as do exacerbated immunity gaps caused by COVID routine immunisation interruptions.
- **Development and implementation of a national cholera control plan:** Mozambique has experienced persistent cholera outbreaks in recent years which have required OCV campaigns. Country stakeholders are developing a multisectoral national cholera control plan which includes planned, preventive OCV campaigns in high-risk areas (supported by Gavi) to reduce risk of future outbreaks. WHO/GTFCC support is available to help develop and operationalize these plans.

3.3.5 Innovation initiatives of interest

The innovation catalogue has been read with interest and the country is interested in the following initiatives:

Communication: Need: Engagement with communities in order to re-establish immunization services (including management of misunderstandings and rumours about vaccination)

- **Interaction via WhatsApp between parents and health technicians**
  - About the solution: tool that allows engagement between EPI health technicians, parents and health technicians in general
  - The tool can be used to provide accurate information on any subject related to vaccination
  - Monitor outbreaks and disease surveillance by health technicians
  - Store feedback from parents / caregivers to improve the quality of service.
    - Provider: Praekelt (Village Reach)
      - Challenge: Need for additional effort in areas with limited telephone network access.
- **Data collection and information sharing tool**
  - *About the solution: This is software that is linked to SMS that can be used as a community engagement tool with surveys / research, information sharing.*
  - The software can be used to create automatic chats that answer questions using standard information
  - The information collected from the surveys is presented on dashboards to assist in the decision-making process.
    - Provider: U-Report.
      - Solution challenge: Information can be limited depending on the breadth of issues. (p69-71).

Country note: this should be interoperable with the MoH community DHIS2 platform which houses information on community actors and would allow other programmes to benefit from information gathered.

It should be noted the following innovations have already been designed by the country for HSS2:

- **Demand:**
  - Social listening to analyse public sentiment and share targeted information, as part of support to development of MoH's digital communication strategy; this involves financing a position to perform this function. *The technical assistance described in Gavi's catalogue indicates Facebook provide free access to its advanced insights tools and capacity building, which would be advantageous.*
  - Sending SMS to mothers / fathers as a reminder to return to the health facility to receive their child's next vaccination.
  - Sending mass messages to the general public about the vaccination schedule in summary form (e.g.: Did you know that newborn children at 9 months of age should be vaccinated against measles ...)
  - Creation of a brand / logo that attracts everyone's attention, such as vaccinate to reap health, or ... in many instruments such as notebooks, diary covers, ATM's, water bottles, etc ... (if possible, at bank branches as they are locations where many people crowd, at least in district headquarters)
  - Create partnerships with other institutions to raise awareness and disseminate vaccination services and their importance.
- **Service delivery:**
  - Following completion of a feasibility assessment, the country hopes to develop, pilot and eventually scale up, an electronic immunisation register (EIR) for routine services, outreach, campaigns, and train health personnel in its use.
  - Through digitisation of the RED/REC strategy, the country aims to use GIS to provide realistic population estimates in order to define accurate targets, as well as to digitally map health areas.
  - In 2020, VillageReach has been conducting a wastage study; conclusions and recommendations are not known at the time of writing.
- **Finance:**
  - Design of a tool to verify compliance with payment processes according to the financial management procedure based on SISTAFE, which will serve as a kind of pre-audit to mitigate the problems later verified through audits.
  - Expansion of the funds management tool from the instruction on the processes to the payment that allows expenses to be viewed by activity line and respective balances, which avoids deviation of application and use of funds above what was foreseen in the plan for each activity.

3.4 Roadmap for further medium/long-term planning

Briefly outline your roadmap for developing a more detailed medium/long-term recovery plan to restore immunisation services and address any immunity gaps created by the COVID-19 pandemic.

3.4.1 Need for an assessment of the COVID-19 pandemic impact on immunisation services to facilitate the development of a longer-term response plan

An assessment on the effects of COVID-19 was performed (Appendix 2), providing visibility of the availability of vaccination services. The assessment was used by EPI to define strategies to mitigate the

challenges COVID-19 brought to immunisation and informed PPR strategy development. However, a more detailed and comprehensive assessment of the impact of COVID-19 on immunisation services is required. It may be possible to use data from other sources e.g. the National Health Observatory, rather than starting from scratch.

A more robust assessment would allow inquiry into factors affecting immunisation services uptake generally, as well as in relation to the continually evolving COVID-19 context in the country and could inform eventual introduction of the COVID-19 vaccine. Investigation could consider issues such as accessibility of services, mapping vaccination posts etc.

This assessment could inform longer term planning, supported by information from rapid assessments to identify missed communities, under-immunised and zero-dose children in the country and social listening/rumour tracking activities initiated as part of the MoH response to COVID-19. These latter are particularly important given the foreseeable complexities of introducing HPV and COVID-19 vaccines.

3.4.2 Envisioned planning process, including efforts to engage communities in the development of the plans, to join broader health sector planning exercises, and to ensure harmonisation of support with all relevant bi-lateral and multi-lateral development partners

EPI is keen to rationalise its planning activities given the tremendous pressure the management teams have worked under this year. The annual planning exercise (for 2021) is nearing completion and it was informed by EPI's PSR, PPR and HPV introduction plans as well as the previously mentioned plans developed by MoH in response to COVID-19. There is the possibility planning for the introduction of a COVID-19 vaccine may be required as early as quarter one of 2021.

Faced with this uncertainty, EPI intends to retain the 2021 annual plan and to institute a cycle of reviewing and updating its plans every six months – or more regularly if the emerging situation so requires. In this way, recovery of children lost to immunisation will become routine.

Reviews will focus on reducing pre-existing and new (COVID-19-related) iniquities caused by access to services and will be informed by:

1. Regular monitoring of operational indicators and administrative data on routine immunisation to assess performance and ensure responsiveness to contextual changes
2. Evaluation of the effectiveness of intensive outreach – with a view to improvement and replication as a regular EPI strategy to address inequities, locate missed communities and zero-dose children.
3. Mapping – to be developed – of hard-to-reach and missed communities
4. Rapid demand assessments – to be developed – in communities prioritised through point 1 and identified in 3, to understand why they are being missed and inform strategies to increase uptake of routine immunisation.
5. Data from social listening and rumour tracking – currently performed as part of the MoH COVID-19 response but also included in HSS2.
6. Reports on stock levels – this will be facilitated as SELV V3 is phased in.
7. Progress in rollout of the National community engagement strategy.

8. Coverage surveys – EPI is about to initiate district-level surveys in 14 districts in seven provinces – with the aspiration to regularly repeat these. In addition, a DHS is planned for 2021.
9. Future results of the human-centred design study currently being conducted by JSI.
10. Future results of the vaccine wastage study which will be conducted by VillageReach.
11. Other relevant information sourced from other health programmes or partners.

This information will be used to review and target routine service delivery as well as adapt communication as required. HSS2 plans include initiation of **human centred design (HCD) approaches**, which are included in the EPI Communication Strategy. EPI is planning a discussion in the Technical Group around use and appropriate level for using HCD in immunisation, drawing on the knowledge and experience of partners e.g., UNICEF, JSI and Path. JSI has been performing an HCD study to understanding data specific pain-points and challenges faced by health workers and managers at all levels in delivering immunization services in Mozambique (sites Maputo, Zambézia, Nampula); results from this study will inform the discussion.

The National Community Involvement Strategy and lessons learned from the implementation of (PPR) intensified outreach mean renewed focus on how best to involve community structures e.g. health structures, APEs, local leaders etc. in improving uptake of outreach. It will be important to define their involvement and how to engage with them in order to secure their support to promote immunisation services (including for future HIV and/or COVID-19 vaccines) before and after the pandemic, to identify under-immunised / zero-dose children in the community and on ensuring infection prevention and control measures are in place.

By early 2021, EPI expects to have a **capacity building strategy** that will guide its training activities away from more traditional class-based sessions to a range of different approaches, including use of digital technology.

In addition, multiple communities in Mozambique are displaced or affected by insurgency in Cabo Delgado, violence in Manica/Sofala and (still) the impacts of cyclones Idai and Kenneth in 2019. This situation is continuously changing and may involve implementation of PHC campaigns, including immunisation with multiple antigens (as a minimum) those required to prevent disease outbreaks.

It should be noted, immunisation services are integrated in health facilities and for outreach with the nutrition (administration of vitamin A, deworming, and screening for malnutrition) and MCH programmes through the 'Healthy Child Consultations' approach.

3.4.3 Development of a holistic, harmonised technical assistance plan

The country has recently completed its annual planning exercise. This exercise, the development of the PPR in late 2019, community strategy/continuity of services strategy, introduction of HPV and the PSR have informed this planning. The planning was an opportunity to identify EPI's TCA requirements, however, development of the OneTA Plan has yet to initiate. Its development will indicate to us if there are current partners with the required expertise to meet all our TCA needs. TCA requirements identified to date are detailed in Section 3.2.

Each iteration of the OneTA Plan has improved in terms of its responsiveness to EPI requirements and more clear definition of the expectations in relation to deliverables and skills transfer from each partner.

3.4.4 Planning initiated for a potential introduction of a COVID-19 vaccine

At country level, discussions have already started, including development of guidance documents to prepare the country for the probable introduction of a vaccine against COVID-19. This discussion is led jointly by the Technical-Scientific Commission coordinating the response to COVID-19 and the National Directorate of Public Health.

A COVAX Task Force has been established based on existing EPI Technical Group, expanded to include non-traditional EPI partners e.g. World Bank, FCDO, Friends in Global Health, in addition to traditional partners. The Task Force is involved in preparation of COVAX readiness assessments, the vaccine and TCA request forms and other related activities. The involvement of these partners is expected to extend from COVAX planning to support to implementation – for which period planning and discussions are ongoing. The Task Force acts as a platform to bring together all interested parties and ensure a good coordinating mechanism throughout the process, from preparation to implementation of COVAX.

EPI's Technical Group completed the WHO/UNICEF VIRAT country readiness assessment. From December, the integrated WHO/UNICEF/World Bank tool will be used. For COVID-19 discussions, the Technical Group will be enlarged to include new partners interested in contributing to introduction of a COVID-19 vaccine in the country. Existing technical subgroups will be used to share workload and organise the New Vaccine Development Plan.

Appendices – Numbers 1-14 provided separately

Appendix 15 – In-country dialogue process

Processo de Diálogo entre Múltiplos Interessados (DMI)

Assunto: Processo da Gavi de Diálogo entre Múltiplos Interessados para 2020 à luz do COVID-19
Data: 14 de Setembro de 2020
Versão: Versão Final

4 Visão geral do modelo do DMI

O modelo tem três secções:

Secção 1: Situação no País (2019)	Secção 2: Impacto do COVID-19 (2020)	Secção 3: Prioridades e Planificação
•Visão geral do desempenho do apoio às vacinas, implementação da subvenção HSS, PEF-TCA e outros apoios da Gavi, até finais de 2019/início de 2020; pré-COVID-19 incluindo	•Actualização sobre o impacto COVID-19 na prestação dos serviços e cobertura da imunização (em 2020) e estado da implementação do plano de recuperação da COVID-19	•Planos para reforçar / reestabelecer actividades de imunização de rotina, recuperar as crianças perdidas e potencialmente reactivar algumas das novas introduções e/ou campanhas planeadas, no contexto dos planos de resposta / recuperação de epidemias do país

A maior parte da informação contida nas secções 1 e 2 é pré-preenchida por Gavi a partir de documentos existentes e completada / revista pelo país. Na secção 3, o país deve:

- Definir actividades de curto/médio prazo para manter/restaurar a imunização de rotina e recuperar a cobertura, conforme necessário. Para estas, será necessário um plano de trabalho e orçamento (a base é o PPR do país).
- Definir um roteiro para a redistribuição/planificação de actividades não capturadas aqui, considerando o plano de recuperação do país a médio/longo prazo, os recursos internos e os disponíveis de outros parceiros de desenvolvimento, as lições aprendidas e abordagens inovadoras utilizadas para lidar com a epidemia, e sinergias com todos os intervenientes relevantes, incluindo as OSC, com a visão de "reconstruir melhor". O foco está nas prioridades do país.

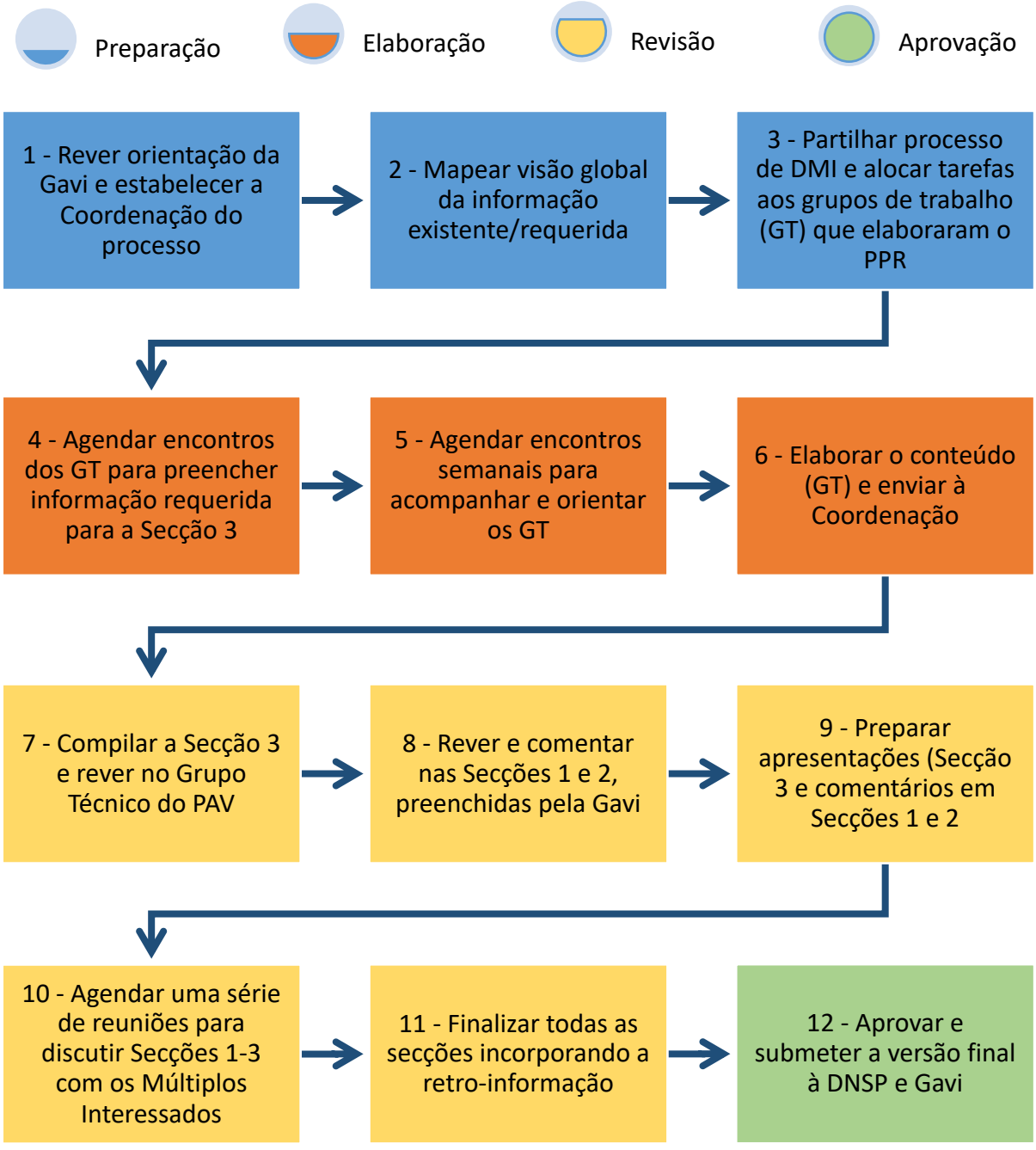
5 Destaques da apresentação da Gavi sobre o DMI

- Ênfase na garantia de um forte envolvimento das OSC para ajudar a reconstruir a confiança da comunidade e identificar lacunas e soluções
- Identificação das principais necessidades de assistência técnica
- Nenhuma modalidade prescrita para a forma como o DMI 2020 é conduzido a nível nacional
- Basear-se no PPR: como lidar com as perturbações que não estão cobertas pelas subvenções existentes, existem necessidades adicionais de médio / longo prazo?
- Coordenar com outros programas e doadores: o médio / longo prazo deve fazer parte de um "plano de recuperação/continuidade de CSP" mais amplo.

- Discutir os requisitos de financiamento: utilização do orçamento de HSS 2020 (realocação) ou saldos existentes de subvenções não-HSS no país?

6 Visão geral do processo

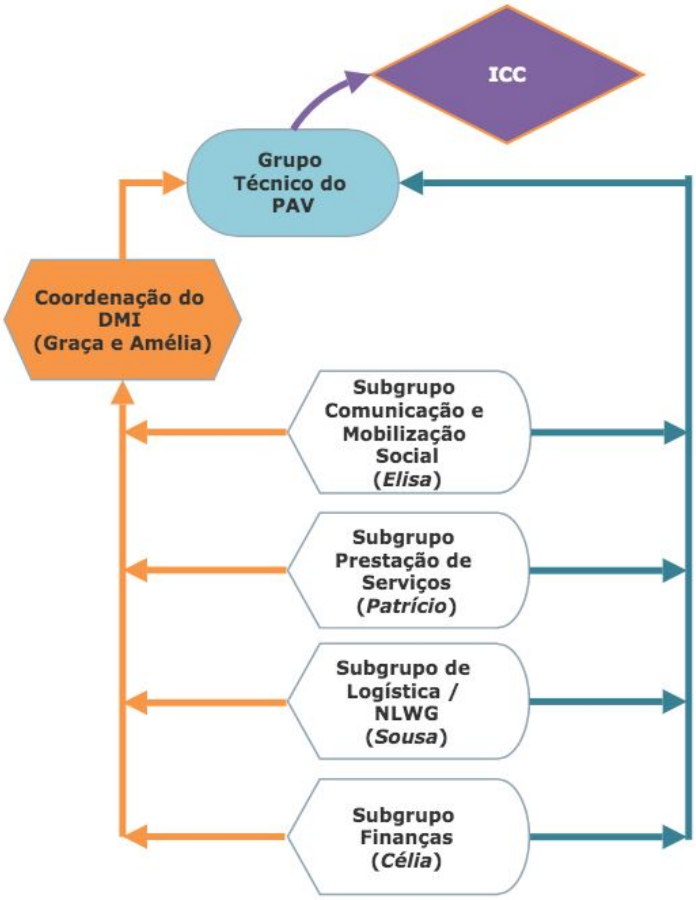
O processo envolve quatro fases: preparação, elaboração, revisão e aprovação. O enfoque é na elaboração da Secção 3. Nota-se que o processo não é linear, particularmente na fase de revisão.



O Grupo Técnico vai rever o conteúdo da Secção 3 antes da sua apresentação nas reuniões com os múltiplos interessados fora do país. É previsto organizar pelo menos três chamadas com os interessados para rever c ada secção na medida que esteja pronta para revisão.

7 Visão geral de preparações e contribuições

Mantemos a estrutura criada para elaborar o PPR:



- Um grupo restrito tem responsabilidade para coordenar o DMI
- Os subgrupos criados para elaborar o PPR mantêm-se, podendo alargar a sua participação, sob responsabilidade dos mesmos chefes de grupo
- Sistema de encontros semanais de 1-2 horas para apresentação de conteúdo
- Os parceiros no âmbito de TCA – devem preencher a tabela (Ponto 5 abaixo) e enviar à Coordenação
- Apoio a coordenação e compilação do documento e tradução de quaisquer secções do PPR – Kate

Observações:

- Haverá necessidade de rever o documento da PSR para identificar actividades que possam ser adiantadas
- Investigar oportunidades de criar sinergias com CSP e outros programas por exemplo na área de comunicação, criação de demanda, formação etc.

8 Agosto – Novembro 2020 Calendário

Não existe prazo específico, portanto, o PAV gostaria de completar o MDI dentro do mês de setembro. As actividades de preparação (fase 1) já foram completadas e as de elaboração (fase 2) estão em curso.

SETEMBRO							OUTUBRO							NOVEMBRO						
2ª	3ª	4ª	5ª	6ª	S	D	2ª	3ª	4ª	5ª	6ª	S	D	2ª	3ª	4ª	5ª	6ª	S	D
	1	2	3	4	5	6				1	2	3	4							1
7	8	9	10	11	12	13	5	6	7	8	9	10	11	2	3	4	5	6	7	8
14	15	16	17	18	19	20	12	13	14	15	16	17	18	9	10	11	12	13	14	15
21	22	23	24	25	26	27	19	20	21	22	23	24	25	16	17	18	19	20	21	22
28	29	30					26	27	28	29	30	31		23	24	25	26	27	28	29
														30						

1ª reunião do diálogo com múltiplos interessados para rever os conteúdos: 30 de setembro de 2020 das 10:00-12:00

Appendix 16 – Participants MSD meeting on 30 September 2020

The first MSD virtual meeting involving external partners took place on 30 September from 10:00 to 12:00. Participants attending are listed below:

International partners: Cyril Nogier, Irina Petkova, Gustavo Correa, Messeret Shibeshi, Niklas Danielsson, Abiola Ojumu, Nasmiyu Kuloba,

EPI team: Graça Matsinhe, Amélia Dipuve, Basília Vaz, Elsa Madivadua, Sousa Ribe

EPI in-country partners: Betuel Sigauque, Aida Mahomed, Aida Coelho, Abdul Ibraimo, Guillaume Deschamps, António Sambo, Kate Brownlow, Anita Odallah, Catarino Quissico, Custódio Mondlane, Eduardo Binasse, Esmeralda Karajeanes, Elísio Freitas, Carlos Funzamo, Hélder Mendes, Luís da Silva, Sílvia Chicuecue

Appendix 17 – Participants MSD meeting on 13 October 2020

The second MSD virtual meeting involving external partners took place on 13 October from 10:00 to 12:00. Participants attending are listed below:

International partners: Cyril Nogier (Gavi), Irina Petkova (Gavi), Gustavo Correa (Gavi), Abiola Ojumu (Gavi), Gurleen Hans (Gavi) Messeret Shibeshi (WHO), Niklas Danielsson (UNICEF), Nasmiyu Kuloba, Gertrude, Helena Ballester-Bon, Tejal, Machekanyangaz, Flint Zulu, Juliet Nabyonga, Isak Bello, Daniel Fussum, Sara Sá Silva

EPI team: Graça Matsinhe, Amélia Dipuve, Basília Vaz, Elsa Madivadua, Patrício Patrício, Albino Boana, Elisa Mavili, Melina Matusse, Eduardo Binasse

EPI in-country partners: Aida Mahomed (UNICEF), Aida Coelho (VillageReach), Abdul Ibraimo (VillageReach), Guillaume Deschamps (UNICEF), António Sambo (Acasus), Mauro Cuna (Acasus), Kate Brownlow (Acasus), Custódio Mondlane (CHAI), , Esmeralda Karajeanes, Elísio Freitas, Carlos Funzamo (WHO), Hélder Mendes (CHAI), Luís da Silva, Sílvia Chicuecue (Zenysis), Elisio Freitas (Zenysis), Angela Marques (UNDP), Lenka Tucek (UNDP), Melanie Picolo (PATH), Ruth Bechtel (VillageReach), Philippe Jaillard (EpiLinks), Zeferino Saugene (U. Oslo), Dulce Nhassico (USAID), Timóteo Chaluco (VillageReach)