APPLICATION FORM FOR GAVI NVS SUPPORT

Submitted by

The Government of Zimbabwe

for

Typhoid conjugate vaccine routine, with catch-up campaign

Gavi
The Vaccine Alliance

Reach Every Child
www.gavi.org

1 Gavi Grant terms and conditions

1.2 Gavi terms and conditions

1.2.1 Gavi terms and conditions

The terms and conditions of the Partnership Framework Agreement (PFA) between Gavi and the Country, including those provisions regarding anti-corruption and anti-terrorism and money laundering, remain in full effect and shall apply to any and all Gavi support made pursuant to this application. The terms and conditions below do not create additional obligations or supersede those of the PFA. In the event the Country has not yet executed a PFA, the terms and conditions of this application shall apply to any and all Gavi support made pursuant to this application.

GAVI GRANT APPLICATION TERMS AND CONDITIONS

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

AMENDMENT TO THE APPLICATION
The Country will notify Gavi in its Joint Appraisal, or in any other agreed annual reporting mechanism, if it wishes to propose any change to the programme(s) description in its application. Gavi will document any change approved by Gavi according with its guidelines, and the Country's application will be amended.

RETURN OF FUNDS
The Country agrees to reimburse to Gavi all funding amounts that Gavi determines not to have been used for the programme(s) described in its application. The Country's reimbursement must be in US dollars and be provided, unless otherwise decided by Gavi, within sixty (60) days after the Country receives Gavi's request for a reimbursement and be paid to the account or accounts as directed by Gavi.

SUSPENSION/ TERMINATION
Gavi may suspend all or part of its funding to the Country if it has reason to suspect that funds have been used for purpose other than for the programme(s) described in the Country’s application, or any Gavi-approved amendment to the application. Gavi retains the right to terminate its support to the Country for the programme(s) described in its application if a misuse of Gavi funds is confirmed.

NO LIABILITY
The Country shall be solely responsible for any liability that may arise in connection with: (i) the implementation of any programme(s) in the Country; and (ii) the use or distribution of vaccines

and related supplies after title to such supplies has passed to the Country.
Neither party shall be responsible for any defect in vaccines and related supplies, which remain the responsibility of the relevant manufacturer. Gavi shall not be responsible for providing any additional funding to replace any vaccines and related supplies that are, or became, defective or disqualified for whatever reason.

INSURANCE
Unless otherwise agreed with Gavi, the Country shall maintain, where available at a reasonable cost, all risk property insurance on the Programme assets (including vaccines and vaccine related supplies) and comprehensive general liability insurance with financially sound and reputable insurance companies. The insurance coverage will be consistent with that held by similar entities engaged in comparable activities.

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

ANTI-TERRORISM AND MONEY LAUNDERING
The Country confirms that funds provided by Gavi shall not be used to support or promote violence, war or the suppression of the general populace of any country, aid terrorists or their activities, conduct money laundering or fund organisations or individuals associated with terrorism or that are involved in money-laundering activities; or to pay or import goods, if such payment or import, to the Country’s knowledge or belief, is prohibited by the United Nations Security Council.

AUDITS AND RECORDS
The Country will conduct annual financial audits, and share these with Gavi, as requested. Gavi reserves the right, on its own or through an agent, to perform audits or other financial management assessment to ensure the accountability of funds disbursed to the Country.
The Country will maintain accurate accounting records documenting how Gavi funds are used. The Country will maintain its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of Gavi funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against Gavi in connection with any audit.

CONFIRMATION OF LEGAL VALIDITY
The Country and the signatories for the Country confirm that its application, or any other agreed annual reporting mechanism, is accurate and correct and forms legally binding obligations on the Country, under the Country's law, to perform the programme(s) described in its application, as amended, if applicable.

COMPLIANCE WITH GAVI POLICIES
The Country confirms that it is familiar with all Gavi policies, guidelines and processes relevant

to the programme(s), including without limitation the Transparency and Accountability Policy (TAP) and complies with the requirements therein. All programme related policies, guidelines and processes are available on Gavi's official website and/or sent to the Country.

USE OF COMMERCIAL BANK ACCOUNTS
The Country is responsible for undertaking the necessary due diligence on all commercial banks used to manage Gavi cash-based support. The Country confirms that it will take all responsibility for replenishing Gavi cash support lost due to bank insolvency, fraud or any other unforeseen event.

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

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

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

1.3 Gavi Guidelines and other helpful downloads

1.3.1 Guidelines and documents for download

Please refer to the relevant guidelines concerning your request for support.

Please ensure to consult and download all documents. It is important to note that some documents must be completed offline, and will need to be uploaded in the final steps of your application.

This application form is designed to collect information needed by Gavi to process requests for support, plan procurement of vaccines, plan technical assistance, track data for future reporting, and more.

A key component of the application is a solid operational plan (New Vaccine Introduction Plan for routine support, or Plan of Action for campaign support), explaining how the country will

introduce the vaccine or conduct the envisaged campaign, with a corresponding budget. The New Vaccine Introduction Plan or Plan of Action must be submitted together with this application form and will be considered as the foundation of the support request.

For more information on the documents to submit with your application and what they should contain, please refer to the appropriate guidelines: http://www.gavi.org/support/process/apply/

2 Review and update country information

2.1 Country profile

2.1.1 Country profile

Eligibility for Gavi support

Eligible

Co-financing group

Initial self-financing

Date of Partnership Framework Agreement with Gavi

17 May 2013

Country tier in Gavi's Partnership Engagement Framework

3

Date of Programme Capacity Assessment

No Response

2.1.2 Country health and immunisation data

Please provide the following information on the country’s health and immunisation budget and expenditure.

What was the total Government expenditure (US$) in 2016?

US$4,918,941,118

What was the total health expenditure (US$) in 2016?

US$298,482,119

What was the total Immunisation expenditure (US$) in 2016?

US$31,905,530

Please indicate your immunisation budget (US$) for 2016.

US$30,982,779

Please indicate your immunisation budget (US$) for 2017 (and 2018 if available).

2017 US$27,535,696
2018 US$64,107,119

2.1.3 National health planning and budgeting cycle, and national planning cycle for immunisation:

The government planning cycle starts on the

1 January

The current National Health Sector Plan (NHSP) is

From	2016
To	2020

Your current Comprehensive Multi-Year Plan (cMYP) period is

2016-2020

Is the cMYP we have in our record still current?

Yes☐	No☒

If you selected “No”, please specify the new cMYP period, and upload the new cMYP in country documents section.

Note 1

From	2020
To	2024

If any of the above information is not correct, please provide additional/corrected information or other comments here:

The cMYP and National Health Strategy are aligned and current for 2016-2020. However, the proposal for TCV routine vaccination support will be beyond the current cMYP; a new cMYP will be developed in 2019 to cover 2021-2025.

2.1.4 National customs regulations

Please describe local customs regulations, requirements for pre-delivery inspection, and special documentation requirements that are instrumental for the delivery of the vaccine.

Regulatory requirements for importation of the vaccines are as follows: application for import permits from the Medicines Control Authority of Zimbabwe (MCAZ) for registered vaccines to comply with the Medicines and Allied Substance Control Act (Import and Export of Medicines) regulations, 2008 (S.I 57 of 2008), application for MASCA [Chapter 15:03] section 75 authorization of importation for unregistered vaccines and submission of vaccine protocols to MCAZ for the lot release procedures for consignments imported into the country.
Regulatory requirements for importation of the vaccines are as follows: application for import permits from MCAZ for registered vaccines to comply with the Medicines and Allied Substance Control Act (Import and Export of Medicines) regulations, 2008 (S.I 57 of 2008), application for MASCA [Chapter 15:03] section 75 authorization of importation for unregistered vaccines and submission of vaccine protocols to MCAZ for the lot release procedures for consignments imported into the country. A commercial invoice is also required.

2.1.5 National Regulatory Agency

Please provide information on the National Regulatory Agency in the country, including status (e.g. whether it is WHO-certified). Please mention a point of contact with phone number and e-mail address. UNICEF will support the process and may need to communicate licensing requirements to the vaccine manufacturers where relevant.

The NRA is WHO-certified and the details are as below:
Medicines Control Authority of Zimbabwe
106, Baines Avenue,
Harare
Zimbabwe
Contact Person: The Director-General, Ms GN Mahlangu
Tel: +263 4 736 981/7, 708 255, 2901327-31

2.2 National Immunisation Programmes

2.2.2 Financial Overview of Active Vaccine Programmes

Please note that co-financing projections for existing programs will be provided offline.

2.3 Coverage and Equity

2.3.1 Coverage and equity situation analysis

Note: If a recent analysis of the coverage and equity analysis is already available, for example as part of a Joint Appraisal report, you may simply reference the report and section where this information can be found.

Describe national and sub-national evidence on the coverage and equity of immunisation in the country and constraints to improvement. In particular, identify the areas and groups of low coverage or high inequity linked to geographic, socioeconomic, cultural or female literacy considerations, as well as systematically marginalized communities. Specify both the areas and/or populations with low coverage (%) and those with the largest absolute numbers of un-/under-vaccinated children. Among data sources, consider administrative data, coverage surveys, DHS/MCS, equity analyses, Knowledge-Attitude-Practice surveys, and patterns of diseases like measles.

Describe the challenges underlying the performance of the immunisation system, such as:

- Health work force: availability and distribution;
- Supply chain readiness;
- Gender-related barriers: any specific issues related to access by women to the health system;
- Data quality and availability;
- Demand generation / demand for immunisation services, immunisation schedules, etc;
- Leadership, management and coordination: such as key bottlenecks associated with the management of the immunisation programme, the performance of the national/ regional EPI teams, management and supervision of immunisation services, or broader sectoral governance issues;
- Financing issues related to the immunisation programme that impact the ability to increase coverage, including bottlenecks related to planning, budgeting, disbursement and execution of resources;
- Other critical aspects: any other aspect identified, for example based on the cMYP, EPI review, PIE, EVM or other country plans, or key findings from available independent evaluations reports.

Describe lessons learned and best practices on the effectiveness of implemented activities to improve coverage and equity; recommendations on changes or new interventions that might be required to accelerate progress (include data to support any findings or recommendations).

Coverage and equity:

Inequality patterns in Zimbabwe are consistent with worldwide equity patterns related to rural/urban/urban slums, wealth and parental education disparities. Urban infants are more likely to be immunized than rural infants or those living in urban slums. There is clear correlation between household wealth and education of women, where increasing wealth and education tends to associate with higher coverage rates. Previous studies have shown that the likelihood of a child being vaccinated increases the higher the wealth quintile. The children from wealthier households are more likely to be vaccinated than those from poor families.

Zimbabwe has vast experience in successfully introducing new vaccines. DTP-HepB-Hib was introduced in 2008, PCV 13 in 2012, Rotavirus in 2014 and the latest MR/MSD in 2015 that was introduced in a campaign mode targeting all children 9 months up to 15 years. However, the EPI Programme in Zimbabwe faces many issues like accuracy of denominator, number and distribution of vaccinators, lack of health care workers, weak supervision, monitoring and evaluation mechanisms.

Provinces that achieved high coverage for DTP3 were Harare at 97% with Mash West and Mat North 92% and 93% respectively. The rest of the provinces had DTP3 coverage ranging between 80-89% with Bulawayo and Mash East being the least at 81% followed by Midlands at 82%. For MR1 coverage, Harare City, Masvingo and Mat North had coverage above 90% while the rest of the provinces were above 80% but below 90% with Midlands being the least at 80%. For MR2, Harare City, Mat South and Mat North had coverage above 80% while the rest of the provinces were below 80% with the least being Chitungwiza and Midlands with coverage <70% as shown in the score card below. All provinces had an increase in the number of unvaccinated children for Penta 3 except for Chitungwiza and Masvingo that had a decrease. Children not vaccinated with Measles 1 showed a decrease from 2015 to 2016 and were on the rise again in 2017. Provinces such as Midlands, Mash East, Mash Central, Bulawayo and Chitungwiza Cities had increases. Dropout rates for all antigens remained below 10% except for MR1 – MR2, which was 14%.

Reasons for low performance varies from province to province and district to district. Mash East and Mash Central provinces and their respective districts such as UMP and Centenary attribute their low performance to overstated denominators. In other districts such as Gokwe North, Chiredzi, Gokwe South and Mbire have hard to reach populations by distance and terrain. Furthermore, these districts have sparsely distributed health facilities. If transport and outreach funding are affected in such districts, they will not meet their targets. Urban areas such as Chitungwiza and Mutare have been adversely affected by low morale of health workers due to prolonged none payment of salaries. Districts such as Mutare, Gwanda, Makoni, Buhera, Shamva and Gutu's low performance is attributed to vaccine hesitancy groups.
According to the most recent Zim Demographic and Health Survey (ZDHS) in 2015, 76% of children age 12-23 months had received all basic vaccinations, up from 65% in 2010-11. Although coverage for all basic vaccinations among children age 12-23 months in Zimbabwe decreased steadily between 1994 and 2005-06 (from 80 to 53 percent), coverage increased to 65 percent in 2010-11 and 76 percent in 2015. Accordingly, the percentage of children with no vaccinations has followed the opposite trend, from 21% of children never having received any vaccinations in 2010-11, to 10% in 2015. Slums, informal settlements in and around cities and illegal settlements where there are no social amenities such as health facilities and schools, makes mapping of underserved communities difficult. As a result, the actual numbers of

unvaccinated children are not known and maybe masked by high coverage in some cities such as Harare. The above scenario is coupled by lack of capacity to do proper micro-planning which assists in the in mapping where the underserved communities are and equitable distribution of resources.

When it comes to monitoring and reporting of childhood vaccinations, 93% of children age 12-23 months have had a vaccination card at some point in time; 78 percent of children had vaccination cards that were observed by interviewers in the 2015 ZDHS. While minimal to no differences in immunisation coverage have been identified by gender, urban/rural, or socio-economic status, there are some faith groups that have lower immunisation acceptance.
The ZDHS also shows that the proportion of children who are unvaccinated increases the higher the birth order. This demonstrates that caregivers are generally more careful with their first-born children than those who are born later, and where distances to a health facility or outreach point are long it is not easy to carry more than one child, and this affects booster doses uptake.

The last Gavi Joint Appraisal occurred in July and August 2018, which noted and expanded on the below issues related to coverage and equity. In addition, a Knowledge-Attitude-Practice (KAP) survey was conducted in Q4 2018 and findings are currently being analyzed and summarized, which may help inform vaccine introduction strategy for TCV once results are available.

Gender:
The ZDHS 2015 found that there were slightly more female children (77.3%) aged 12-23 months who were vaccinated compared to their male counterparts (74.8%). In some minority religious sects, there are gender disparities between boys and girls that can also hinder access to health care services.

Previous surveys have shown that the level of education of mothers/caregivers is an important determinant of uptake of immunisation services. The higher the educational level of the mother/caregivers the more likely will the child be vaccinated. The ZDHS found that among mothers/caregivers who never went to school, 68.8% had their children vaccinated, which increased to 79.6% among those with primary level of education, and then to 90.3% of the mothers/caregivers with secondary education.

Geography:

Zimbabwe has five ecological regions ranging which experience different climatic conditions. Some of these conditions can negatively impact the socio-economic status of local communities. The following geographical barriers directly or indirectly impact vaccine service delivery: urban versus rural settings, long distances from schools and health centres, mountains, flooded rivers, and poor road infrastructure.

The ZDHS 2015 and the MICS 2014 have shown that immunisation coverage is higher in urban than in rural areas. In the ZDHS, the proportion of children aged 12-23 who did not receive any vaccination at the time of the survey was 9.8%, which was higher in rural (11.6%) compared to urban (5.7%) areas. Distance from local health facilities is a major determinant of immunisation. In urban areas, the proximity of the health facilities to households increases the likelihood of children being vaccinated compared to rural areas. In rural areas, the caregivers may be unable to carry more than one child or visit facilities at all due to the burden of carrying multiple children to health facilities, which in most cases is far away from areas of residence.

Outreach activities are critical in Zimbabwe as they service hard to reach areas by distance and geographical setting. Adequate funding for immunisation ensures conducting of consistency in provision of outreach services. Some rural districts, such as the Gokwe North and South, Chiredzi, Binga and Mbire have very rough and rocky roads, shortening the lifespan for outreach vehicles and incurring high maintenance costs. Despite efforts to conduct outreach, it is evident that not all children are reached with vaccinations.

Though immunisation services are free in Zimbabwe, women in rural areas usually do not have funds for transport to health facilities. Outreach activities are conducted in hard to reach areas to reduce distances caretakers walk to seek immunisation services and improve access but still the outreach services are inadequate and inconsistent. In some areas, caregivers maybe scared to walk alone to health facilities or outreach points due to presence of wild animals, In the Doma area, a motor bike has been provided by WHO as a pilot to assist following the mobile population in their camping sites and vaccinate the children.

Economic challenges:

Budgeting sufficient financial resources required by the EPI programme are the essential functions of the government in order to achieve and sustain high and equitable coverage. However, currently the government provides co-financing, human resources, infrastructure and some transport for the programme. The government is also raising funds (health levy) from which EPI programme is benefitting (e.g., allowances for HPV campaign, co-financing of new and underutilised vaccines). Despite these efforts by the government to support the EPI programme, there is over-reliance on partners for the procurement of vaccines and supplies as well as programmatic activities. The government has no specific budget line for the immunisation program meme, instead it is embedded in medicines, vaccines and technology supplies. As a result, the financial resources for vaccines are not adequately availed. Furthermore, national economic challenges, such as the liquidity crunch and scarce food availability, also inhibit access to vaccination.

Leadership, management and coordination:

There are a number of issues related to leadership, management and coordination of immunisation services in Zimbabwe; staffing, finance for immunisation and micro-planning. The EPI Manager has oversight of the immunisation programme in the country. Below the EPI Manager are the EPI Surveillance Officer responsible for disease surveillance; and the EPI Logistics Manager responsible for the Immunisation Supply Chain Management.

At provincial level EPI is headed by the Provincial Nursing Officer (PNO) who reports to the PMD. The PNO is assisted by the Provincial EPI Officer who is solely for EPI activities in the provinces. There are no established posts for Cold Chain Technicians and Store officers at provincial level. Currently the programme depends on borrowed staff such drivers, Nurses and General Hands who were provided with on-job training in refrigerator maintenance and vaccine management. The only qualified cold chain technician is at national level and reacts mainly to breakdowns.

Health workforce capacity:

The Service Availability Readiness Assessment (SARA) of 2015 revealed that Zimbabwe core health workforce density (36%) was below half of the WHO standard rate of 23/10,000

recommended for adequate coverage for key primary health care interventions as prioritised in the MDGS. The SARA also found out that the health workforce was inequitably distributed with a higher density in urban areas than rural. In an effort to address the shortage of the health workforce, the Government of Zimbabwe has employed more nurses in 2018 and deployed them to all levels for health service provision. Though positive in a way, the employment of these nurses into government service posed a challenge to some local authorities as nurses moved to government employment for better conditions of service. Some local authorities such as Chitungwiza and Mutare were left with inadequate staff thereby affecting health service delivery including immunisation services in those cities. This may lead to recruitment of inexperienced staff with inadequate skills to manage immunisation services and underutilization of those who might have experience in immunisation programme management.

Vacancy levels in the public health sector and massive health professional migration has resulted in the decimation of experienced workers, leaving those with skills strained to train new cadres well enough to meet the national demands. This has resulted in the loss of quality cadres capable of working with minimum supervision, and inadequately trained cadres at the point of care. The Primary Care Nurses who staff the rural health centers have limited knowledge and skills in EPI. However, the staffing situation has improved from 2010 levels. Additionally, the Village Health Workers who provide basic maternal and child health care are inadequate in number and receive very minimal allowances which do not motivate them. The high ratio of children to vaccinators is further complicated by geographical spread, training issues and weak accountability mechanisms.

The Central Vaccine Stores have four qualified personnel headed by the Logistics Manager for effective and efficient management of vaccines and supplies. Of the four, three posts (1 National Cold Chain Technician, 1 Stores Officer and 1 Stores Assistant) are funded by Gavi on the understanding that the Government will take over when Gavi support ends. Gavi is also funding for four security services at the Central Vaccine Stores. Provincial Vaccine Stores have an average of three personnel each, headed by an EPI Officer. The EPI Officer is the only substantive position for immunisation at provincial level with the other posts of Provincial Storekeeper and Cold Chain Technician being designate. These members of staff are not qualified for the job and have received their training on the job, compromising their ability to maintain the vaccines and supplies efficiently and effectively. The responsibility of vaccine management is assigned to Community Health Nurse and Nurse-in-Charge at districts and service delivery levels respectively. WHO and UNICEF also provide invaluable technical support to the immunisation supply chain management in the country.

There are no programme-specific posts for M&E, Accounting and Health Promotion officers' thereby compromising programme monitoring, financial management and demand creation and promotion activities, respectively. While the latest Joint Appraisal form 2018 reports that integration is good, the programme tends to suffer at times due to inadequate planning, monitoring and data analysis, such that some gaps are noted at national level which could have been dealt with at lower levels. Micro-planning is an essential part in budgeting and planning cycle and should be strong at service delivery level, yet there is lack of capacity to do so.

Lack of education regarding vaccine-preventable diseases and benefits of vaccination:

Zimbabwe carried out a Vaccination Acceptability Assessment in January to February 2015. Findings form this report state that caregivers generally associated vaccination with 'disease' but had no clear perception of the specific disease(s). They understood vaccination as merely 'injections' and lacked the confidence to ask health workers for further information. Without this

information, caregivers will not fully understand the risks of missing/skipping vaccines in the child vaccination schedule. Alternately, those who accepted vaccines emphasized the benefits of vaccination in terms of preventing vaccine-preventable diseases. Findings from the recent KAP survey will show if these perceptions and beliefs have changed in recent years as new vaccines have been added to childhood immunisation and there has been an increased focus and effort on educating caregivers around VPDs and the benefits of vaccination. These findings will help guide advocacy and communication materials for TCV introduction.

Socio-cultural and religious factors determining vaccination:

Some caregivers and community leaders who object to the use of vaccines perceived vaccines to cause ill-health and weaken the body of children, and conflict with their religious beliefs, such as in Apostolic communities.

Health worker interactions with caregivers:

Some caregivers report ill-treatment by health workers when they miss scheduled appointments, which can cause some caregivers to skip subsequent appointments. Caregivers have also indicated that some health workers may not take the time to explain the vaccines, symptoms of the disease prevented by the vaccine, the benefits of vaccination, and the importance of respecting the vaccination schedule. It is also important to understand health workers' attitudes and responses in context, particularly conditions of work, heavy workload, and the overlap of professional and personal lives in close-knit communities.

Vaccine vial handling:

While stock-outs are seldom reported, health workers and caregivers highlighted the challenges posed by multi-dose vials in certain areas of the country. In instances where the number of children to be immunized for a specific vaccine is limited, health workers have reportedly encouraged caregivers to mobilize others until the threshold number for opening the vial is reached, otherwise they would turn caregivers back home.

Data reporting and quality:

According to the 2017 DQR, there are frequent shortages of daily tally sheets due to shortages of bond paper and printer toner, as well as the breakdown of printer/photocopier machines. As such, different versions of the daily tally sheets are in use as facilities may revert back to available older forms to combat the shortage issue. In addition, there is varying degrees of availability of DHIS2 and access to the system. However, there are daily back-ups of the system and centralised server, and the system can be accessed from anywhere the internet is available. Stable and long serving Health Information Officers ensure the system stable, reliable and up-to-date, however utilization of the data analysis capabilities of DHIS2 are under used.

Supply Chain:

Zimbabwe has a well-defined immunisation supply chain structure consisting of four levels. These are the Central, Provincial, District and Service Delivery levels. The Central and all eleven Provincial Vaccine stores are equipped with cold rooms and conventional vaccine refrigerators for storage of vaccines. Districts stores and Service delivery facilities are equipped with conventional refrigerators, all WHO compliant at the time of purchase. All facilities at all levels have adequate cold chain capacity for both vaccines and dry materials.

The country conducted an Effective Vaccine Management Assessment (EVMA) in 2016 and achieved a global score of 79%. Major areas of concern included buildings and equipment maintenance, temperature monitoring and unavailability of EVM standard operating procedures (SOPs). Subsequent to the EVMA, the country developed costed improvement plan with timelines for implementation. Most of the concerns have since been addressed.

The Central and Provincial level vaccine stores have been equipped with state of the art remote temperature monitoring devices. EVM SOPs were developed and printed in 2017 and distributed to all levels beginning 2018. At least two health workers per subnational store (National and District Vaccine Stores) were capacitated in effective vaccine management through Gavi support. Vaccine management at district level was improved by the rolling out of a computerised stock management tool (SMT) in all the 63 districts in January 2017. The Central and Provincial levels had rolled out this system some few years ago.

Supplies management data (computerised) from provincial and district vaccine stores is shared with national level on monthly basis. Compliance is 100% at provincial level and 50% at district level. Low performance at district level is attributable to lack of capacity to run computer based SMT by some health workers, limited internet accessibility and to some extend non-allocation of focal person for vaccine management in some districts. The ordering system continued the “pull system” where supplies were being issued on request. The Central and Provincial levels delivered vaccines to lower levels while at district level it was a mix with some having their supplies delivered by the district and some collecting from the district.

The central and provincial levels have cold chain maintenance plans in place as recommended in the last EVMA. However, implementing the activities outlined in the plans remained a challenge due to multi-tasking especially at provincial level where there are no substantive cold chain technicians and store officers posts. The other reason for not following the plan was lack of funding for daily subsistence allowances and transport. Despite all these challenges, the Gavi Joint Appraisal in 2018 found that the cold chain system at all levels remained intact, with no vaccines reported to have been damaged due to exposure to adverse temperature. In addition, temperature recording was generally being done twice daily at all levels, and this was in addition to remote continuous monitoring at central and Provincial levels.

Approaches to Improving Coverage Equity and Access to Immunisation Services:

• In 2018, Zimbabwe was able to conduct Community Dialogues in 18 districts, where over 6,480 community members were reached. Community Dialogues were used to better understand bottlenecks, barriers, weaknesses, strengths and enablers to uptake of immunisations, and to design effective evidence-based interventions. The community dialogues targeted health facilities/hotspot areas that districts regarded as underserved and as having under-immunized/unimmunized children. The community dialogues were unable to reach all health facilities in the 18 districts as such EPI community action plans were developed together with communities to address the needs in those specific areas. The community dialogue trainings helped equip frontline health workers with community engagement, interpersonal communication skills and building of partnerships with the communities.

• The African Vaccination Week (AVW) conducted every year during the last week of April to promote EPI activities through engaging communities at all levels of health care, giving information on immunisation, and encouraging them to take children for vaccination in order to protect them from vaccine preventable diseases. The AVW provides timely behavioural

prompts to caregivers, through the use of Public Service Announcement on Radio and TV, Press Statements, SMS, interpersonal communication engagement by health workers at various levels etc. The AVW assists to gunner up political/traditional leadership commitment for childhood immunisation and child health services. Other activities involve, giving due and overdue vaccinations to children and active surveillance for EPI diseases targeted for elimination and eradication. In the year 2017, the AVW week was conducted under the theme "Vaccines protect everyone, get vaccinated and the slogan was "Vaccinated communities, Healthy communities". The AVW EPI activities were integrated with Vitamin A supplementation, deworming with Albendazole, screening children for oedema, checking their mid arm circumference and monitoring weight for height. Mai Chisamba TV Talk Show was also conducted to reach more communities with EPI information and promoting the AVW.

In 2018, the AVW continued promoting EPI activities as well as creating awareness on the Human Papilloma Virus Vaccine (HPV vaccine) which was going to be introduced to girls 10-14 years May 2018. High level political engagement was conducted with the First Lady being engaged to launch HPV vaccine roll out. The AVW provides timely behavioural prompts to caregivers, through the use of Public Service Announcement on Radio and TV, Press Statements, SMS, interpersonal communication engagement by health workers at various levels.

• Local Immunisation Days are conducted in priority, low performing districts. This was done in an effort to improve coverage equity within the country. Village Immunisation Days were conducted to ensure each and every eligible child got due and over-due vaccines. With resources permitting local immunisation days should be done by all districts in Zimbabwe not just low performing districts. All districts must be resourced to conduct demand generation activities within their areas of operation.

• The My Village My Home Initiative in Chipinge and Makoni Districts of Manicaland Province is being used to improve immunisation equity and coverage. This is through engagement of community leaders and Village Health Workers (VHWs) to closely monitor and track defaulters of vaccine eligible children at village level. VHWs register all children in their village and this is validated by the village heads and track defaulters.

• Other innovative strategies being implemented to improve coverage equity are the "Bereka Mwana" initiative in Zaka District of Masvingo Province where caregivers are encouraged to carry their children on their backs to the nearest service delivery point for immunisations services. This initiative has greatly improved the coverage of antigens for the district.

• Cell phones are widely used in Zimbabwe such that the EPI Programme is planning to engage the network providers to send information on EPI and reminders to caregivers to bring children for vaccinations.

• RED Strategy is going to be implemented to improve on community engagement coupled with Community Dialogue and interventions such as My Village My Home to improve on microplanning and improve EPI services in hard to reach areas. Health workers in HSS districts have been trained on IPC to improve on their communication with communities whom they serve. IEC materials for EPI have been produced in major and minority languages to allow lowly educated men and women to be able to read the information and make informed decisions regards immunisation for their children. Recruitment of male and female health workers and VHWs may ease information giving to male and female caregivers and enhance participation

and reduce barriers in participation in some areas where men do not like their women served by male healthy workers and vice versa.

2.4 Country documents

2.4.1 Upload country documents

Please provide **country documents** that are relevant for the national immunisation programme and for multiple vaccines, to be taken into account in the review of your application. If you have already provided one or more of these country documents, you do not need to upload it/them again unless the document version changed. If documents cannot be provided, please use the comment functionality to explain why, or by when they will be available.

Note that only general country documents are uploaded here; at the end of section 3 (sub-section “Upload new application documents”) you will be required to provide those documents that are specific to the support requested (for example the new vaccine introduction plan and/or campaign plan of action, new budget, application endorsements etc.)

Country and planning documents

✓	**Country strategic multi-year plan** Comprehensive Multi-Year Plan for Immunisation (cMYP) or equivalent country strategic plan	Zimbabwe EPI cMYP Revised 10 Sept 201810091819.12.59_17-01-19_09.56.30.docx
✓	**Country strategic multi-year plan / cMYP costing tool**	ZimcMYPCostingToolV3.9.4Sept 201810091819.14.48_17-01-19_09.56.47.xlsx
✓	**Effective Vaccine Management (EVM) assessment**	Zimbabwe2016EVMReportFinal 112011818.10.55_17-01-19_09.19.28.pdf
✓	**Effective Vaccine Management (EVM): most recent improvement plan progress report**	ZimEVMAImprovement Plan Implementation StatusSept201807091811.43.25_17-01-19_09.20.00.xlsm

✓	**Data quality and survey documents: Final report from most recent survey containing immunisation coverage indicators**	Zimbabwe 2017 draft 0 DQR Report071217 Group 6 216071805.06.04_17-01-19_09.22.40.docx
	Data quality and survey documents: Immunisation data quality improvement plan	**No file uploaded**
	Data quality and survey documents: Report from most recent desk review of immunisation data quality	**No file uploaded**
	Data quality and survey documents: Report from most recent in-depth data quality evaluation including immunisation	**No file uploaded**
✓	**Human Resources pay scale** If support to the payment of salaries, salary top ups, incentives and other allowances is requested	Circular 01 2015 to UN Entities_DSA Rates for Govt & IP Officials_24-04-18_14.53.04.pdf

Coordination and advisory groups documents

✓	**National Coordination Forum Terms of Reference** ICC, HSCC or equivalent	ZICC Terms of Reference12011818.19.26_17-01-19_09.25.18.pdf ICC Chair signature_10-09-18_18.01.05.pdf

✓	**National Coordination Forum meeting minutes of the past 12 months**	Revised ICC Minutes Don10091817.57.39_17-01-19_09.25.53.docx

Other documents

✓	**Other documents (optional)** Please also provide other country documents to support the review of the applications, for example Health Facility Assessment Reports, Knowledge-Attitude-Practice surveys or other demand-related surveys, if available.	ZimAMR_17-01-19_09.29.27.pdf Zim DHS 2015_17-01-19_09.28.33.pdf TCV mass vaccination GAVI proposal FINAL 16072018_20-08-18_15.47.09.pdf

3 Typhoid conjugate vaccine routine, with catch-up campaign

3.1 Vaccine and programmatic data

3.1.1 Choice of presentation and dates

For each type of support please specify start and end date, and preferred presentations.

Note 2

Typhoid conjugate vaccine routine

Preferred presentation	TCV, 5 doses/vial, liq
Is the presentation licensed or registered?	Yes ☐ No ☒
2nd preferred presentation	
Is the presentation licensed or registered?	Yes ☒ No ☐
Required date for vaccine and supplies to arrive	1 November 2019

Planned launch date	1 April 2020
Support requested until	2024

Typhoid conjugate vaccine catch-up campaign

Preferred presentation	TCV, 5 doses/vial, liq
Is the presentation licensed or registered?	Yes ☐ No ☒
2nd preferred presentation	
Is the presentation licensed or registered?	Yes ☒ No ☐
Required date for vaccine and supplies to arrive	1 November 2019
Planned launch date	1 April 2020
Support requested until	2020

3.1.2 Vaccine presentation registration or licensing

If any of the selected presentations are not yet licensed or registered, please describe the duration of the registration or licensing procedure, whether the country's regulations allow the expedited procedure for national registration of WHO-pre-qualified vaccines, and confirm whether the licensing procedure will be completed ahead of the introduction or campaign.

The country will invoke Section 75 of the Medicines and Allied Substances Act which then allows importation of unregistered products into the country as long as these products are WHO pre-qualified.

3.1.3 Vaccine procurement

Gavi expects that most countries will procure vaccine and injection supplies through UNICEF or PAHO's Revolving Fund.Does the country request an alternative mechanism for procurement and delivery of vaccine supply (financed by the country or Gavi)?

Yes☐ No☒

If you have answered yes, please attach the following in the document upload section:* A description of the mechanism, and the vaccines or commodities to be procured by the country through this mechanism.* A confirmation that vaccines will be procured from the WHO list of pre-qualified vaccines, indicating the specific vaccine from the list of pre-qualification. OR, for the procurement of locally-produced vaccines directly from a manufacturer which may not have been prequalified by WHO, a confirmation should be provided that the vaccines purchased comply with WHO's definition of quality vaccines, for which there are no unresolved quality problems reported to WHO, and for which compliance is assured by a fully functional National Regulatory Authority (NRA), as assessed by WHO in the countries where they are manufactured and where they are purchased.

3.2 Target Information

3.2.1 Targets for routine vaccination

Please describe the target age cohort for the routine immunisation:

Note 3

Children 9 months of age country-wide.

	2020	2021	2022	2023	2024
Population in the target age cohort (#)	464,123	468,764	473,452	478,187	482,969
Target population to be vaccinated (first dose) (#)	464,123	468,764	473,452	478,187	482,969
Estimated wastage rates for preferred presentation (%)	15	15	15	15	15

3.2.2 Targets for campaign vaccination

Please describe the target age cohort for the campaign: e.g. 9 months to < 15 years.Gavi will only provide support up to 15 years of age.

Children 9 months to <15 years country-wide

2020

Population in the target age cohort (#)	6,165,503
Target population to be vaccinated (first dose) (#)	5,857,228
Estimated wastage rates for preferred presentation (%)	10

3.3 Co-financing information

3.3.1 Vaccine and commodities prices

Price per dose (US$) - Typhoid conjugate vaccine routine

	2020	2021	2022	2023	2024
5 doses/vial, Liquid	1.5	1.5	1.5	1.5	1.5

Commodities Price (US$) - Typhoid conjugate vaccine routine

	2020	2021	2022	2023	2024
AD syringes	0.04	0.04	0.04	0.04	0.04
Reconstitution syringes	0.04	0.04	0.04	0.04	0.04
Safety boxes	0.47	0.47	0.47	0.47	0.47
Freight cost as a % of device value	0.05	0.05	0.05	0.05	0.05

Price per dose (US$) - Typhoid conjugate vaccine catch-up campaign

	2020
5 doses/vial, Liquid	1.5

Commodities Price (US$) - Typhoid conjugate vaccine catch-up campaign (applies only to preferred presentation)

	2020
AD syringes	0.04
Reconstitution syringes	0.04
Safety boxes	0.47

Freight cost as a % of device value	0.05

3.3.2 Country choice of co-financing amount per vaccine dose

The table below shows the estimated financial commitment for the procurement of vaccines and supplies for the country, and the portion of Gavi support

Note 5

	2020	2021	2022	2023	2024
Country co-financing share per dose (%)	13.33	13.33	13.33	13.33	13.33
Minimum Country co-financing per dose (US$)	0.2	0.2	0.2	0.2	0.2
Country co-financing per dose (enter an amount equal or above minimum)(US$)	0.2	0.2	0.2	0.2	0.2

3.3.3 Estimated values to be financed by the country and Gavi for the procurement of supply

Typhoid conjugate vaccine routine

	2020	2021	2022	2023	2024
Vaccine doses financed by Gavi (#)	593,400	480,600	485,400	490,300	495,200
Vaccine doses co-financed by Country (#)	91,300	74,000	74,700	75,500	76,200
AD syringes financed by Gavi (#)	661,200	517,200	522,400	527,600	532,900
Total value to be financed (US$)	1,570,000	855,500	864,500	873,000	596,000
AD syringes co-financed					

by Country (#)					
Safety boxes financed by Gavi (#)	7,275	5,700	5,750	5,825	5,875
Safety boxes co-financed by Country (#)					
Freight charges financed by Gavi ($)	2,177	1,704	1,720	1,738	1,755
Freight charges co-financed by Country ($)	545	426	431	435	439

	2020	2021	2022	2023	2024
Total value to be co-financed (US$) Country	137,000	111,000	112,500	113,500	114,500
Total value to be financed (US$) Gavi	920,000	744,500	752,000	759,500	767,000

Typhoid conjugate vaccine catch-up campaign

	2020
Vaccine doses financed by Gavi (#)	6,501,600
AD syringes financed by Gavi (#)	6,443,000
Safety boxes financed by Gavi (#)	70,875
Freight charges financed by Gavi ($)	26,519

	2020

Total value to be financed (US$) Gavi	10,044,000
Total value to be financed (US$)	10,044,000

3.3.4 Co-financing payment

Please indicate the process for ensuring that the co-financing payments are made in a timely manner.

The Ministry works together with the Ministry of Finance & Economic Development (MoFED) to ensure that treasury is aware of all financial commitments emanating from the support with the Finance Minister being one of the key persons with the final decision. When Gavi notifies the country on approval and country co-financing obligation, the MoHCC Finance Director communicates with counterparts at treasury so that the funds are availed. However, for existing obligations, co-financing amounts are part of the MoHCC budget which is submitted to MoFED at year end in preparation for the oncoming fiscal year. The government ensures that the co-financing payment is remitted to UNICEF SD before the end of the year.

If your country is in the accelerated transition phase for Gavi support, please answer the following question:

Please provide evidence that the co-financing obligations for the new introduction have been budgeted for, and elaborate on how the country plans to pay for the fully self-financing amounts. Please discuss the extent to which medium-term immunisation/health plans and medium-term expenditure frameworks incorporate the additional costs associated with this introduction. Discuss any co-financing defaults that may have happened in the last five years.

Not Applicable

Following the regulations of the internal budgeting and financing cycles the Government will annually release its portion of the co-financing funds in the month of:	December

The payment for the first year of co-financed support will be made in the month of:

Month	December

Year	2020

3.4 Financial support from Gavi

3.4.1 Routine Vaccine Introduction Grant(s)

Typhoid conjugate vaccine routine

Live births (year of introduction)

488,551

Gavi contribution per live birth (US$)

0.8

Total in (US$)

390,840.8

Funding needed in country by	31 October 2019

3.4.2 Campaign Operational Costs Support grant(s)

Typhoid conjugate vaccine catch-up campaign

Population in the target age cohort (#)

Note 6

6,165,503

Gavi contribution per person in the target age cohort (US$)

0.65

Total in (US$)

4,007,576.95

Funding needed in country by	31 October 2019

3.4.3 Operational budget

Please complete the Gavi budgeting and planning template to document how the Gavi Vaccine Introduction Grant and the Campaign Operational Costs support grant will be used to facilitate the timely and effective implementation of critical activities in advance of and during the campaign and the introduction of the new vaccine. Please ensure to upload the completed budgeting and planning template as part of this application.

If Gavi's support is not enough to cover the full needs please indicate how much and who will be complementing the funds needed in the Operational Budget template. In the following fields please provide an overview of your request.

Total amount - Gov. Funding / Country Co-financing (US$)

862000

Total amount - Other donors (US$)

148000

Total amount - Gavi support (US$)

4398418

Amount per target person - Gov. Funding / Country Co-financing (US$)

0.14

Amount per target person - Other donors (US$)

0.0

Amount per target person - Gavi support (US$)

0.71

3.4.4 Key Budget Activities

List the key budgeted activities to be undertaken in implementing the requested support. Please provide details on the key cost drivers, inputs and assumptions required for these activities.

Planning & Preparations
This activity will include micro-planning whose main cost drivers are per diems, fuel and conference facilities for meetings. These meetings will be convened for national, provincial and district personnel to come up with comprehensive plans for the introduction of the vaccine. The micro-planning meetings will be conducted in four clusters. Training of health workers will also be done starting with training of trainers who will then cascade to lower levels. The aim of the trainings is to impart knowledge on health workers. Since the vaccination will be conducted at schools and other places, orientation of school health coordinators will be part of the planning and preparations. Costs will be incurred for daily subsistence allowances, bus fares, fuel and conference facilities.
Demand Generation
The aim of the activity is to create awareness among communities on Typhoid Conjugate Vaccine. This will be achieved by use of Information, Education & Communication (IEC) material, electronic media and meetings. In order to achieve this, posters, banners, pamphlets and body media will be produced and distributed to communities. In addition, radio & television messages will be produced and flighted in different languages. There are also plans to engage mobile communication service providers so that short messages will be sent. The Ministry will also engage service providers for conducting of road shows in all provinces as a means of demand generation.
Service Delivery
The actual vaccination will have health workers visiting schools and outreach points for implementation. These workers will require DSA, fuel and airtime as key enablers to successful introduction.
Monitoring & Evaluation
Monitoring & evaluation activities will be conducted before, during and after the introduction. The purpose of the activity is to ensure compliance, provide on job training and documentation of practices. The activity will be conducted by supervisors from the national, provincial and district levels. All participants will require DSA, vehicles and fuel to conduct planned supervision. Therefore funds will be required for procurement of fuel, payment of DSAs while vehicles already in the system will be used for transport.
Procurement & Supply Chain Management
The introduction of TCV will involve procurement of emergency kits, hand sanitizers and tools for participatory health & hygiene education kits.

3.4.5 Financial management procedures

Please describe the financial management procedures that will be applied for the management of the NVS direct financial support, including any procurement to be incurred.

The financial and procurement management will be guided by the Partnership Framework Agreement between Gavi and Zimbabwe. This agreement refers to the current legislation and procedures on Financial Management and Public Procurement.

3.4.6 Fiduciary management

Please indicate whether funds for operational costs should be transferred to the government or WHO and/or UNICEF and when funding is expected to be needed in country. Attach banking form if funding should be transferred to the government. Please note that UNICEF and WHO will require administrative fees as follows.

- **UNICEF Tripartite Agreement: 5%**
- **UNICEF Bilateral Agreement: 8%**
- **WHO Bilateral Agreement: 7%.**

Currently all Gavi cash grants are disbursed to the country through UNICEF.

3.4.7 Use of financial support to fund additional Technical Assistance needs

Gavi funds through its Partner Engagement Framework / TCA, tailored and differentiated technical assistance in response to specific country needs. Please review the currently approved technical assistance plan (also referred to as the "One TA plan") with a view to assess that required support for the implementation of the new vaccine support is contained in the approved technical assistance plan. If gaps in technical assistance are identified for the new vaccine support, the additionally required technical assistance may be funded through the vaccine introduction grant or campaign operational costs support. In this case, the relevant costs must be reflected in the budgeting and planning template. In addition, please indicate the programmatic areas for additional technical assistance needs and the respective agencies providing the technical assistance (if already identified) below.

Note 7

Technical support will be needed in the following areas:
- Social mobilization (PATH, UNICEF)
- Planning and preparation (WHO, PATH)
- Monitoring and supervision (WHO)
- Coverage Survey and PIE (PATH, WHO)

3.5 Strategic considerations

3.5.1 Rationale for this request

Describe the rationale for requesting these new programme(s), including the burden of disease. If already included in detail in the Vaccine Introduction Plan or Campaign Plan of Action, please cite the sections only.

Please refer to the Plan of Action which provides justification for the introduction of TCV in Zimbabwe

3.5.2 Alignment with country strategic multi-year plan / comprehensive multi-year plan (cMYP)

Please describe how the plans and key assumptions in this request align with the most recent country strategic multi-year plan (cMYP) and other national health and immunisation plans.

The current cMYP 2016-2020 has been revised to include Typhoid Conjugated Vaccine for 2020. However, drafting and finalizing the next cMYP for 2021-2025 will be conducted in 2019. This cMYP will be uploaded to the country documents/distributed to Gavi as soon as available.

3.5.3 Coordination Forum (ICC, HSCC or equivalent) and technical advisory committee (NITAG)

Provide a description of the roles of the national Coordination Forum (ICC, HSCC or equivalent body) and national immunization technical advisory group (NITAG) in developing this request.
If any of Gavi's requirements to ensure basic functionality of the relevant national Coordination Forum (ICC, HSCC or equivalent) were not met, please describe the reasons and the approach to address this. Requirements can be found in the general application guidelines.
In the absence of a NITAG, countries should clarify the role and functioning of the advisory group and describe plans to establish a NITAG.

The MOHCC provides policy formulation and guidance on all health issues in the country. The EPI works in collaboration with partners who are coordinated by the Inter Agency Coordinating Committee (ICC). The ICC has two main roles, that is, mobilizing resources and providing an independent oversight to EPI operations. There are several technical committees complementing the ICC one of which is the National Immunization Technical Advisory Group (NITAG). NITAG was established in 2011 to provide technical guidance on immunization policies including introduction of new vaccines and operational research among others. The NITAG's role is to issue a decision for new vaccine introduction based on current available disease burden data and country EPI priorities.

In summary, the ICC's role is to provide technical expertise on the following (see full ICC TOR attached with country documents):
1. Policies and strategies relating to vaccination in general and to vaccines for children as well as the rest of the population.
2. Introduction of new vaccines and new technologies and their impact on the health systems and immunisation program
3. Updated information on the safety and quality of vaccines and on the fight against diseases that could be avoided through the use of new vaccines
4. Any topics concerning vaccines and vaccination in general for which the Ministry requires

scientific and technical recommendations
For TCV introduction, the NITAG was tasked with deliberating on whether Zimbabwe should introduce TCV, and if so, what strategy should be employed to introduce TCV in the country, taking into account disease burden, TCV safety and immunogenicity profile, other EPI priorities, and EPI programmatic capacity sustainability, including financial aspects of introducing TCV. Given the regularly occurring outbreaks in Harare and the recent outbreak in Gweru, along with the option of Gavi support for a safe vaccine, the decision was made to move forward with TCV introduction.

Following this decision, the NITAG convened several technical working group (TWG) meetings, held in September 2017, December 2018 and January 2019, to conduct a thorough review process of available evidence to help inform the introduction strategy , including a critical appraisal of the evidence, grading the evidence, and coming up with policy recommendations. This process involved review and discussion of all available information to-date on disease burden data in country, the safety and immunogenicity of Bharat Biotech's TCV, other new vaccine introductions planned in the near term. Information was then put into a TCV Recommendation Framework and organized into four main areas for discussion with respect to Zimbabwe: vaccine characteristics; typhoid disease; economic and operational considerations; and health policy and programmatic issues. Through discussion of issues pertaining to these four main areas, the NITAG was able to put forth a strategy recommendation for ICC review, input and endorsement, to introduce TCV nationwide through catch-up campaigns in children 9 months to 15 years of age, and routine immunization at 9 months.

Governance The MOHCC provides policy formulation and guidance on all health issues in the country. The EPI works in collaboration with partners who are coordinated by the Inter Agency Coordinating Committee (ICC). The ICC has two main roles, that is, mobilizing resources and providing an independent oversight to EPI operations. There are several technical committees complementing the ICC one of which is the National Immunization Technical Advisory Group (NITAG). NITAG was established in 2011 to provide technical guidance on immunization policies including introduction of new vaccines and operational research among others. The NITAG's role is to issue a decision for new vaccine introduction based on current available disease burden data and country EPI priorities.

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2. Introduction of new vaccines and new technologies and their impact on the health systems and immunisation program
3. Updated information on the safety and quality of vaccines and on the fight against diseases that could be avoided through the use of new vaccines
4. Any topics concerning vaccines and vaccination in general for which the Ministry requires scientific and technical recommendations
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3.5.4 Financial sustainability

Please discuss the financing-related implications of the new vaccine programs requested, particularly how the government intends to fund the additional co-financing obligations. Please mention if any defaults occurred in the last three years and, if so, describe any mitigation measures that have been implemented to avoid future defaults. Additionally has the country taken into account future transition from Gavi support?

The country is aware of the co-financing obligation resulting from this planned introduction and is committed to meeting this over and above the existing co-financing for vaccines already introduced into the routine immunisation program. The funds for co-financing will be mobilised locally through treasury. The country has not defaulted in meeting co-financing obligation over the years, instead, has made significant improvement in raising funds through the health levy. The long term plan is for the country to be able to fund for procurement of traditional vaccines then gradual transition from Gavi support if the economic situation improves.

3.5.5 Programmatic challenges

Summarise programmatic challenges that need to be addressed to successfully implement the requested vaccine support, and describe plans for addressing those. These may include plans to address the barriers identified in the coverage and equity situation analysis section, and include vaccine supply chain, demand generation/ community mobilisation, data quality/ availability/ use and leadership, management and coordination, etc.

As described in the coverage and equity section, human resources/staffing shortages, data quality and reporting, and leadership and management coordination are all issues. Additionally, the EPI Program in Zimbabwe also faces lack of accountability and AEFI surveillance issues. Efforts will be made to address these concerns as follows:
Data quality and reporting:
As previously mentioned, shortages of paper supplies and printer toner, lack of properly working printers, and inconsistencies in reporting are challenges. Additional programmatic challenges include:
• Unavailability of data collection tools and/or tools are not updated because of lack of resources.
• Lack of coordination at national level, with too many registers leaving the health worker

overwhelmed.
• Inadequate capacity of health workers to analyse and use data.
• Power outages and internet interruptions which negatively affect data entry and submission.
• Unreliable denominators, as the population of the country has become highly mobile.
However, conditions concerning data quality and reporting are improving, with the most recent desk review reporting an increase in stable and long-serving Health Information Officers as well as the addition of M& E Officers deployed to provinces. Furthermore, a new HMIS Strategic Plan is under development, as is a new data quality improvement plan, and DHIS and been introduced to integrate data collection. These existing efforts will be built upon and strengthened through additional training and supportive supervision provided during TCV introduction, including:
• Improvement of the availability of data collection tools through drafting, printing and distributing updated vaccination cards and coverage tracking forms to health facilities.
• Monitoring timeliness and completeness of vaccine coverage reporting for all antigens during routine immunisation.
• Strengthening RED Strategy and use of vaccination coverage monitoring charts at all levels

AEFI Surveillance
In 2017, the country failed to meet the case reporting rate target of 10/100000 surviving infants. In addition, AEFIs were reported by only a few provinces, such as Harare, Bulawayo and Matabeleland North. There is need to ensure better representativeness of AEFI surveillance through follow ups after training and targeted support supervision. Also, the country has challenges in getting histology results after a post-mortem has been performed, so usually the Pharmacovigilance Committee relies on clinical/verbal autopsies for classification.
In order to address under-performance, the following actions have recently been put in place:
• Doctors at the district level were trained on conducting post-mortems in order to give objective results following post-mortems.
• The country has committees at district provincial and national level to manage AEFIs and to respond to any issues related to AEFIs.
• All staff at the implementation level were trained on how to manage and notify AEFIs, while committees at district, provincial and national levels were trained on investigating of AEFIs.
TCV introduction will build upon these existing efforts to ensure any AEFIs are properly identified, investigated, and responded to, as well as ensure the chain of reporting is properly followed. This will be included as part of training for introduction activities.

Linking VPD prevention with WASH activities:
The country faces a serious problem with the lack of clean drinking water. Poor WASH conditions are perpetuated by an increasing urban population using a water and sewer system designed for use by far fewer people, chronic underinvestment in the maintenance of water and sanitation infrastructure, and high cost of updating the system. Cross-contamination of water and sewage systems is common due to mixed systems of water-borne and pit latrines, as well as dug wells and piped water. Furthermore, distribution of free soap by Unicef has resulted in the soap being turned around and sold at markets. While efforts are being made in each province to address the lack of clean water and sanitation services, the percentage of GDP allocated to these services needs to be increased. Vaccination is only one intervention in a toolkit to reduce enteric infections such as typhoid, and it is only through WASH interventions and infrastructure improvement that sustainable prevention of enteric pathogens is achievable. Through TCV introduction, advocacy and communications will be a vital part of immunisation activities and involve partners such as Unicef, WHO and the MOHCC to develop effective messaging which targets preventing enteric disease through proper handwashing and sanitation practices. These messages will be integrated with any and all forms of social mobilization tools

and will be disseminated in a variety of outreach materials, including posters at schools and health facilities, banners at vaccination sites during catch-up campaigns, pamphlets, radio messages and integrated into tv spots. Emphasis will be placed on how typhoid is transmitted through the fecal oral route, and how proper WASH practices can help prevent disease.
Though it is recognized that soap, clean water and effective latrines are not always accessible, EPI will work with WASH counterparts in WHO and Unicef to integrate TCV into existing and future WASH initiatives and interventions, and align messaging with the country's Sanitation and Hygiene Policy. Current projects working toward improving WASH in Zimbabwe include:
• The Participatory Health and Hygiene Education (PHHE) initiative, where 432 sanitation action groups and 388 health clubs are being supported to provide hygiene messages to rural children and families in 45 districts.
• Village Pump Mechanics (VPMs) under the Rural Water, Sanitation and Hygiene (WASH) programme are being trained to repair broken boreholes to provide safe water.
• A Rural Wash Information Management System SMS Notification Response (RWIMS.SNR) project in Matabeleland South Province is being piloted to use mobile devices to track pump functionality of boreholes, water yields and water quality) in real time.
WASH efforts targeting school-based interventions will complement TCV introduction activities. Where possible, EPI and MOHCC will work with Unicef on the following:
• School assessments to make sure the number of children in school/learning programmes have access to 3 litres of water per child per day (for drinking and handwashing)
• Children have access to sanitation and hygiene kits (comprising soap, aqua tabs and IEC material, including information on TCV)

Human resources/staffing:
Every effort will be made to build human resource capacity in terms of providing health care workers and others involved in RI service delivery with adequate training and support in order to empower vaccinators with information to effectively communicate to caregivers regarding the benefits of vaccination as well as messaging on how typhoid is transmitted and prevented through other methods in addition to vaccination. Training and communication efforts will build upon lessons learned from previous vaccine introductions.

3.5.6 Improving coverage and equity of routine immunisation

Explain how the proposed NVS support will be used to improve the coverage and equity of routine immunisation, by detailing the proposed activities and budget will contribute to overcoming key barriers.

Though routine vaccination coverage in Zimbabwe is high overall, the requested support from Gavi would enable EPI to reinforce its existing strategy to reach underserved communities, especially that "last 10%" who are routinely missed. Through this support, monitoring and supportive supervision capacities of the programme will be enhanced at all levels, which will strengthen program management. The training imparted to the health workers for TCV introduction will enhance program performance for antigens beyond TCV, as aspects of the trainings will reinforce general aspects of vaccine service delivery, such as administration and waste management. Through effectively planned social mobilization activities, TCV will support RI in demand generation at grassroot level. Involving local community influencers and religious leaders will also enhance knowledge of the community regarding immunization overall. Dissemination of information on importance of vaccines will improve the community trust. A comprehensive PIE planned following introduction will go beyond evaluating coverage to

highlight equity-related barriers and facilitators, and build upon existing initiatives and programs in place to build community awareness and engagement in VPDs.
Findings from a Vaccination Acceptability Assessment in 2015 state that caregivers generally associated vaccination with 'disease' but had no clear perception of the specific disease(s). They understood vaccination as merely 'injections' and lacked the confidence to ask health workers for further information. Without this information, caregivers will not fully understand the risks of missing/skipping vaccines in the child vaccination schedule. Alternately, those who accepted vaccines emphasized the benefits of vaccination in terms of preventing vaccine-preventable diseases. Findings from the recent KAP survey will show if these perceptions and beliefs have changed in recent years as new vaccines have been added to childhood immunization and there has been an increased focus and effort on educating caregivers around VPDs and the benefits of vaccination. These findings will help guide advocacy and communication materials for TCV introduction.

Below is more detail on strategic areas for improving coverage equity of routine immunisation
Microplanning:
Microplans developed during the preparation of the introduction will identify routinely underserved populations and will be used by the EPI programme to target these communities and ensure equitable distribution of resources.
Outreach to rural and underserved areas:
• Set up outreach points at major markets and vending sites for both catch-up campaigns and during routine immunisation.
• Prioritise allocation of resources to districts with hard to reach populations by distance and geographical barriers, e.g. add more people in teams, more vaccination teams and vehicles.
• Engage motorized Environment Health Technicians (EHTs) to identify new points to reach caregivers.
• Engage village health workers, school leadership, and community-based workers to sensitise, mobilise and follow-up with caregivers to increase vaccination coverage.
Outreach to religious and faith-based groups:
To address this issue, women who fear being seen accessing modern health services and having their children vaccinated are attended by health workers in rooms and spaces that offer privacy. In addition, health workers have addressed this issue by holding flexible opening hours for religious objectors seeking medical care and vaccination. Continuing to engage community and faith leaders and strengthening their knowledge about the benefits of vaccination will improve vaccine acceptability. When provided with information on vaccines and the benefits of vaccination, religious leaders express support for child vaccination. Experience gained in the engagement and use of GAVI HSS funded community dialogue in creating demand will be adapted and employed in the TCV vaccination program. There will also be continuing efforts to reach out to hesitant faith groups through their leaders using the NVS. The constitution has recently been adjusted to clarify that children cannot be denied vaccination due to parents' faith.
• Engage and involve religious leaders in planning and implementation of the campaign. Health facility and district micro-planning process to continue with engagement and involvement of these leaders to strengthen RI.
• Provide routine vaccination services at agreed places, e.g. religious gathering areas during convenient times.
Outreach to minority groups:
Minority nomadic ethnic groups-Khoisan in Tsholotsho district in Mat North & Bulilima district in Mat South as well as Doma in Mbire District of Mash Central Province will be reached according to the following:

• Identify and map their locations during microplanning for catch-up campaigns.
• Engage the leaders and involve them in the planning process to reach the community; the engagement process will continue to cater for routine immunisation.
• Identify members from this group to be part of mobilisation and vaccination teams.
• Develop IEC materials, radio and TV productions in local languages.
• Use known and appropriate channels (with help of traditional/local leaders) of communication to reach them.

3.5.7 Synergies

Describe potential synergies across planned introductions or campaigns. If relevant, comment on capacity and appropriate systems to introduce multiple vaccines in a year. Also describe how the country will mitigate any programmatic and financial risks associated with multiple introductions.

Note 8

One major synergy is to build upon the TCV emergency response efforts planned for Q1 2019 in 8 suburbs of Harare. Though this would be about a year prior to TCV catch-up campaigns and the introduction of TCV into RI, lessons learned with regard to training, social mobilization and other applicable activities will be useful to help tailor materials and communication strategies to scale-up for national introduction.

HPV second-dose will be rolled out in Q2 2019, as well as IPV and MR campaigns, which will be conducted in Q3.

3.5.8 Chosen Immunisation Strategy

Please provide an explanation of the chosen immunisation strategy (routine only versus routine and catch-up) and the target age of vaccination; if this information is provided in the NVIP / POA, please cite sections only.

Please refer to the "Rationale for the Introduction of TCV" section in the Plan of Action

3.5.9 Risk-Based or Phasing and Explanation

Will a risk based or phased introduction approach be adopted?

Yes☐ No☒

If a risk-based or phased approach will be adopted, please provide an explanation for this approach, if this information is provided in the NVIP / POA, please cite sections only.

N/A

3.6 Report on Grant Performance Framework

3.6.1 Grant Performance Framework – Application Instructions

The Grant Performance Framework (GPF) contains all indicators that will be used to monitor programmatic performance for your requested type of support. Targets that were entered for number to be vaccinated in section 3 on the Target Information tab, have been carried over into their respective indicators in the GPF. Based on these numbers, coverage and dropout rate targets were calculated (where applicable). These appear as “calculated targets”. If you wish to revise these target values, please revise in the application form – they are not editable in the performance framework. In addition, as a part of your application, there are several items to be filled directly into the GPF. These are broken into required and optional items, below:

Required
1. In addition to the calculated targets, country targets are required to be submitted for outcome indicators. These targets should align to those in your cMYP or NHSP. If these targets are not in your cMYP or NHSP, or are the same as the calculated targets, please enter “NA” for each target value.
2. Additional indicators that appear in the Performance Framework that are not included in the application form. Please enter targets for these indicators.
3. For many indicators, reporting dates have been pre-populated. For those that have not yet been pre-populated, please add reporting dates.

Optional
1. Adding data sources to existing indicators: If there are data sources for indicators that you would like to include, you may add an additional source by clicking on the pencil icon next to the indicator name.
2. Adding new indicators: Gavi requires all countries to report on core indicators, which are already included in the GPF. If you wish to add supplemental indicators to monitor performance, you may do so by clicking the “Add indicator” button at the respective performance level (Outcome, Intermediate Result, or Process).

Please note that the GPF is filtered by default to only show indicators that are relevant to the specific types of support contained in the application. You may view the entire GPF by using the “Grant Status” filter. Please ensure your pop-up blocker is disabled when launching the GPF.

If you have any questions, please send an email to countryportal@gavi.org.

3.7 Upload new application documents

3.7.1 Upload new application documents

Below is the list of **application specific documents** that must be provided with your application.

In the case a document cannot be provided, please use the comment box to explain why, or by when it will be available.

Application documents

✓	**New vaccine introduction plan (NVIP) and/or campaign plan of action (PoA), including checklist & activity list and timeline** If support for a campaign and routine introduction is requested at the same time, the new vaccine introduction plan and campaign plan of action can be combined into one document to minimise duplication.	ZimTCV Plan of ActionFinal27January2019_01-02-19_17.30.27.docx
✓	**Gavi budgeting and planning template**	ZimTCVBudgeting and Planning Template25 Jan2019_01-02-19_17.31.04.xlsm
	Most recent assessment of burden of relevant disease If not already included in detail in the Introduction Plan or Plan of Action.	**No file uploaded**
✓	**Campaign target population (if applicable)**	Typhoid population projections 9munder 15 yrs2020_01-02-19_17.44.04.xlsx

Endorsement by coordination and advisory groups

✓	**National coordination forum meeting minutes, with endorsement of application, and including signatures**	ICC letter to Gavi TCV Planning endorsement final_01-02-19_17.46.54.docx

NITAG meeting minutes

with specific recommendations on the NVS introduction or campaign

ZIMNITAG MINUTES6 sept 201810091819.59.53_18-01-19_15.51.47.docx

Technical Dossier NITAG_Typhoid Conjugate Vaccine recommendation_18-01-19_15.51.20.doc

MINUTES OF THE ZIMNITAG_TYPHOID CONJUGATE VACCINE AND TETANUS TECHNICAL WORKING GROUPS MEETING HELD AT THE CENTRAL VACCINE STORES BOARDROOM ON 20TH NOVEMBER 2018_18-01-19_15.50.04.docx

Other documents

Other documents (optional) **No file uploaded**

4 Review and submit application

4.1 Submission Details

Country vaccine funding summary

Please review the estimated projections for new vaccine programmes included in this application.

Please note that co-financing projections for existing programs will be provided offline.

New Vaccine Programme Support Requested

Total country co-financing (US$)
Total Gavi support (US$)
Total value (US$) (Gavi + Country co-financing)

Contacts

Person(s) who should be contacted in case Gavi needs to ask for more information in regard to the application.

Name	Position	Phone Number	Email	Organisation
Joan Marembo	EPI Manager	+263772935466	jmarembo@gmail.com	
Dr Portia Manangazira	Director Epidemiology & Disease Control	+263773711060	directoredc@gmail.com	

Comments

Please let us know if you have any comments about this application

No comments

Government signature form

The Government of Zimbabwe would like to expand the existing partnership with Gavi for the improvement of the immunisation programme of the country, and specifically hereby requests Gavi support for:

Typhoid conjugate vaccine routine, with catch-up campaign

The Government of Zimbabwe commits itself to developing national immunisation services on a sustainable basis in accordance with the national health and immunisation strategic plans. The Government requests that Gavi and its partners contribute financial and technical assistance to support immunisation of children as outlined in this application.

The co-financing commitments in this application include the amount of support in either supplies or cash that is requested from Gavi, and the financial commitment of the Government for the procurement of this new vaccine.

Please note that Gavi will not review this application without the signatures of both the Minister of Health and Minister of Finance (and Minister of Education, if applicable) or their delegated authority.

We, the undersigned, affirm that the objectives and activities in this request are fully aligned with the national health and immunisation strategic plans (or equivalent), and that funds for implementing all activities, including domestic funds and any needed vaccine co-financing will be included in the annual budget of the Ministry of Health.

We, the undersigned, further affirm that the requested funding for salaries, salary top-ups/allowances, per diems and incentives does not duplicate funding from other sources (e.g. from other donors).

We, the undersigned, further affirm that the terms and conditions of the Partnership Framework Agreement between Gavi and the Country remain in full effect and shall apply to any and all Gavi support made pursuant to this application.[1]

Minister of Health (or delegated authority)	**Minister of Finance (or delegated authority)**
Name	Name
Date	Date
Signature	Signature

For countries requesting HPV support, with a school linked strategy, the signature of the Minister of Education (or delegated authority) is also required.

Minister of Education (or delegated authority)

Name

Date

Signature

[1] *In the event the Country has not yet executed a Partnership Framework Agreement, the terms and conditions of this application shall apply to any and all Gavi support made pursuant to this application.*

Appendix

NOTE 1
The new cMYP must be uploaded in the country document section.

NOTE 2
* For more information on the vaccine presentations available, please refer to the detailed product profiles available here: http://www.gavi.org/library/gavi-documents/supply-procurement/detailed-product-profiles/

* Please note Gavi may not be in a position to accommodate all countries first product preferences. In such cases, Gavi will contact the country and partners to explore options.

* Due to a variety of factors, the launch date may vary compared to the date stipulated in the application. Gavi will work closely with countries and their partners to address these issues.

* For routine vaccine introduction, support is usually requested until the end of the country's valid cMYP, as per the guidelines and may be extended in the future. If you wish to request Gavi support for a shorter time period than the end of your cMYP you may do so.

* For campaigns the "support requested until" field will normally be one calendar year from the launch date, but can be extended for a phased campaign.

NOTE 3
* The population in the target age cohort represents 100% of people in the specified age range in your country.

* The target population to be vaccinated is the number of people in the cohort that are expected to be vaccinated.

* For indicative wastage rates, please refer to the detailed product profiles available here: http://www.gavi.org/about/market-shaping/detailed-product-profiles/

* The wastage rate applies to first and last dose.

NOTE 4
* The target population to be vaccinated is the number of people in the cohort that are expected to be vaccinated.

* For indicative wastage rates, please refer to the detailed product profiles available here: http://www.gavi.org/library/gavi-documents/supply-procurement/detailed-product-profiles/

NOTE 5

Co-financing requirements are specified in the guidelines.

NOTE 6

Note: The population in the target age cohort used here is the number you entered for year one in the target information section.

NOTE 7

A list of potential technical assistance activities in each programmatic area is available here: http://www.gavi.org/support/pef/targeted-country-assistance/

NOTE 8

E.g. if two introductions are planned in the same year, there should be synergies at least in training and social mobilisation events.