

## TANZANIA

### 2018 Programme Support Rationale

Strategic period (2019-2023)

The Programme Support Rationale (PSR) presents the rationale and objectives for the programming of Gavi support for the upcoming period, and - together with the online vaccine application(s) mentioned below - replaces the previous application forms used to request new support.

- The PSR is developed approximately once every five years based on and in alignment with the national health and immunisation strategic plan(s) and budgets.
- It incorporates the Joint Appraisal in the year of its review.
- **Stock levels and requests for vaccine renewals or product switches need to be reported on the Gavi Country Portal between late March and 15 May.**
- All required reporting has to be submitted on the country portal, as per the reporting guidelines.
- The PSR builds on robust analysis of country data and evidence of progress made (or persistent challenges) on the coverage and equity situation.
- In parallel to the PSR, the Gavi budgeting and planning template and Gavi grant performance framework (GPF) are completed to complement the objectives presented in the PSR. This should be reflected in the country's own operational budget and workplan.
- The Coordination Forum (ICC, HSCC or equivalent body) is required to endorse the PSR prior to final submission to Gavi.
- Signatures of both the Minister of Health and Minister of Finance or their delegated authority are required to endorse the final PSR before submission to Gavi.
- The PSR will be reviewed by members of the independent review committee (IRC) who will make a recommendation to Gavi on the full portfolio of support for the duration of the PSR, including any current support that needs to be renewed.
- Following the independent review there will be a period for countries to respond to any 'issues to be addressed' ahead of final Gavi approval and disbursement.
- **It is recommended that this process be initiated 15-18 months prior to expected grant disbursement.**
- **Vaccine applications are developed via Gavi's online country portal and submitted for review and approval 15 to 18 months before the planned vaccine launch or campaign.**
- On an annual basis, the budget will be reviewed and updated to take into account implementation progress and any new information from the joint appraisal.



Visit Gavi's website (<http://www.gavi.org/support/process/apply/>) for available programmatic and process guidance to support the development of the PSR and vaccine applications. For a **list of mandatory documents** to be submitted together with this PSR, please refer to Annex 1 of the Application guidelines.

## Abbreviations

AEFI	Adverse Effects Following Immunisation
C4D	Communication for Development
CCE	Cold Chain Equipment
CCEOP	Cold Chain Equipment Optimisation Platform
CCHP	Comprehensive Council Health Plan
CCIT	Cold Chain Inventory Tool
CHAI	Clinton Health Access Initiative
CHMT	Council Health management Team
CHW	Community Health Worker
cMYP	Comprehensive Multi-Year Plan
CSO	Civil Society Organisation
CVS	Central Vaccine Store
DHFF	Direct Health Facility Financing
DIVO	District Immunisation and Vaccines Officer
DQA	Data Quality Audit
DQS	Data Quality self-Assessment
DRCHCO	District Reproductive and Child Health Coordinator
DVDMT	District Vaccine Data Management Tool
DVS	District Vaccine Store
EIS	Electronic Immunisation System
EPI	Expanded Programme on Immunisation
EVMA	Effective Vaccine Management Assessment
GoT	Government of Tanzania
GPF	Grant performance Framework
HMIS	Health Management Information System
HPV	Human Papilloma Virus
HSS	Health Systems Strengthening
HSSP	Health Sector Strategic Plan
ICC	Interagency Coordination Committee
IPV	Inactivated Polio Vaccine
IVD	Immunisation and Vaccine Development
JRF	Joint Report Form
JSI	John Snow Inc.
LGA	Local Government Authorities
MDG	Millennium Development Goal
MCSP	Maternal and Child Survival Programme
MICS	Multiple Indicator Cluster Survey
MLM	Middle Level Management
MoF&P	Ministry of Finance and Planning
MoH	Ministry of Health
MOHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
MoU	Memorandum of Understanding
MR	Measles Rubella
NITAG	National Immunisation Technical Advisory Group
NGO	Non-Governmental Organisation
PBF	Performance Based Financing
PCA	Programme Capacity Assessment
PIRI	Periodic Intensification of Routine Immunisation
PO-RALG	President's Office-Regional Administration and Local Government
PS	Permanent Secretary
PSE	Preservice [Training]
REC	Reaching Every Child
RHMT	Regional Health Management Team
RIVO	Regional Immunisation and Vaccines Officer
RMNCHA	Reproductive, Maternal, Newborn and Child Health and Adolescents
RMOs	Regional Medical Officers
RRCHCOs	Regional Reproductive and Child Health Coordinator
RVS	Regional Vaccine Store
SARA	Service Availability and Readiness Assessment
SBCC	Social and Behavioural Change and communication
SMT	Stock Management Tool
SOPs	Standard Operating Procedures

TDHS	Tanzania Demographic and Health Survey
ToR	Terms of Reference
ToT	Training of Trainers
TWG	Technical Working Group
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VIG	Vaccine Introduction Grant
VPD	Vaccine Preventable Diseases
VIMS	Vaccination Immunisation System
WHO	World Health Organisation

## Part A: Overview of portfolio of support

All grey boxes to be pre-filled by the Gavi Secretariat  
 All white boxes to be filled by Country

### 1. Vaccines: Projected country co-financing and Gavi support requested for current and new Gavi-funded vaccines

#### 1.1 Co-financing for current Gavi-funded vaccines

Programme and type of support		Estimated projections <sup>1</sup>				
		2019	2020	2021	2022	2023
Pentavalent routine	Country co-financing (US\$)	1,522,542 \$	1,478,700\$	501,508 \$	588,607 \$	691,026 \$
	Gavi support (US\$)	3,950,000\$	4,080,500\$	4,991,586 \$	5,017,572 \$	5,032,159 \$
Pneumococcal routine	Country co-financing (US\$)	1,418,087 \$	1,324,760 \$	2,246,072 \$	2,636,781 \$	3,095,573 \$
	Gavi support (US\$)	23,154,500 \$	22,739,000 \$	20,566,244 \$	20,650,668 \$	20,677,811 \$
Rotavirus routine	Country co-financing (US\$)	879,600\$	834,600\$	933,228 \$	1,095,566 \$	1,286,191 \$
	Gavi support (US\$)	8,257,500\$	7,835,000\$	8,669,457 \$	8,707,124 \$	8,721,050 \$
Measles Rubella routine	Country co-financing (US\$)	888,409 \$				
	Gavi support (US\$)	825,000 \$				
IPV routine	Country co-financing (US\$)	n/a	n/a	n/a	n/a	n/a
	Gavi support (US\$)	4,674,834 \$	4,879,485 \$	4,980,487 \$	5,084,131 \$	5,190,180 \$
HPV routine	Country co-financing (US\$)	290,822 \$	296,028 \$	551,322 \$	619,493 \$	695,034 \$
	Gavi support (US\$)	6,319,000 \$	6,489,500 \$	5,044,323 \$	4,847,938 \$	4,638,992 \$
a) Total Country co-financing for current vaccines (US\$)		<b>4,999,460\$</b>	<b>3,934,088\$</b>	<b>4,232,130\$</b>	<b>4,940,447\$</b>	<b>5,767,824\$</b>
b) Total Gavi support for current vaccines (US\$)		<b>47,180,834\$</b>	<b>46,023,485\$</b>	<b>44,252,097\$</b>	<b>44,307,433\$</b>	<b>44,260,192\$</b>
c) Total cost of current vaccines (a+b) (US\$)		<b>52,180,294 \$</b>	<b>49,957,573 \$</b>	<b>48,484,227 \$</b>	<b>49,247,880 \$</b>	<b>50,028,016 \$</b>

#### 1.2 Vaccine presentation and implementation dates: Country to complete all columns for each new vaccine introduction and campaign planned over the duration of the PSR and for which the country seeks support.

Programme and type of support	Preferred presentation <sup>2</sup>	Target submission date of request	Desired date for vaccines to arrive	Planned launch date	Support requested until <sup>3</sup>

<sup>1</sup> These estimates provide visibility to the total funding needs that a country should plan to complement the Gavi financing. These estimates are projections and may differ from actual commitments, which are calculated year-by-year and reflected in Gavi decision letters. The source of these estimates are the latest input received from country, with adjustments performed by the Gavi Secretariat (eg price updates, supply constraints, etc.)

<sup>2</sup> For vaccine presentations, please refer to the detailed product profiles available here: <https://www.gavi.org/about/market-shaping/detailed-product-profiles/>

<sup>3</sup>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 the same or one calendar year from the launch date, but can be extended for a phased campaign.

### 1.3 New vaccine support to be requested:

For types of vaccine support and guidelines, please refer to

<http://www.gavi.org/support/process/apply/vaccine/>

Programme and type of support	Year	Year 1	Year 2	Year 3	Year 4	Year 5
<b>[Type of support 1]</b> (e.g. Measles second dose routine)	Population in the target age cohort (#)	#	#	#	#	#
	Target population to be vaccinated (first or only dose) (#)	#	#	#	#	#
	Target population for last dose (#)	#	#	#	#	#
	Estimated wastage rates <sup>4</sup>	%	%	%	%	%
	Country co-financing (US\$)	\$	\$	\$	\$	\$
	Gavi support (US\$)	\$	\$	\$	\$	\$
<b>[Type of support 2]</b> (e.g. Meningitis A routine)	Population in the target age cohort (#)	#	#	#	#	#
	Target population to be vaccinated (first or only dose) (#)	#	#	#	#	#
	Target population for last dose (#)	#	#	#	#	#
	Estimated wastage rates	%	%	%	%	%
	Country co-financing (US\$)	\$	\$	\$	\$	\$
	Gavi support (US\$)	\$	\$	\$	\$	\$
d) Total Country co-financing for new vaccines requested (US\$)	\$	\$	\$	\$	\$	\$
e) Total Gavi support for new vaccines requested (US\$)	\$	\$	\$	\$	\$	\$
f) Total cost of new vaccines requested (a+b) (US\$)	\$	\$	\$	\$	\$	\$

### 1.4 Total cost and co-financing summary for vaccine support

a) Total Country co-financing for current and new vaccines requested (a+d) (US\$)	4,999,460\$	3,934,088\$	4,232,130\$	4,940,447\$	5,767,824\$
Total Gavi support for current and new vaccines requested (b+e) (US\$)	47,180,834\$	46,023,485\$	44,252,097\$	44,307,433\$	44,260,192\$
Total cost of current and new vaccines requested (g+h) (US\$)	52,180,294 \$	49,957,573 \$	48,484,227 \$	49,247,880 \$	50,028,016 \$

**1.5 Request for vaccine presentation switches<sup>5</sup> for current support (if applicable)<sup>6</sup>:** Please note that this requires further documentation containing cold chain capacity, stock levels of the current product, and a costed activity plan (to be submitted via the Country Portal, here: <http://www.gavi.org/support/process/country-portal/> in the Supporting Documents section).

Current presentation	Desired new presentation	Desired switch month and year	Rationale for the switch in presentation including any anticipated impact on coverage and equity	Do you request a product switch grant in the vaccine renewal request on the country portal?

<sup>4</sup> For indicative wastage rates for preferred presentations (%), please refer to the detailed product profiles available here: <https://www.gavi.org/about/market-shaping/detailed-product-profiles/>

<sup>5</sup> Gavi aims to meet country's preferences on vaccine presentation to the extent possible. When there is not enough supply of a desired product to meet country demand, Gavi will consider the rationale for the switch in order to prioritise supply between countries.

<sup>6</sup> For a detailed description of the vaccine product profiles, please see here: <https://www.gavi.org/about/market-shaping/detailed-product-profiles/>

## 2 Financial support requested

### 2.1 Country health and immunisation data and national health planning and budgeting cycle Country to complete table below

Country health and immunisation data- All figures in US\$	2017 (Mainland Tanzania)	2017 (Zanzibar)	2018 (Mainland Tanzania)	2018 (Zanzibar)
Total government expenditures (past year)	\$6,434,014,295.00	\$299,878,274	Not applicable	Not applicable
Total government health expenditures (past year)	\$795,321,637	\$5,591,035	Not applicable	Not applicable
Immunisation budget (past & current year)	14,785,650	s\$477,944	15,000,000 <sup>7</sup>	\$679,832.467

### 2.2 National health planning and budgeting cycle, and national planning cycle for immunisation

National cycles <sup>8</sup>	From	To
Years of National Health Strategic Plan IV (HSSP IV)	2015	2020
Years of immunisation strategy (e.g. cMYP)	2016	2020
Start and end dates of fiscal period	July	June

### 2.3 Currently active Gavi financial support (only grants already approved but not yet closed) Entire table prefilled by Gavi Sec (PO)

Type of support	Amount committed	Amount approved	Amount disbursed	Year(s) of support
HSS1	\$13,512,765	\$13,343,575	\$11,343,575	2014-2018
IPV VIG	\$1,599,000	\$1,599,000	\$1,599,000	2017-2019

<sup>7</sup> Estimate for the financial year 2018/2019.

<sup>8</sup>The years of the cMYP and the fiscal period for Zanzibar and mainland Tanzania are the same.

**2.4 New financial support requested:** Country to complete table below. For all types of vaccine support and guidelines, please refer to: <http://www.gavi.org/support/process/apply/>

Target start and end date for financial support:	Month & year January 2019					
Please note the country's total HSS ceiling for the coming 5 years <sup>9</sup> : (US\$ ceiling amount)	Indicative estimates					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
<b>Health Systems Strengthening support (HSS)</b>						
1. To improve access, quality and utilisation of immunisation and other RMNCHA services with a focus on populations systematically missed.	2,917,696	1,686,801	1,702,701	1,811,241	970,021	9,088,460
2. To improve immunisation supply chain and efficiency to 90% or above by 2023.	63,182	11,037,170	564,019	280,518	223,242	12,168,129
3. To improve data management and utilisation at all levels.	2,481,963	1,397,973	2,099,880	1,210,437	252,523	7,442,775
4. To strengthen leadership, management and coordination to improve governance and financial sustainability for better immunization outcomes by 2023.	1,762,672	2,959,125	1,905,202	1,214,193	1,196,212	9,037,404
5. To improve community participation and utilization of immunization services particularly in rural, urban slums and hard to reach areas by 2023.	471,401	360,933	471,401	347,545	458,013	2,109,293
<b>Total HSS (US\$)</b>	<b>7,696,912</b>	<b>17,442,001</b>	<b>6,743,203</b>	<b>4,863,934</b>	<b>3,100,010</b>	<b>39,846,061</b>

**2.5 Data verification option for calculating HSS/Performance Based Funding (PBF) payments**

Country to indicate one data verification mechanism among the proposed ones (please mark with an "X" in the relevant box. Please note that the selected option will be utilized for the whole duration of the HSS grant.

Use of country admin data	X	Use of WHO/UNICEF estimates	...	Use of surveys	...
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<sup>9</sup> If circumstances warrant, and the source of the CCEOP country joint-investment is Gavi HSS, this amount should be deducted from the HSS ceiling.

## Part B: Country immunization system analysis & past performance review

**Part B replaces the Joint Appraisal for this year and reviews the performance of the immunisation system**, including a thorough analysis of immunisation coverage and equity and any constraints to improving sustainable and equitable coverage. It should focus on the evolution/trends observed over the past two to three years and particularly on changes since the last Joint Appraisal took place.

Information in this section will substantially draw from the recommended analysis on coverage and equity and other relevant programme aspects which can be found in the **Joint Appraisal analysis Guidance** (<http://www.gavi.org/support/process/apply/report-renew/>).

This section also describes the progress in grant implementation and improvements in the immunisation system. By complementing the data as reported via the country portal (e.g. the updated grant performance framework, financial reports, data quality assessment etc.), this section explains over and under achievement of goals and targets, associated implementation challenges and key lessons from the past reporting period.

→ **This section is the basis for the identification of objectives, to be defined in Section D on future programming**

### 3. Coverage & equity situation

**Describe national and sub-national evidence on the coverage and equity of immunisation in the country and constraints to improvement.** In tables 3.1 and 3.2, identify trends in coverage and equity, across geographical areas, economic status, populations and communities, including urban slums, remote rural settings and conflict settings (consider population groups under-served by health systems, such as slum dwellers, nomads, ethnic or religious minorities, refugees, internally displaced populations or other mobile and migrant groups). Relevant information includes: overview of districts/communities which have the lowest coverage rates, the highest number of under-vaccinated children, disease burden: number and incidence of vaccine preventable diseases (VPD) cases as reported in surveillance systems in regions/districts, etc.

**Among data sources available, consider** administrative data, coverage surveys, DHS/MICS, equity analyses, Knowledge-Attitude-Practice surveys, and patterns of diseases like measles. Please clearly reference the source(s) of the data used in this section.

→ **This section is key to determine the target geographies and/or population groups for prioritising interventions**

→ **Provide any relevant trend analysis or additional evidence available.**

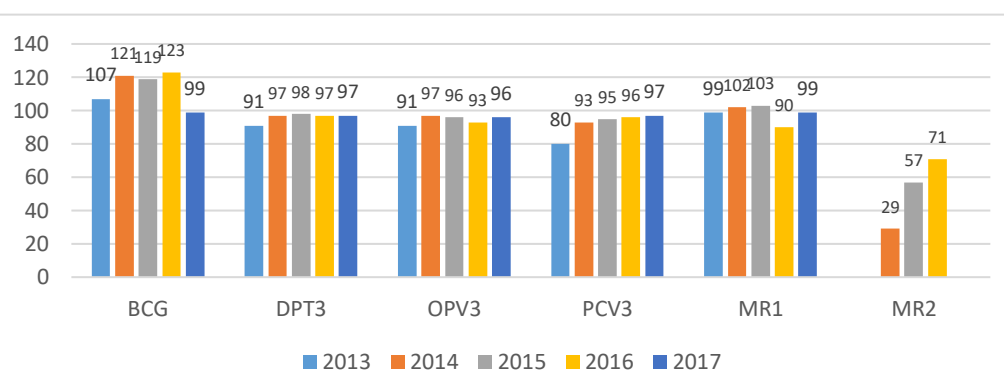
→ **Please also refer to the Guidance on gender related barriers to immunisation** (<https://www.gavi.org/support/process/apply/additional-guidance/#gender>)

#### 3.1 At the national level: (Include data source & year for each)

Coverage:  
DTP3, MCV2, etc.

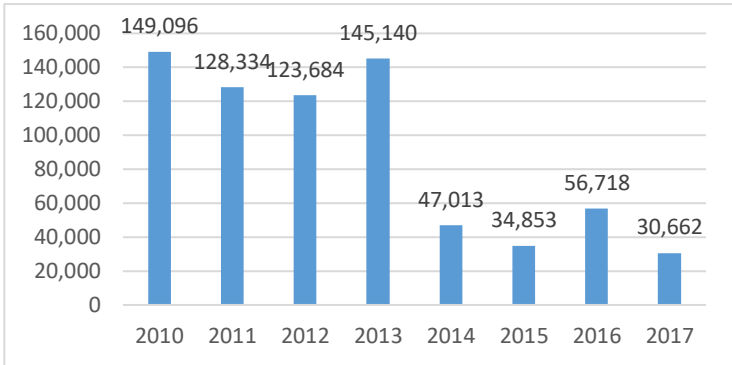
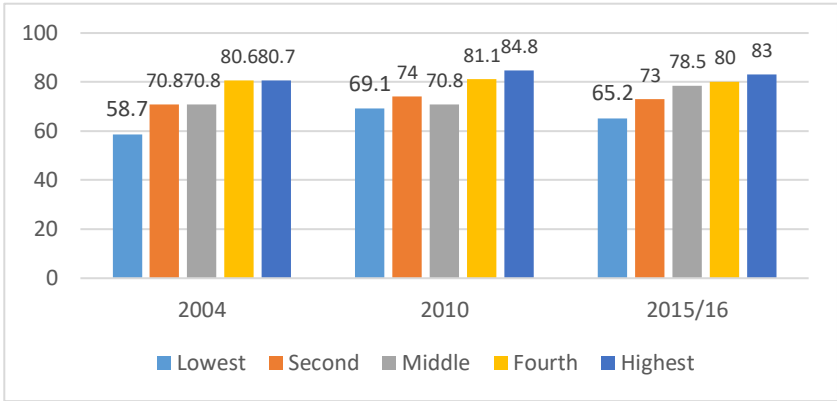
**Trends in vaccination coverage by antigen:** Over the last 5 years, immunization coverage in Tanzania has been above 90% for all antigens except MR2 (Table 3.1.1) based on routine immunisation data.

**Figure 3.1.1: Immunisation coverage in Tanzania 2013-2017<sup>10</sup>**



<sup>10</sup>Tanzania JRF reports 2013-2017



	<p>Coverage for PCV3 and Rota2 were &lt;90% in 2013 because they were just introduced in the same year. Coverage, however, for these 2 antigens picked up in 2014. The TDHS also measures progress in immunisation coverage: in 1999, the proportion of children aged 12-23 months who were fully immunised was at 68% rising to 71%, 75% and 75% in 2004, 2010 and 2015/2016, respectively<sup>11</sup>. The TDHS also demonstrates that only about 50% of the children aged 12-23 months are fully vaccinated by 12 months<sup>12</sup>.</p>																								
<p>Coverage: <b>Absolute numbers of un- or under-immunised children</b></p>	<p><b>Absolute numbers of unvaccinated children in Tanzania:</b> Figure 3.1.2 shows the number of unvaccinated children in Tanzania over the period 2010-2017.</p> <p><b>Figure 3.1.2: Trends in unimmunised children in Tanzania</b></p>  <table border="1"> <thead> <tr> <th>Year</th> <th>Number of unimmunised children</th> </tr> </thead> <tbody> <tr> <td>2010</td> <td>149,096</td> </tr> <tr> <td>2011</td> <td>128,334</td> </tr> <tr> <td>2012</td> <td>123,684</td> </tr> <tr> <td>2013</td> <td>145,140</td> </tr> <tr> <td>2014</td> <td>47,013</td> </tr> <tr> <td>2015</td> <td>34,853</td> </tr> <tr> <td>2016</td> <td>56,718</td> </tr> <tr> <td>2017</td> <td>30,662</td> </tr> </tbody> </table> <p>Figure 3.1.2 shows that the number of unvaccinated children in Tanzania has been going down with an exception of 2013 when it rose from 123,342 in 2012 to 145,013 before going down to 47,013 in 2014<sup>13</sup>. The TDHS also shows that the proportion of unvaccinated children has been decreasing from 4% in 2004 to 2% in 2010 and 2015/2016<sup>14</sup>.</p>	Year	Number of unimmunised children	2010	149,096	2011	128,334	2012	123,684	2013	145,140	2014	47,013	2015	34,853	2016	56,718	2017	30,662						
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<p>Equity:</p> <ul style="list-style-type: none"> <li>• <b>Wealth (e.g. high/low quintiles)</b></li> <li>• <b>Education (e.g. un/educated)</b></li> <li>• <b>Gender</b></li> <li>• <b>Urban-rural</b></li> <li>• <b>Cultural, other systematically marginalised groups or communities e.g. from ethnic religious minorities, children of female caretakers with low socioeconomic status, etc.</b></li> </ul>	<p><b>Trends in vaccination coverage by wealth status:</b> Figure 3.1.3 shows that immunisation coverage increases the higher the wealth quintile. Between 2004 and 2016, there was not much change in the 4<sup>th</sup> and highest quintile but there was a significant increase in the proportion of children who were vaccinated in the 3 lowest quintiles e.g. an 8-percentage and 6-percentage points increase in the lowest and middle quintiles.</p> <p><b>Figure 3.1.3: Proportion of children aged 12-23 months fully vaccinated by wealth quintile<sup>15</sup></b></p>  <table border="1"> <thead> <tr> <th>Year</th> <th>Lowest</th> <th>Second</th> <th>Middle</th> <th>Fourth</th> <th>Highest</th> </tr> </thead> <tbody> <tr> <td>2004</td> <td>58.7</td> <td>70.8</td> <td>70.8</td> <td>80.7</td> <td>80.7</td> </tr> <tr> <td>2010</td> <td>69.1</td> <td>74</td> <td>70.8</td> <td>81.1</td> <td>84.8</td> </tr> <tr> <td>2015/16</td> <td>65.2</td> <td>73</td> <td>78.5</td> <td>80</td> <td>83</td> </tr> </tbody> </table> <p>Among those in the 4<sup>th</sup> quintile, there was no change in coverage while among those in the highest quintile; there was an increase between 2004 and 2010. Between 2010 and</p>	Year	Lowest	Second	Middle	Fourth	Highest	2004	58.7	70.8	70.8	80.7	80.7	2010	69.1	74	70.8	81.1	84.8	2015/16	65.2	73	78.5	80	83
Year	Lowest	Second	Middle	Fourth	Highest																				
2004	58.7	70.8	70.8	80.7	80.7																				
2010	69.1	74	70.8	81.1	84.8																				
2015/16	65.2	73	78.5	80	83																				

<sup>11</sup>TDHS 2015/2016, Page 95.

<sup>12</sup>TDHS 2015/2016, Page 206.

<sup>13</sup>Tanzania JRF reports 2013-2017.

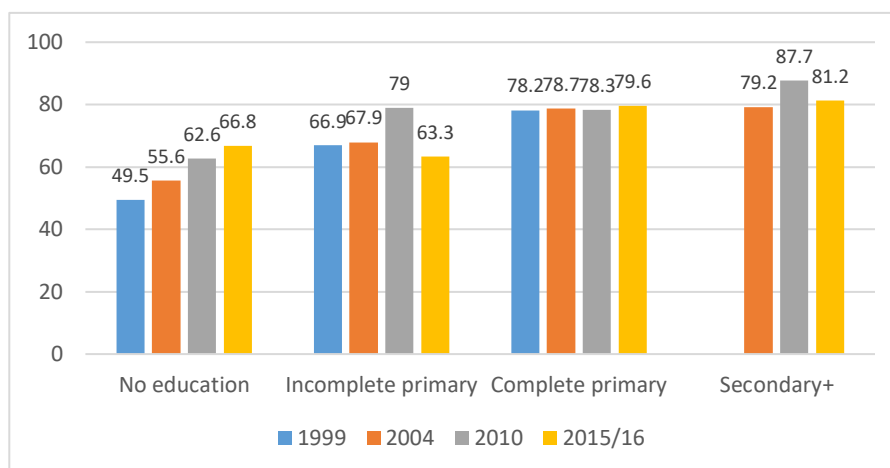
<sup>14</sup>TDHS, 2015/2016, Page 206

<sup>15</sup> TDHS, 2015/2016, page 207

2016, there was a 1-percentage drop. Most of the increase in coverage occurred among the poor.

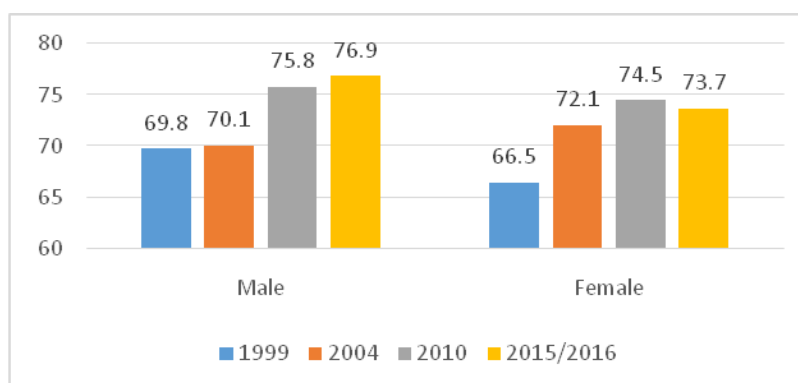
**Trends in vaccination coverage by education:** The TDHS has shown that immunisation coverage increases the higher the educational level of the mother/guardian. Between 1999 and 2015/16, immunisation coverage has improved among persons with no education e.g. in 2004 56% of the children aged 12-23 received all vaccinations by the time of survey and this increased to 63% in 2010 and then 67% by 2015/2016 as can be seen in Figure 3.1.4.

**Figure 3.1.4: Proportion of children aged 12-23 months who are fully vaccinated**



**Trends in vaccination coverage by gender:** Figure 3.1.5 below shows trends in vaccination coverage by gender between 1999 and 2015/2016

**Figure 3.1.5: Trends in vaccination coverage by gender<sup>16</sup>.**



Among both boys and girls, vaccination coverage has been increasing with an exception of girls when coverage did not really change between 2010 and 2016. Overall, the proportion of boys who are vaccinated is slightly higher than girls.

**Trends in vaccination coverage by rural/urban residence:** With an exception of 2010, in all the other years, vaccination coverage in Zanzibar is higher than in mainland Tanzania e.g. in 2015/2016 immunisation coverage in Zanzibar was at 81% compared to 75% in mainland Tanzania as can be seen in Table 3.1.1.

**Table 3.1.1: Immunisation coverage 1999-2015/2016<sup>17</sup>**

Location	1999	2004	2010	2015/2016
Mainland Tanzania	68.3	71.0	75.1	75.2

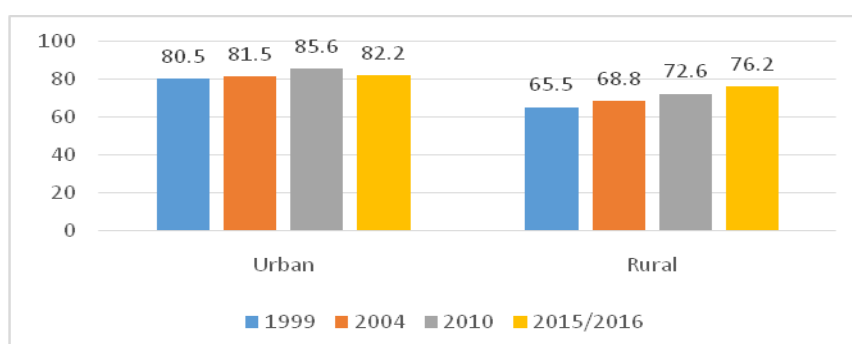
<sup>16</sup> TDHS 1999, 2004, 2010 & 2015/16

<sup>17</sup> TDHS 1999, 2004, 2004, 2010 & 2015/16.

Urban	80.5	81.5	86.3	82.2
Rural	65.5	68.8	72.5	72.6
Zanzibar	70.0	74.7	72.5	80.8
Pemba	51.8	59.9	79.7	80.4
Unguja	89.4	85.8	74.0	81.1

In both rural and urban areas, there has been an increase in coverage. However, in urban areas between 2010 and 2016 coverage decreased from 86% to 82% in Zanzibar. In mainland Tanzania, immunisation coverage is higher in urban areas than rural areas throughout this period. For Zanzibar, in 2015/2016, there was no significant difference between Pemba and Unguja, Overall, as can be seen in Figure 3.1.6, for the United Republic of Tanzania (mainland and Zanzibar), coverage is higher in urban areas than in rural area.

**Figure 3.1.6: Vaccination coverage by rural/urban residence<sup>18</sup>**



During stakeholders' consultations and the country engagement framework (CEF) workshop (25-29 June 2018), there was also a concern that immunisation coverage in urban areas is dropping. The issue of data compromised by the unreliable denominators does not provide a comprehensive situation on immunisation in urban areas. This is why in this HSS2 proposal; there are a number of interventions including the scaling up of the EIS to national level in order to address the quality of data.

**3.2 At the sub-national level identify the target areas and groups of low coverage and equity:** (Include data source & year for each)

→ **Identified target groups to be used in subsequent sections for tailored interventions**

<p><b>Coverage by geographies/population group:</b> DTP3, MCV2, etc.</p>	<p>In 2017, there were 15 districts which had a DTP3 coverage of &lt;80% and these were as follows: Ilala (71%), Temeke (79%), Ubungo (56%), Hai (72%), Moshi (59%), Mwanza (65%), Rombo (69%), Same (66%), Siha (78%), Morogoro (65%), Rufiji (58%), Nzega (71%), Uyui (79%), Central (79%) and Urban (74%). The rest of the districts in mainland Tanzania and Zanzibar had DTP3 coverage of &gt;80%<sup>19</sup>. Incorrect denominators compromise immunisation coverage data<sup>20</sup>. Hence, a 2017 desk review of immunisation data used 3 factors to determine poor performing districts: (i) coverage of &lt;80% for DTP3 and MR2; (ii) a decrease in number of children who were vaccinated overtime; and (iii) existence of discrepancies between DTP3 and OPV3. Based on these criteria, 56 districts (Annex 1) have been described as low performing in Tanzania. This is an innovative approach to determining poor performing districts instead of just looking at districts with DTP3 coverage of less than 80%, as has usually been the case in mainland Tanzania, Zanzibar and other countries in the region.</p> <p>In term of targeting for the 5 objectives, the following criteria will be used during the implementation of the HSS2 grant:</p> <ol style="list-style-type: none"> <li>1. While all the districts will be targeted for support with HSS2 funds, the focus for <b>service delivery</b> (Objective 1) and <b>demand creation</b> (Objective 5) shall be on</li> </ol>
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<sup>18</sup>TDHS, Page 206.

<sup>19</sup>JRF reports MoHCDGEC, 2017

<sup>20</sup> EPI comprehensive review 2015, Page 55 & 76

	<p>poor performing districts/councils as defined above and as contained in Annex 1. Within these districts, special attention will also be paid to urban areas, pastoralists, fishing communities and hard to reach areas.</p> <ol style="list-style-type: none"> <li>2. <b>Data management</b> will be improved in all councils. VIMS will be scaled up using the HSS1 funds to national level. By December 2018, EIS will be operational in 10 regions out of the 31 regions in mainland Tanzania and Zanzibar. The focus for HSS2 will be scaling up EIS in the remaining 21 regions in mainland Tanzania and Zanzibar. Annex 2 is a list of regions and specific districts where EIS will be implemented with HSS2 grant.</li> <li>3. The focus for HSS2 grant will be on filling the remaining gaps on the <b>CCE requirement</b>, ensuring an effective temperature monitoring system and availability of skilled staff to manage supply chain system. Tanzania has been awarded a CCEOP grant of US\$11 million which covers about 54% of the initial quantified need estimated at \$20.3 million. The focus for HSS2 will be new health facilities, facilities without CCE, those with obsolete equipment and facilities which use LP gas run fridges<sup>21</sup>.</li> <li>4. <b>Leadership, management and coordination</b> will focus on capacity building, monitoring and governance of the immunisation programme at all levels.</li> </ol> <p>The 2016 immunisation equity assessment reported that children among pastoralists and fishing communities and those resident in urban areas were likely to be unvaccinated or partially vaccinated<sup>22</sup>. There is a need for more comprehensive studies to determine coverage and inform the development of interventions to reach these communities. The 2015/2016 TDHS showed that the proportion of children aged 12-23 months in Tanzania (including Zanzibar) who were fully vaccinated decreased from 86% to 82%<sup>23</sup>. Routine immunisation data collected between 2014 and 2017 shows that coverage for 4 urban councils in Dar es Salaam had fallen from more than 90% to less than 90% and these councils are Ubungo (56%), Kinondoni (62%), Ilala (81%) and Temeke (89%). Routine data from Zanzibar also shows that the proportion of children who are vaccinated in urban areas has been decreasing as can be seen in Figure 3.2.1 below.</p>
<p><b>Coverage by geographies/population group:</b> Absolute numbers of un- or under-immunised children</p>	<p>Due to the prevailing challenges of determining denominators, it is difficult to estimate the exact numbers of children who are unvaccinated by district or by urban areas. Annex 1, instead, provides the numbers of children who were vaccinated over the years 2014-2017. Districts with decreasing numbers of children vaccinated over this period, those with huge discrepancies between DPT3 and OPV3 and those with low DPT3 coverage have been described as poor performing (see Annex 1).</p>
<p><b>Equity by geographies/population group:</b></p> <ul style="list-style-type: none"> <li>• Wealth (e.g. high/low quintiles)</li> <li>• Education (e.g. un/educated)</li> <li>• Gender</li> <li>• Urban-rural</li> <li>• Cultural, other systematically marginalised groups or communities e.g. from ethnic religious minorities, children of female caretakers with low</li> </ul>	<p>At district level, data is not available by wealth status, educational attainment, gender and urban/rural residence. The TDHS provides vaccination coverage by these variables at national level. There is no major difference between male and female children and that, in general, vaccination coverage is higher in urban than rural areas and that coverage also increases the higher the educational level of the mother/caregiver.</p> <p><b>Vaccination coverage in urban areas is decreasing:</b> The desk data review identified 3 municipality councils (urban) which have low immunisation coverage and these are Shinyanga, Nyamagana and Sumbawanga. The rationale for identifying these municipality councils as low performing included their coverage, the decreasing number of children who have been vaccinated over the period 2014-2017 and the prevailing huge discrepancies between DPT3, OPV3 and MR1. The 2017 Joint Appraisal also noted that there was a need to pay special attention to urban areas as there is a significant number of unvaccinated children in these areas<sup>24</sup> and recommends more research to determine equity challenges in urban</p>

<sup>21</sup> Tanzania CCEOP deployment plan.

<sup>22</sup> UNICEF. (2016). Immunisation equity assessment-documentary review report. Dar es Salaam: UNICEF, Page 13

<sup>23</sup>TDHS, 2015/2016, Page 206.

<sup>24</sup>Joint appraisal 2017, Pages 8, 21, 24 & 28.

socioeconomic status, etc.

areas including slums<sup>25</sup>. In Zanzibar, the number of vaccinated children between 2014 and 2016 decreased as can be seen in Figure 3.2.1.

**Figure 3.2.1: Numbers of children vaccinated in Mjini and Magharibi in Zanzibar 2014 & 2016<sup>26</sup>.**

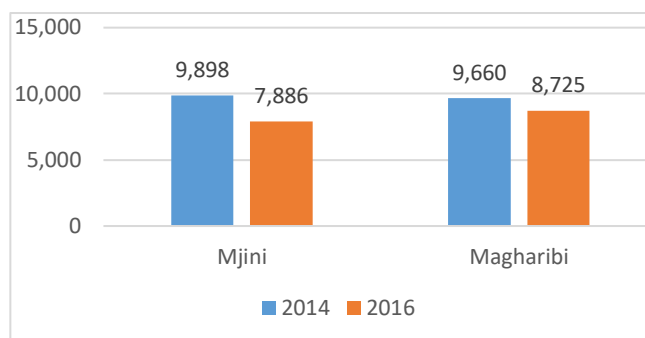
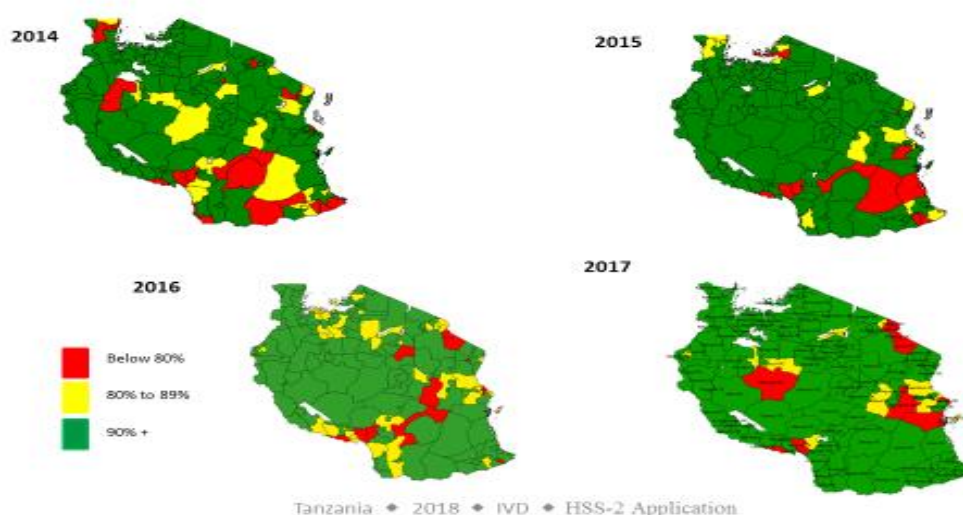


Figure 3.2.1 shows a decrease in immunisation coverage in urban Zanzibar which needs to be further investigated and addressed.

**Vaccination coverage among nomadic pastoralists is low:** Nomadic populations are highly mobile for most part of the year and they are very hard to reach with immunisation and other health services<sup>27</sup>. In areas where nomadic populations live, poor road networks make it very difficult to effectively deliver vaccines. Studies have found lower vaccination coverage among pastoralists compared to national coverage. These pastoralist populations are less likely to access immunisation services<sup>28</sup>.

To further elaborate on sections 3.1. and 3.2 above, **countries are strongly encouraged to include heat maps or similar to show immunisation coverage trends over time**, and to reference the source of data, which may be added here. Examples of such analysis are available in the Joint Appraisal Analysis Guidance (available here: <http://www.gavi.org/support/process/apply/report-renew/>)

**Figure 3.2.2: Heat maps showing immunisation coverage for Tanzania<sup>29</sup>**



<sup>25</sup>Joint appraisal 2017, Pages 21 & 24

<sup>26</sup>EPI Zanzibar presentation during CEF workshop, White Sands Hotel, 25<sup>th</sup> June 2018.

<sup>27</sup>2016 UNICEF equity analysis report, Page 13.

<sup>28</sup>Kruger et al., 2013, Page 7.

<sup>29</sup>Lyimo, D. (2018). National immunisation programme performance. (Presentation at the CEF workshop, White Sands Hotel, Dar es Salaam. 25<sup>th</sup> June 2018).

### 3.2 Key drivers of sustainable coverage and equity at the national level

Please highlight the key health system and programmatic drivers of the levels of coverage and equity from the section above. To the extent possible, please list the barriers below by order of priorities with regards to coverage and equity bottlenecks, prioritising and ranking the 3-5 biggest issues. If any of these will not be supported by Gavi, indicate why and who will support it. Provide evidence and lessons learned from previous activities.

→ ***This prioritisation is to be reflected in Part D on objectives of requested Gavi support***

Up to 500 words

#### 1. Service delivery

- Existence of districts with high number of unimmunised children, high dropout rates<sup>30</sup>.
- Limited access and utilization of immunization services due to existence of hard to reach, unplanned settlement in urban areas<sup>31</sup>, migrant pastoralists, seasonal farmers and fishing communities<sup>32</sup>.
- Inadequate evidence-based information on immunization service delivery.

#### 2. Supply chain

- There is 46% gap of CCE need to equip all immunizing facilities following award of CCEOP grant worth US\$11 million<sup>33</sup>.
- Lack of capacity for fleet and transport management at IVD following transition of distribution functions from MSD to IVD<sup>34</sup>.
- Inadequate knowledge and skills on vaccine handling at national level for 2 consecutive EVMA<sup>35&36</sup>.

#### 3. Data availability, quality and use

- Parallel data collection and reporting systems (HMIS and IVD programme reporting systems) which also impose unnecessary inconsistency of data across the two sources<sup>37</sup>.
- Missing of cold chain and vaccine stock monitoring and reporting in DHIS2 system.
- Lack of linkage between VPD's case-based and laboratory databases which imposes unnecessary inconsistency of data.
- Community data not being reported and visible in Tanzania's health management information system.

#### 4. Leadership, management and coordination

- Outdated national immunization policy and protocols on immunization services.
- Lack of staff motivation and retention due to poor remuneration, absence of capacity building and opportunities<sup>38</sup>.
- Inadequate supervisory, mentoring, and monitoring systems in health facilities.
- Insufficient quality improvement mechanisms including audits, financial analysis, sustainability plan and regular review of performance
- Lack of financial accounting systems such as EPICOR system.

#### 5. Demand creation for immunisation services

- Lack of community mobilisation and materials for information, education, communication, advocacy and behaviour change.
- Insufficient advocacy efforts to increase awareness on benefits of immunization services.
- Suboptimum involvement of community and existing community structures in immunization issues including planning.

### 2.6 Key drivers of sustainable coverage and equity at the sub-national level

Please highlight the key health system and programmatic drivers of the levels of coverage and equity from the section above. To the extent possible, please list the barriers below by order of priorities with regards to coverage and equity bottlenecks, prioritising and ranking the 3-5 biggest issues. If any of these will not be supported by Gavi, indicate why and who will support this.

→ ***This prioritisation is to be reflected in Part D on objectives of requested Gavi support***

Up to 500 words

<sup>30</sup> IVD admin data 2017.

<sup>31</sup> Joint Appraisal 2017, Page 21&24.

<sup>32</sup> UNICEF immunisation equity analysis 2016, Page 13.

<sup>33</sup> Tanzania CCEOP application and decision letter.

<sup>34</sup> Roadmap for Transition.

<sup>35</sup> EVMA 2015, Pages 24&35.

<sup>36</sup> EPI comprehensive review 2015, Page 26.

<sup>37</sup> EPI comprehensive review 2015, Page 29.

<sup>38</sup> Tanzania HSSP 2016-2020.

**1. Service delivery**

- Limited availability of immunization services in hard to reach areas due to cancellation outreach services and provision of services once per week<sup>39</sup>.
- Low utilization of immunizations services in urban setting and unplanned settlement<sup>40</sup>.
- Suboptimal mechanism of defaulters and dropouts tracking<sup>41</sup>.
- Inadequate capacities in detection, investigation and reporting of VPDs<sup>42</sup>.
- Limited capacity to identify, notify and investigate AEFI.
- Inadequate linkage of defaulter tracking mechanism between facility and community level.

**2. Supply chain**

- Stock outs of vaccines and injection materials supplies in health facilities<sup>43</sup>.
- Limited capacity of vehicles to transport vaccines and supplies due to increased volume per fully immunized child<sup>44</sup>.
- Lack of timely visibility of cold chain temperature monitoring deviations for timely response<sup>45</sup>.
- Shortage of designated storage space (District vaccine stores) for CCE and related supplies in 35 districts<sup>46</sup>.
- Suboptimal waste management at health facilities as only 30% of primary health facilities have incinerators<sup>47</sup>.

**3. Data management, analysis and utilisation**

- Poor data quality (consistency, accuracy, timeliness and completeness)<sup>48</sup>.
- Multiple reporting tools at the facility and district level (DVDMT, SMT, CCIT monthly report and HIMS report)<sup>49</sup>.
- Inadequate capacity among health care workers on data management and use<sup>50</sup>.
- Inaccurate or uncertain target population for calculating immunization rates. For instance, 45% of councils reported over 100% coverage for DTP-3 in 2017<sup>51</sup>.
- Reluctance and underutilisation of electronic immunisation systems at all levels.
- Inefficient referral and linkage of immunisation data between communities and facilities.

**4. Management, leadership and coordination**

- Inadequate knowledge, skills and competency at regional, district and facility levels in the provision of immunization service<sup>52</sup>.
- Inadequate capacity of staff at lower level to plan and manage finance and other resources.
- Shortages of staff, high labour turnover and low recruitment rate<sup>53</sup>.
- Inadequate funds allocated to immunization operations program<sup>54</sup>.
- Lack of competency-based training for immunization staffs including preservice and in-service.

**5. Demand creation**

- Inadequate linkage/communication between health facilities and communities on immunization services.
- Lack of mechanism to provide feedback and dissemination of immunization information to the community.
- Non-existence of community champions on immunization.
- Lack of male involvement in vaccination related health issues.
- Limited community accountability/engagement in immunisation services.

<sup>39</sup> SARA 2017, Page 26-27 & SARA 2012 Page 28-29.

<sup>40</sup> Joint Appraisal 2017, Page 21&24.

<sup>41</sup> EPI comprehensive review 2015, Pages 30 & 76.

<sup>42</sup> Tanzania & Zanzibar cMYPs.

<sup>43</sup> SARA 2012 & SARA 2017.

<sup>44</sup> IVD asset register.

<sup>45</sup> EVMA 2015 & EPI comprehensive review 2015.

<sup>46</sup> Tanzania cMYP 2016-2020.

<sup>47</sup> SARA 2017.

<sup>48</sup> DQA 2017.

<sup>49</sup> EPI comprehensive review 2015.

<sup>50</sup> EPI comprehensive review 2015.

<sup>51</sup> JRF 2017.

<sup>52</sup> EPI comprehensive review 2015.

<sup>53</sup> EPI comprehensive review 2015, Tanzania HSSP 2016-2020 & Zanzibar cMYP.

<sup>54</sup> EPI comprehensive review 2015.



### 3 National programme management

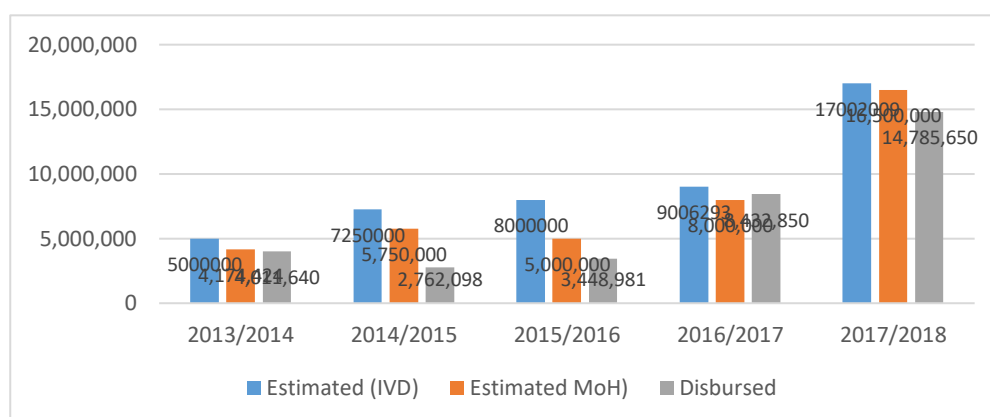
#### 3.1 Immunisation financing

- **Availability of national health financing framework and medium-term and annual immunisation operational plans and budgets**, whether they are integrated into the wider national health plan/budget, and their relationship and consistency with micro planning processes
- **Allocation of sufficient resources in national health budgets for the immunisation programme/services**, including for Gavi and non-Gavi vaccines, (integrated) operational and service delivery costs. Discuss the extent to which the national health strategy incorporates these costs and any steps being taken to increase domestic resources for immunisation. If any co-financing defaults occurred in the last three years, describe any mitigation measures that have been implemented to avoid future defaults.
- **Timely disbursement and execution of resources**: the extent to which funds for immunisation-related activities (including vaccines and non-vaccine costs) are made available and executed in a timely fashion at all levels (e.g., national, province, district).
- **Adequate reporting** on immunisation financing and timely availability of reliable financing information to improve decision-making.

*Not exceeding 250 words*

An immunisation line item exists in budgets for mainland Tanzania and Zanzibar. HSSPs and cMYPs have projected resources for immunisation. The IVD works closely with PO-RALG in delivery of immunisation services. The PO-RALG has assigned assistant accountants to health facilities to ensure financial resources are properly managed. Each year, government ministries and departments submit budgets to MoF&P. The MoF&P sets ceilings for ministries/departments after scrutinising submissions. This results into cutting down planned activities. Figure 3.1.1 shows IVD and MoH budget estimates and amounts actually disbursed to IVD over the period 2013/14-2017/18.

**Figure 3.1.1: Budgets estimates for IVD and what is disbursed 2013/14-2017/18<sup>55</sup>**



Council also do not allocate adequate resources for immunisation. Budgets for co-financing of new and underutilised vaccines with GAVI and purchase of traditional vaccines are ring-fenced and there has been no defaulting on co-financing. Operational costs are grossly inadequate.

Zanzibar and mainland Tanzania hold annual stakeholders' meetings where IVD/EPI present progress in implementation of activities including challenges experienced. Development partners and CSOs do come in to cover operational expenses e.g. trainings, supportive supervision and purchase of equipment. The IVD has conducted advocacy meetings with MoF&P and has managed to get more resources e.g. for co-financing with GAVI. Inconsistencies existence in disbursement of funds from MoF&P as it depends on revenue and not all funds in budgets are disbursed MoF&P. This impacts negatively on service delivery. Financial reports for GAVI are produced on time. However, both internal and external audit reports are in some cases not produced on time.

<sup>55</sup> IVD.



### 3.2 Priority needs

#### 4.2.1 Programme management: leadership and management capacity of the EPI team, functionality of the Coordination Forum (ICC, HSCC or equivalent body) and the national immunisation technical advisory group (NITAG or equivalent):

- **Challenges** related to structure, staffing and capabilities of the national/ regional EPI team (including implementation of annual operational plan for immunisation)
- **Engagement of different stakeholders**(including WHO, UNICEF, CSOs, donors) in the immunisation system
- **Effective functioning of the relevant Coordination Forum: To what extent does it meet Gavi requirements? If it does not, what are the steps needed to address these gaps?**

*(To be eligible for new Gavi vaccine or financial support, countries need to demonstrate a basic functionality of their coordination forum. Requirements are further described at <http://www.gavi.org/support/process/apply/additional-guidance/under-the-heading-‘Leadership, management and coordination’>)*

Where a NITAG does not exist, Gavi recommends that countries include plans to establish one and briefly describe such plans here.

*Not exceeding 250 words*

#### **Challenges relating to structure, staffing and capabilities of the national/regional EPI:**

- Limited supportive supervision.
- Inadequate financial and human resources for service delivery including immunisation at all levels.
- Inadequate knowledge and skills among health workers at all levels.

#### **Engagement of different stakeholders**

- In mainland Tanzania, the ICC is active and draws membership from various stakeholders including MoF&P, WHO, UNICEF, USAID, PO-RALG and NGOs/CSOs (Christian Social Services Commission, BAKWATA, PATH, JHPIEGO, Red Cross, CHAI, JSI and AMREF). The PS in the MOHCDGEC in mainland Tanzania and the PS in MoH in Zanzibar chair ICCs. The ICC’s role is to advise on immunisation, monitor progress in the implementation of immunisation services and mobilise resources for the programme. Tanzania has a NITAG that advises policy and strategic directions including introduction of new vaccines. Other functional committees include National Polio Committee, National AEFI Committee and the IVD TWG. Some faith-based health facilities, private for profit facilities and NGOs/CSOs also provide immunisation services but the proportion is quite low<sup>56</sup>.

#### **Extent to which ICC meets GAVI requirements**

- In both mainland Tanzania and Zanzibar, the ICCs exist. The ToRs for Tanzania have been revised and conform to the requirements of GAVI. The ToRs for Zanzibar, however, need to be revised. ICC membership in Zanzibar is limited, meetings are infrequent, and this affects the functionality of the ICC.

#### 4.2.2 Vaccine management: Priority areas for improvement to manage risks to vaccine stocks, e.g. based upon recent audits or assessments

*Not exceeding 250 words*

#### **The following priority areas to manage risks to vaccine stocks have been highlighted in various audits including the 2015 EPI review, the SARA and the 2017 PCA.**

- Strengthen the distribution system for vaccines from the CVS to the RVS and then to districts<sup>57</sup> as the fleet is old and volumes of vaccines have increased since these vehicles were purchased in 2006.
- Install temperature monitoring devices for monitoring the distribution and storage of vaccines<sup>58</sup>.
- Purchase refrigerators for new districts and health facilities; health facilities with old/unfunctional CCE; and replacement of some fridges run on LP gas<sup>59</sup>.
- Construct storage facilities for vaccines for about 30 districts which do not have the DVS<sup>60</sup>.
- Carry out preventive maintenance and repairing of refrigerators<sup>61</sup>.
- Decommission outdated CCE including other pieces of equipment<sup>62</sup>.

<sup>56</sup> SARA 2017.

<sup>57</sup> EPI comprehensive review 2015.

<sup>58</sup> EPI comprehensive review 2015.

<sup>59</sup> Tanzania CCEOP application to GAVI.

<sup>60</sup> Tanzania CCEOP application to GAVI.

<sup>61</sup> EPI comprehensive review 2015.

<sup>62</sup> SARA report 2017.

- Train health workers in EVMA<sup>63</sup>.

#### 4.2.3 Financial Management: Priority areas to address financial management gaps

*Not exceeding 250 words*

**The 2017 Programme Capacity Assessment (PCA) made the following recommendations on financial management:**

- Recruit a GAVI HSS coordinator.
- The Finance Section at IVD should report to the Programme Manager; and the Chief Accountant in the MOHCDGEC should oversee the section to ensure financial transactions and financial reports are in line with existing government financial management regulations.
- Finance staff at IVD should visit districts receiving support from GAVI to validate financial reports.
- GAVI funds should be included in the government budget.
- Install EPICOR accounting system at IVD for financial reporting and budget monitoring and abandon the use of excel to manage financial transactions.
- Budget for both internal and external audits in GAVI funded programmes and these should be produced in a timely manner.

### 3.3 Polio transition planning (if applicable)

If transitioning out of immunisation programme support from other major sources, such as the Global Polio Eradication Initiative, briefly describe the transition plan. If none exists, describe plans to develop one and other preparatory actions.

*Not exceeding 100 words*

WHO's funding of polio activities has been decreasing since 2015. Polio funds supported regional offices (Tanga, Iringa, Mwanza and Dodoma), routine immunisation, staff employment, specimen transportation and disease surveillance; hence, withdrawal of polio funds will negatively affect IVD. WHO will fund polio activities (US\$240,000/year) until 2020. This represents a 70% reduction in annual funding. Measles sample transportation will be affected by the phasing out of polio funds. This will negatively affect the measles elimination agenda. The Government of Tanzania (GoT) has received US\$600,000 from USAID's Global Health Security Agenda (2018-2020) to mitigate impacts of withdrawal of polio funds. The GoT is putting some polio-funded activities into national plans and mobilising resources to avert negative impacts.

<sup>63</sup> EPI comprehensive review 2015.

## 4 Past performance of Gavi support, implementation challenges and lessons

Briefly comment on the performance of the vaccine support and health systems and immunisation strengthening support (HSS, Ops, VIGs, CCEOP, transition grants) received from Gavi

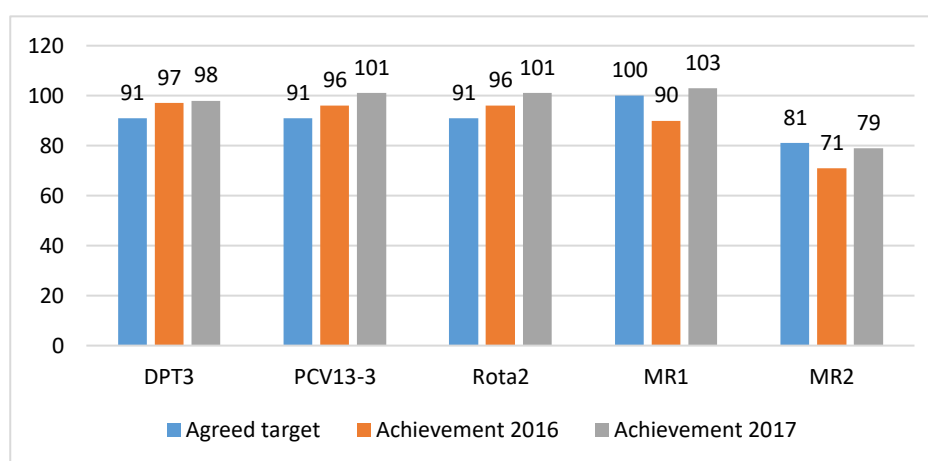
### 4.1 Programmatic performance of Gavi grants, in terms of:

- Achievements against agreed targets
- Overall implementation progress, lessons learned and best practices
- Progress and achievements specifically obtained with Gavi’s HSS and CCEOP support
- Usage and results achieved with performance based funding (PBF)
- If applicable, implementation progress of transition plan, implementation bottlenecks and corrective actions

Not exceeding 500 words

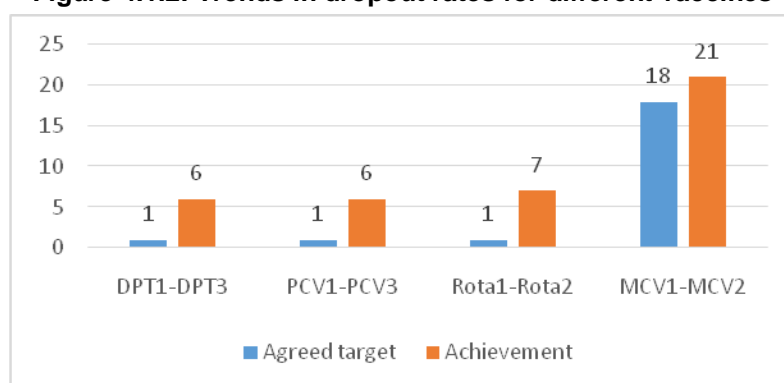
**Achievements against agreed targets:** Figure 4.1.1 shows that all targets in GPF were achieved by 2017 with an exception of MR2.

**Figure 4.1.1: Trends in immunisation coverage 2016-2017**



The shortage of MR vaccine in 2016 contributed to non-achievement of the target. The lack of knowledge about MR2 is a major cause for coverage of <80%. All other targets in the GPF were achieved as detailed in the 2017 Joint Appraisal with an exception of the dropout rate as can be seen in Figure 4.1.2.

**Figure 4.1.2: Trends in dropout rates for different vaccines**



**Overall implementation progress, lessons learned and best practices:** Tanzania received an HSS1 grant of US\$13,512,765 (2014-2018). By July 2017, GAVI had disbursed US\$5,604,801.00 to the MOHCDGEC and 80% (US\$4,478,534.00) had been used leaving a balance of just over US\$1 million. UNICEF is currently managing US\$5,017,336 of the HSS grant on behalf of Government: expenditure to date is at US\$ 3,023,310. The delays in implementation of HSS1 grant have been due to (i) the fact that the IVD in early 2018 was busy introducing 2 vaccines (IPV & HPV) and developing the HSS2 proposal; (ii) long discussions between UNICEF and the MOHCDGEC on product specifications and brand requirement; and (iii) long preparatory activities for zonal trainings before the disbursement of funds. The implementation plan for HSS1 has been revised to fit in the remaining 4 months and all activities will be implemented by December 2018. GAVI and the GoT have agreed to spend the remaining HSS funds

for training and supervision, procurement of vehicles, CCE and for scaling up of the EIS<sup>64</sup> (2017 Joint Appraisal). The remainder of the GAVI HSS funds (US\$754,220) and the 2016 PBF funds GAVI gave to Tanzania (US\$1.6 million) will be used for the CCEOP co-payment. GAVI will also pay the CCEOP procurement fee amounting to US\$188,338.

The HSS1 grant was used to implement REC; provide refresher trainings; implement outreaches; procure CCE; purchase bicycles, vehicles and motorcycles; and conducting supportive supervision, mentorship and demand creation activities. These activities were conducted in low performing districts. The funds were also used to support coordination committees such as ICC; conducting biannual progress review meetings, zonal surveillance meetings and the immunisation week<sup>65</sup>. These activities contributed to an increase in immunisation coverage in Tanzania. The HSS grant also supported the conduct of both internal and external audits of GAVI funds.

**Usage of PBF:** The 2015 GAVI PBF grant (US\$800,000) is being used to rehabilitate the IVD warehouse at Mabibo which will be the new CVS. The 2016 PBF grant (US\$1.6 million) is managed by GAVI and will co-finance the approved CCEOP grant.

**New vaccines introduction:** In 2018, HPV and IPV were introduced into routine immunisation. Major lessons learnt from this introduction include: CHVs and teachers were useful in identifying girls eligible for immunisation; integration of training sessions (for health workers and teachers) saves money and time; social mobilisation materials should be adapted to local contexts; determining the denominator is a challenge; supervision is key to successful introduction of new vaccines; and districts and communities should be given enough time to prepare for new vaccines introduction.

#### 4.2 Financial management performance, in terms of:

- Financial absorption and utilisation rates
- Compliance with financial reporting and progress in addressing audit requirements
- Major issues arising from review engagements (e.g. Gavi cash programme audits, Gavi programme capacity assessments, annual external/internal audits, etc.) and the implementation status of any recommendations
- Financial management systems, including any modifications from previous arrangements

*Not exceeding 500 words*

**Financial absorption and utilisation rates:** Table 4.2.1 shows the absorption rate for grants Tanzania received from GAVI as of by August 2018.

**Figure 4.2.1: Absorption rate of GAVI funds**

Type of Grant	Amount received	Amount spent	Balance	Proportion used (%)
HSS1 <sup>66</sup>	10,622,136	7,501,810	3,120,326	71
MSD	1,626,000	1,328,000	292,695	82
MR	12,791,000	12,516,000	191,172	98
VIG MR	1,546,500	215,745	1,217,762	23
VIG IPV	1,599,000	0	1,599,000	0
HPV demonstration	225,500	215,745	10,000	96
HPV roll out	1,607,374	1,183,927	322,383	74

Over 80% of the funds for MSD, HPV and MR have been used by MOHCDGEC. For the HSS1 grant, 71% of the funds disbursed had been used by August 2017. All HSS1 funds will be used by December 2018. The funds meant for IPV introduction in routine immunisation have recently been disbursed to UNICEF. Discussions are underway between UNICEF and MOHCDGEC to discuss how it will be used to support IPV uptake and training of health workers. The global shortage of the IPV vaccine affected the utilisation of the IPV funds<sup>67</sup>.

**Compliance with financial reporting and progress in addressing audit requirements:** Initially GAVI funds were transferred directly to the MOHCDGEC. The audit of GAVI cash grants given to MOHCDGEC between 2014 and 2016 found that the Ministry had challenges in complying with the financial reporting requirements with some payments having no any supporting documents and other financial irregularities not in line with GAVI and GoT financial management guidelines. GAVI funds were also not being managed within the Government budget system<sup>68</sup>. Funds amounting to US\$1.3 million were returned by the GoT due to financial management irregularities unveiled by the

<sup>64</sup> Joint appraisal 2017

<sup>65</sup> Joint appraisal 2017.

<sup>66</sup> UNICEF received US\$5,017,336 from GAVI for HSS1 and so far, US\$3,023,310 has been spent. GoT received US\$5,604,800 from GAVI for HSS and by June 2017 US\$4,478,500 had been spent. A total of US\$10,622,136 has been disbursed from GAVI for HSS1.

<sup>67</sup> Joint Appraisal 2017, Page 15.

<sup>68</sup> Joint appraisal 2017.

GAVI audit<sup>69</sup>. Other challenges included weak internal financial controls, inadequate resources to conduct internal audits and non-adherence to national procurement systems<sup>70</sup>.

**Major issues arising from review engagements:** The major issues arising from review engagements include the following:

- Weak internal control systems including non-adherence to GAVI and GoT financial management regulations;
- Shortage of staff in IVD's Finance Unit;
- GAVI funds being managed outside government system;
- Lack of auditing of GAVI funds due to shortage of resources;
- Non-adherence to procurements regulations;
- Lack of oversight over the IVD's accounting section by the Chief Accountant; and
- The lack of electronic financial management system (EPICOR).

A number of these issues have been addressed: 4 accountants have been employed in the IVD Accounting Unit, internal and external auditing of GAVI funds being included in GAVI proposals and that GAVI funds will be incorporated in GoT budget.

**Financial management systems:** Excel sheets are being used at IVD to record accounting data but this will be replaced by EPICOR with HSS2 funds. UNICEF manages the Gavi HSS1 grant while CHAI manages the 2015 PBF grant. A PCA will be conducted later in 2018 in order to determine whether the issues relating to financial management have been addressed and, if they have, then GAVI will start sending funds directly to the MoHCDGEC.

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<sup>69</sup> Joint appraisal 2017

<sup>70</sup> GAVI secretariat 2017.

## Part C: Planning for future Gavi support<sup>71</sup>

### 5 Planning for future support: coordination, transparency and coherence

#### Alignment

#### 2. How does Gavi support align with the country's national health and immunisation strategies including multi-year plans (e.g. cMYP)?

- Explicitly address how Gavi support will complement, both financially and programmatically, the achievement of objectives set out in the most recent strategic multi-year plan (cMYP).
- Given the immunisation strategies proposed in this PSR, explain and show how these will contribute to the national health strategy or if there are gaps, describe what needs to be done to address these.
- Describe the extent to which Gavi's support proposed in this PSR (in areas such as data, supply chain, etc.) will be implemented through national routine systems and processes or explain the steps that are being taken to achieve integration.

→ **Include information on the Gavi budgeting & planning template to capture the gap analysis for requested Gavi support**

*Not exceeding 250 words*

#### **How GAVI will compliment, both financially and programmatically, the achievement of objectives set out in the cMYP:**

- The overall goal of the cMYP 2016-2020 is to contribute towards reduction of morbidity, mortality and disability due to VPDs through provision of immunisation services. The achievement of this goal will be through improved immunisation service delivery, introduction of new vaccines, strengthening of program management, building the capacity of health workers, strengthening supply chain management and creating social demand for immunisation. Mainland Tanzania and Zanzibar, with support from development partners and CSOs, are already implementing some of these interventions. Various reviews demonstrate that funding for operational activities is grossly inadequate<sup>72</sup>; hence, the implementation of these activities is limited. The proposed activities are in line with the objectives set out in the cMYP; hence, HSS2 funds will complement what mainland Tanzania and Zanzibar and partners are doing to achieve the objectives of their cMYPs.

#### **How proposed immunisation strategies in this PSR will contribute to the national health strategy:**

- Tanzania's HSSP IV 2016-2020 aims at reducing U5MR and IMR through sustenance of immunisation services including introduction of new vaccines<sup>73</sup>. The HSSP IV recommends use of REC, daily provision of immunisation services, conducting outreaches and the use CHWs. The proposed strategies in this PSR are contained in cMYPs which are in line with the HSSP IV. As mentioned earlier, the implementation of immunisation services contributes significantly towards reducing child mortality that is one of the overall outcomes of the national health strategy.

#### **The extent to which Gavi's support proposed in this PSR will be implemented through national routine systems and processes or explain the steps that are being taken to achieve integration:**

- All proposed activities will be implemented using national routine systems: (i) Service delivery activities will be implemented through the PO-RALG, faith-based/NGO/CSO facilities and private for profit facilities; (ii) UNICEF will be responsible for procurement of CCE and associated equipment in line with existing MoU with MoHCDGEC and all other activities will be implemented by the Ministry; (iii) With regard to data, partners namely AMREF, PATH, CHAI and JSI will support MOHCDGEC in the development of systems but the training, actual data collection and data analysis will be done by the MoHCDGEC and PO-RALG; (iv) All activities under management, leadership and coordination will be implemented by the MOHCDGEC and PO-RALG in Tanzania and MoH in Zanzibar; and (v) The IVD will be responsible for demand creation activities at different levels in conjunction with the Health Promotion Unit in the MOHCDGEC and JHPIEGO, UNICEF, AMREF and JSI.

<sup>71</sup>The duration of Gavi funding should be discussed in consultation with the Gavi Secretariat to align to the extent possible to a country's strategic period. For Measles Rubella the high-level plan with coherent and integrated measles and rubella disease control activities is expected to cover the next 5 years, regardless of the duration of the national strategy.

<sup>72</sup>EPI comprehensive review 2015 & Tanzania HSSP 2015.

<sup>73</sup>Tanzania HSSP 2015.

### 3.3 Complementarity, coherence and technical soundness

#### 3. What steps were taken to ensure **complementarity, coherence and technical soundness** of Gavi's support across government and stakeholders?

- What role was played by the national coordination forum (ICC, HSCC or equivalent) and the national immunisation technical advisory group (NITAG) in the development of the PSR?

*Not exceeding 250 words*

MOHCDGEC and stakeholders made a decision to apply for HSS2 grant to sustain gains GoT has made in improving immunisation coverage. A review of literature to identify bottlenecks in the delivery and uptake of immunisation services was conducted in May-June 2018. Between 5<sup>th</sup> and 8<sup>th</sup> June 2018 MOHCDGEC and all major stakeholders namely MoH Zanzibar, MoF&P, PO-RALG, WHO, UNICEF, CHAI, JSI, PATH, Amref and Red Cross met at Ramada Hotel, Dar es Salaam. Participants identified some interventions to be considered for inclusion in HSS2 proposal. During the in-country workshop, (June 25-29, 2018), participants drawn from various organisations (including GAVI) developed objectives and activities of the HSS proposal. A budgeting meeting (2-6 July 2018) followed the CEF workshop. There were further consultations in Dodoma (13-25<sup>th</sup> July 2018) where representatives from MOHCDGEC at subnational level made further inputs into the proposal. An extended partners meeting (IVD, MoF&P, PO-RALG and IVD partners) met from 30<sup>th</sup> July to 4<sup>th</sup> August 2018 which provided more inputs. Two subsequent TWG meetings between 13<sup>th</sup> and 25<sup>th</sup> August 2018 were conducted and came up with a budget of US\$39.8 million. A NITAG meeting was convened (27-28 August 2018) where IVD presented HSS2 proposal and participants provided further inputs. The members of the ICC read, made comments and finally approved this proposal for submission to GAVI on 3<sup>rd</sup> September 2018<sup>74</sup>.

<sup>74</sup> See minutes of various meetings attached).



## Part D: Objectives of requested Gavi support

**Section D** details the new vaccine support and health system strengthening support requested for the upcoming 3-5 years, including strategic considerations and prioritized activities. Operational details are presented in the Gavi budgeting and planning template and performance measurement is presented in an updated **grant performance framework**.

**If you plan to request new vaccine support** (routine introductions and/or campaigns) **in the upcoming 3-5 years**, please fill in section 7 below.

**If you plan vaccine routine introductions and/or campaigns in the next 18 months**, in addition, please fill in the relevant vaccine specific request, on the Country Portal, here: <http://www.gavi.org/support/process/country-portal/>

### 6 Strategic considerations supporting the requests for new vaccines (routine or campaigns)

**This section presents information on future vaccine routine introductions and/or campaigns under consideration for Gavi support** (including support for which the country may not be eligible yet). This does not represent a commitment from the country to introduce the vaccines listed below. High level information critical to advance planning and preparation should be outlined here.

**Approximately 15-18 months ahead of the actual introduction in the routine programme or the campaign, the country will be required to fill in the relevant vaccine specific request, on the Country Portal** to obtain Gavi approval. This vaccine-specific request to be submitted will include: evidence to confirm eligibility, operational plan, budget, and essential information to support grant implementation (e.g. procurement and co-financing terms, target population data).

#### Rationale

**Describe the rationale for requesting each of the new vaccine supports**, including the burden of disease. If already included in detail in the Introduction Plan or Plan of Action, please cite the sections only.

*Not exceeding 500 words*

#### Financial Sustainability

**4. Discuss the financing-related implications of the new vaccine support requested**, particularly how the government intends to fund the additional co-financing obligations.

*Not exceeding 250 words*

#### 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.

*Not exceeding 250 words*

### Improving coverage and equity of routine immunisation

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

*Not exceeding 250 words*




## 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.

*Not exceeding 100 words*

## 7 Description of requested support for each new vaccine


 More specific planning needs particular to certain vaccine support listed in table 1.2 are described here. Greater details on activities needed to prepare for the vaccine introduction and/or campaign (addressing the programmatic challenges and bottlenecks outlined above) should be reflected in the country's annual EPI work plan.


**Exclude here vaccines that already approved by Gavi, even if not yet introduced.**

Delete boxes below that are not relevant

## 8 Programmatic description of priority HSS investments from Gavi

### Objectives and priority activities for Gavi financial support

 Given the target geographic and population groups identified and key national and sub-national bottlenecks determined in **Section B**, this section asks you to strategically consider these findings, and develop the **3-5 key objectives and specific activities within these to be supported by Gavi and the rationale for choosing these**. The link between data and evidence and proposed interventions must be clear. **The activities listed here are to be costed in Gavi's budgeting and planning template.**

 Activities proposed must contribute to sustainable improvements in coverage and equity. For **Programming Guidance** for targeting interventions in each of Gavi's strategic focus areas (i) leadership, management and coordination, (ii) supply chain, (iii) data (iv) demand promotion, and (v) immunisation financing, please see the Gavi website here:

<http://www.gavi.org/support/process/apply/hss/>

To apply for CCEOP support, include CCEOP as one of the activities under a supply chain objective. For countries in the accelerated transition stage, dedicate one objective to those activities specific to appropriate transition planning.

<b>Objective 1:</b>	To improve access, quality and utilisation of immunisation and other RMNCHA services with a focus on populations which are systematically missed.
<b>Timeframe:</b>	2019-2023.
<b>Priority geographies/populations on groups or constraint(s) to coverage and/or equity to be addressed by the objective:</b> → <b>List to match those identified in Section B</b>	<ul style="list-style-type: none"> <li>• Councils with less than 80% coverage and more than 10% dropout rate for DPT1-DPT3.</li> <li>• Geographical areas with (i) hard to reach areas; (ii) urban areas; and (iii) migrant pastoralists, seasonal farmers and fishing communities.</li> <li>• Councils with high cancellation of planned outreaches.</li> <li>• Health facilities with health workers with inadequate knowledge and skills in microplanning at health facilities level.</li> <li>• Councils with low performance of VPD surveillance indicators and sentinel sites.</li> <li>• Areas with low reporting of AEFI despite introduction of several new vaccines.</li> </ul>
<b>Describe the tailored interventions to address this constraint</b> and provide evidence of efficacy of the intervention. Describe the critical national capacities that will be established or strengthened as a result of this investment.	
<b>Preamble: a case for recruitment of Community Health Workers (CHWs) mainly for Objectives 1 &amp; 5</b>	
Tanzania has achieved and sustained a high immunisation coverage of >90% over the last 5 years with an exception of MR which is still below 80% <sup>75</sup> as of 2017. In order to reach the 5 <sup>th</sup> child with immunisation and other health services, there is a need for Tanzania to strengthen community health systems. Community Health Volunteers (CHVs) have been used in Tanzania by government and NGOs/CSOs for a long time. However, GoT has observed some challenges with the use of volunteers: inadequate incentives, poor motivation, lack of a scheme of service, difficulties in reinforcing performance and challenges with retention;	

<sup>75</sup> IVD admin data.

hence a decision was made to formalise CHWs<sup>76</sup>. By 2017, over 4,000 formal CHWs had been trained and 9,000 were in training. This training is using a curricula developed by GoT and stakeholders. The salary of a CHW has been pegged at US\$160. With support from the Global Fund and Irish Aid, the MOHCDGEC will recruit 450 CHWs in 6 regions<sup>77</sup> and 215 CHWs in 2 districts, respectively. With HSS2 grant, 600 CHWs will be recruited (Objective 1) and supported to work in 56 low performing districts. The recruitment of 600 CHWs with support from GAVI will complement existing government and Global Fund/Irish Aid efforts to institutionalise CHWs. This investment in the recruitment of CHWs is necessary as they will be based at community level and, among other responsibilities, they will perform home visits linking communities (households) to health facilities for immunization and other services, facilitating community referral systems, community tracking and registration of new-borns and pregnancies and follow-up or community tracking of defaulters. The use of CHWs will, therefore, promote community involvement in immunisation and other health services, strengthen primary health care and effectively contribute towards Tanzania's efforts to achieve universal health coverage. These CHWs will be deployed in hard to reach communities including among special groups of nomadic populations, fishermen and seasonal farmers and urban residents.

### 1.1. Implement country specific Reach Every Child (REC) with involvement of communities

- The REC Strategy has been proven effective since its inception in 2009 in Tanzania. So far, 40% of the regions have been trained to implement REC using the HSS1 grant. Between 2012 and 2016, the number of councils with administrative coverage above 90% increased by 4% and the number of councils with DTP3 coverage below 80% decreased by 5%. This achievement has been attributed to the implementation of the REC strategy<sup>78</sup>.
- The Maternal and Child Survival Program (MCSP) in Tanzania implemented the REC strategy in 3 regions of Tabora, Simiyu and Kagera between July 2015 and June 2016. The strategy led to an increase in the proportion of vaccinated children by 13.2% over this period<sup>79</sup>.
- In order to reach the last child for immunization services, a community link has to be established a portion that has been missing during the implementation of previous REC strategy. Due to inadequate funds, some councils and/or health facilities have not been implementing the REC strategy<sup>80</sup>. RHMT/CHMT should ensure that the REC strategy is being implemented in their respective areas and this should be reflected in CCHPs and health facility micro plans. Strong community involvement is a prerequisite to effectively implement the REC micro plans. There are 56 poor performing districts in Tanzania. Nineteen (19) urban councils (Dar es Salaam (5), Arusha (3), Dodoma (1), Mbeya (3), Mwanza (2), Tanga (2) and Zanzibar (3) are low performing and have large numbers of unimmunised children<sup>81</sup>. Some of the low performing urban councils have been included in the 56 low performing districts. Sixty-six (66) councils including urban ones will be targeted in this intervention. T
- Various trainings at different levels of the health system will precede the implementation of REC: the Training of Trainers (ToT) will be conducted at national level followed by training of the regions and councils. The training will be on Tanzania specific REC guidelines and tools which will be used in the implementation of REC. This will be followed by micro planning exercise at health facility level. The process will be preceded by a comprehensive analysis of health facility data using the standard micro planning tools. Health workers will use micro planning tools to identify villages with large numbers of under/unvaccinated children. Formal CHWs (as will be described later under this objective) will be recruited and oriented on how to identify defaulters among other disease programmes. These CHWs will be supervised by health facilities in order to ensure that they are effectively carrying out their duties. The IVD will work with the Health Promotion Unit within the MOHCDGEC in the recruitment of CHWs.
- The village leaders will be involved during implementation of REC: they will play a role in advocacy and communication for RMNCAH services and will support CHWs in the identification of communities with high numbers of unvaccinated children and children who have defaulted and ensure that they are vaccinated.
- Once micro planning has been completed, follow up of REC micro planning and implementation will be conducted and there will be regular supportive supervision by the national, regional and district levels to monitor the implementation of REC. This will ensure that planned activities are implemented as

<sup>76</sup> Community based health programme strategic plan 2014-2020.

<sup>77</sup> Tanzania National Coordination Mechanism. (2017). RSSH-addendum to malaria funding request. Dar es Salaam: MHCDGEC.

<sup>78</sup> 2017 Joint appraisal report.

<sup>79</sup> MCSP Tanzania Country Summary report, March 2017.

<sup>80</sup> 2017 Joint appraisal report.

<sup>81</sup> IVD admin data.

agreed in the micro plan and that emerging challenges are timely addressed. This monitoring supervision will involve personnel from national, regional and council level.

## 1.2 Support Periodic Intensification of Routine Immunization (PIRI) at health facilities

- Several countries have adopted PIRI as recommended by WHO to improve immunization coverage. This intervention has yielded great achievements and is being used as an opportunity to strengthen routine immunisation services and creating public awareness about immunisation<sup>82</sup>. Geita Region in Tanzania implemented PIRI in February 2018 which resulted into an increase of 26% in MR1 coverage<sup>83</sup>.
- Despite having high immunisation coverage in Tanzania, there are still many unvaccinated children especially in hard to reach communities including among special groups such as **nomadic populations, fishermen, seasonal farmers and urban residents**. For the first two years of the HSS2 grant, 10 low performing councils will be identified and will be supported by their regions to ensure they conduct PIRI exercise in an effective manner. This activity will target health facilities with high numbers of un/under-vaccinated children including urban and migrant populations. This intervention will be used as a vehicle for increasing MR2 coverage as well as reaching un/under vaccinated girls eligible for HPV in schools.

## 1.3. Conduct research to inform policy and programming

- There is a gross shortage of qualitative studies in Tanzania to explore factors which affect the uptake and delivery of immunisation services. Such studies can inform the design of interventions, with input from the communities themselves, which would effectively address inequities in immunisation and other health services.
- The IVD has made tremendous efforts in protecting children against VPDs. More vaccines have been introduced in Tanzania. Research is required to determine the burdens of vaccine preventable diseases to inform decisions for introduction of new vaccines such as yellow fever, MenA and typhoid. The following studies will also be conducted in order to inform programming:
  - A comprehensive countrywide immunization equity assessment as this has only been done in the southern highlands of Tanzania where UNICEF is providing support.
  - Missed opportunities for vaccination.
  - Immunisation assessment in urban areas to identify main drivers of low/decreasing immunisation coverage. Some countries such as Ghana<sup>84</sup> and Kenya<sup>85</sup> have conducted comprehensive assessment of immunisation in urban areas.

These studies will inform the development of evidence-based interventions. The proposed studies will be conducted by postgraduate students including staff from the IVD/MOHCDGEC as part of contributing to the building of capacity of IVD to use evidence to inform programming and policy.

## 1.4 Strengthen VPD and AEFI surveillance systems

- The surveillance of VPDs and AEFI faces several challenges as highlighted earlier as well as in various reports<sup>86</sup>. In order to ensure that the VPD and AEFI surveillance system is strengthened and meet the WHO indicators, HSS2 funds will support regular monitoring of sentinel sites, quarterly review meetings, capacitating resource persons at all levels on AEFI reporting and investigation and conducting active case search twice a year in 10 low performing regions.

## 1.5 Introduce mentorship program in immunization services

- Currently existing supportive supervision is integrated. Such an approach limits time for identifying and effectively addressing immunization bottlenecks due to competing priorities. Under this intervention, a comprehensive mentorship package will be developed covering all the 5 components of the EPI and will be implemented by DIVOs with support from RIVOs in their respective areas of jurisdiction. Immunisation officers at district level will be oriented on the mentorship package. These officers will spend more time supporting the low performing health facilities to effectively deliver immunization services. In each quarter, immunization officers will identify 10 low performing health facilities to work with in 15 low performing councils. This intervention has proven effective in other programs including

<sup>82</sup> WHO, USAID and Immunization Basics. (2009). Periodic intensification of routine immunization: lessons learned and implications for action. Geneva: WHO.

<sup>83</sup> IVD admin data 2018.

<sup>84</sup> JSI. (Not Dated). Technical Assistance to Ghana for Improving Immunization Service Delivery to the Urban Poor. Accra: JSI.

<sup>85</sup> Hossain, I., E. Mokaya and I. Mugoya. (2017). Situation of routine immunization in urban poor areas of Kisumu City, Kenya. Nairobi: JSI.

<sup>86</sup> Joint appraisal 2017 & EPI comprehensive review 2015.

RCH program where ongoing mentorship from experienced personnel has been provided to inexperienced ones to improve program performance. This is a new intervention for the IVD and partners; hence, there will be a need for closely monitoring its implementation before scaling up nationwide.

### 1.6. Strengthening community health workers system

- The MOHCDGEC has developed plans to train and employ CHWs. The MOHCDGEC, as detailed in the Health Sector Strategic Plan IV 2016-2020, reports that by 2020 between 50% and 60% of the villages will be covered<sup>87</sup> with formally trained CHWs. A curriculum for training CHWs has been developed and is being used. A scheme of service has been drawn up. Their roles include reaching households to create awareness on health issues including immunisation. The HSS2 funds will support the IVD to recruit 600 formal CHWs] who will be oriented to track defaulters and those with zero vaccination dose in geographical locations with high numbers of defaulters/unvaccinated children.. The CHWs will be deployed in low performing districts. This intervention complements efforts by GoT, The Global Fund and Irish Aid which are already supporting the GoT to recruit formal CHWs. Where the Global Fund and the Irish Aid have employed formal CHWs, the IVD will use these. These CHWs will also act as a link/bridge between health facilities and communities. The CHWs will be paid US\$150 per month as per established salary structure. The CHWs training misses defaulter tracing hence this will be updated and the CHWs will be oriented and provided with bicycles to facilitate travel in their catchment areas. The MOHCDGEC further plans the introduction of a community module of the EIS (Objective 3 of this proposal) and CHWs will register all children in their catchment areas and will also be able to track defaulters of immunisation services.

List approximately five (5) specific activities to be undertaken to achieve this objective:

→ *Reflect these activities in the budget & planning template*

#### 1.1 Implement country specific REC strategy with the involvement of communities.

- 1.1.1 Conduct REC ToT Training.
- 1.1.2 Conduct REC regional (10 regions) and council trainings (66 districts including urban areas).
- 1.1.3 Conduct REC health facility with community microplanning (10 facilities/council) and members of the health facility governance committee will be included in this training.
- 1.1.4 Monitor and evaluate REC microplanning.

#### 1.2 Support Periodic Intensification of Routine Immunization (PIRI) activities at health facilities.

- 1.2.1 Conduct intensified routine immunization activities in 25 poor performing councils each year.

#### 1.3 Conduct research to inform policy and programming

- 1.3.1 Conduct research on missed opportunities, burden of disease and other studies.
- 1.3.2 Conduct baseline assessment to identify existing drivers of low coverages in urban areas.
- 1.3.3 Conduct baseline assessment to identify reasons for low AEFI reporting.

#### 1.4 Strengthen VPD and AEFI surveillance systems

- 1.4.1 Conduct monitoring of sentinel surveillance system.
- 1.4.2 Conduct biannual sentinel sites review meetings.
- 1.4.3 Support sentinel sites data and performance review meetings.
- 1.4.4 Support FRI active search.

#### 1.5 Introduce mentorship program in immunization services

- 1.5.1 Develop immunization mentorship package.
- 1.5.2 Print mentorship package.
- 1.5.3 Orient mentors and disseminate mentorship package.
- 1.5.4 Conduct mentorship exercise.

#### 1.6 Strengthening community health workers system.

- 1.6.1 Recruit 600 CHWs to conduct community immunisation activities.
- 1.6.2 Procure and distribute bicycles to CHW to support outreach and defaulter tracking.

<sup>87</sup> MOHCDGEC HSSP 2015-2020

- 1.6.3 Develop and update immunisation defaulter tracing package for CHWs.  
 1.6.4 Support orientation of CHWs ToT for regions and councils.  
 1.6.5 Orient CHWs on defaulter tracing using tools such as my home my village.  
 1.6.6 Conduct quarterly monitoring and supportive supervision of CHWs.

### 1.7 Build the capacity of health workers in the health system to effectively deliver immunisation services

- 1.7.1 Orient 50 new health workers (RIVOs, Assistant RIVOs, DIVOs and Assistant DIVOs).

### 1.8 Support programme management to effectively monitor the implementation of program pans.

- 1.8.1 Conduct immunisation performance review sessions at council level.

#### Update the GPF to propose indicators to monitor progress toward this objective:

These provide a means to assess achievement of intermediate results and activity implementation.

→ **Reflect these in the Grant Performance Framework  
SEE GPF WHICH IS UPDATED**

Indicator	Definition	Data Source	Reporting frequency	Baseline (2018)	Target Year (2019)	Target Year (2020)	Target Year (2021)
1. <i>Percentage of health workers trained in REC at regional and district level</i>	Number of health workers trained in REC at regional and district level/target numbers of health workers to be trained multiplied by 100.	IVD/CHMT/RH NT training reports	Biannually	Numerator = 0 Denominator = 316 Percentage = 0%	Numerator = 158 Denominator = 316 Percentage= 50	Numerator =158 Denominator = 316 Percentage =50%	Numerator = 316 Denominator = 316 Percentage = 100%
2. <i>Percentage of health facilities conducting microplanning</i>	. Number of health facilities conducting microplanning/Number of health facilities targeted multiply by 100..	IVD/CHMT/RH NT supervision reports	annual	Numerator = 0 Denominator= 660 Percentage=0 %	Numerator = 660 Denominator= 660 Percentage=100 %	Numerator = 660 Denominator= 660 Percentage=100 %	Numerator = 660 Denominator= 660 Percentage=100 %
3. <i>No. of districts conducting PIRI</i>	No. of targeted districts conducting PIRI	IVD/CHMT/RH NT Reports	Annually	Numerator = 0 Denominator= 10 Percentage=0 %	Numerator = 10 Denominator= 10 Percentage=100 %	Numerator = 10 Denominator= 10 Percentage=100 %	Numerator = 10 Denominator= 10 Percentage=100 %

4. Percentage of planned studies conducted	Number of studies conducted/Percentage of planned studies conducted multiply by 100.	IVD/EPI progress reports	Annually	Numerator = 0 Denominator = 5 Percentage = 0%	Numerator = 2 Denominator = 5 Percentage = 40	Numerator = 3 Denominator = 5 Percentage = 60	Numerator = 5 Denominator = 5 Percentage = 100%
5. No. of sentinel sites meetings conducted	Number of sentinel sites meetings conducted	IVD progress report	Annually	Numerator = 0 Denominator = 2 Percentage = 0%	Numerator = 2 Denominator = 2 Percentage = 100%	Numerator = 2 Denominator = 2 Percentage = 100%	Numerator = 2 Denominator = 2 Percentage = 100%
6. Percentage of councils mentored.	Number of councils mentored/Number of councils targeted multiply by 100.	IVD reports	Annually	Numerator = 0 Denominator = 50 Percentage = 0%	Numerator = 0 Denominator = 50 Percentage = 0%	Numerator = 50 Denominator = 50 Percentage = 100%	Numerator = 50 Denominator = 50 Percentage = 100%
7. Percentage of community health workers recruited.	Number of community health workers recruited/Total number of community health workers to be recruited multiply by 100.	IVD/HR reports	Annually	Numerator = 0 Denominator = 600 (Tanzania mainland) Percentage = 0%	Numerator = 200 Denominator = 600 Percentage = 33%	Numerator = 400 Denominator = 600 Percentage = 66%	Numerator = 600 Denominator = 600 Percentage = 100%
8. Percentage of community health workers trained.	Number of community health workers trained/Total number of community health workers to be recruited multiply by 100.	IVD/HR reports	Annually	Numerator = 0 Denominator = 200 Percentage = 0%	Numerator = 200 Denominator = 600 Percentage = 33%	Numerator = 400 Denominator = 600 Percentage = 66%	Numerator = 600 Denominator = 600 Percentage = 100%
9. Percentage of community health workers reporting being supervised at least once a year	Number of community health workers reporting being supervised at least once a year/Total number of community health workers to be recruited multiply by 100.	IVD/CHMT reports	Annually	Numerator = 0 Denominator = 200 Percentage = 0%	Numerator = 100 Denominator = 200 Percentage = 50%	Numerator = 300 Denominator = 400 Percentage = 75%	Numerator = 500 Denominator = 600 Percentage = 83%

**Technical Assistance:** List the anticipated TA needs and timelines required to support this objective and plans for securing it (e.g., Gavi HSS, PEF/TCA, other sources?)

- Design of urban interventions to improve and sustain coverage [Year 2].
- Process evaluation of the REC approach [Years 1-5].
- Development of an effective system for tracking immunisation and other disease defaulters [Years 1].
- Development of immunization mentoring program [Year 1-2].
- Surveillance [Years 1-5].
- AEFI causality assessment [Year 2].

**Financing:** Justify any requests for Gavi to support major recurrent costs (e.g. human resources) regardless of transition stage.

→ **Countries in the preparatory and accelerated transition phase are restricted from using Gavi funds for recurrent costs** (please refer to the *Guidance on supporting countries' HR capacity, available here:* <http://www.gavi.org/support/process/apply/additional-guidance/>).

How much HSS budget is allocated to this objective:	Years 1-2	US\$ 4,604,497
	Years 3-5	US\$ 3,483,963

→ <b>Reflect the details in the budget and planning template</b>		
<b>Please also provide details on the key cost drivers, inputs and assumptions required for the main activities of this objective, here:</b>		
<b>Key cost drivers</b>	<b>Inputs</b>	<b>Assumptions</b>
<b>Service delivery</b>	REC HF with community microplanning. <ul style="list-style-type: none"> <li>• Transport.</li> <li>• Conference package.</li> <li>• Daily subsistence allowance.</li> </ul>	HF REC microplanning will be conducted in 660 HFs in 66 Councils (56 low performing plus 10 urban) in 24 regions
	PIRI <ul style="list-style-type: none"> <li>• Daily subsistence allowance</li> <li>• Fuel</li> </ul>	The activity will be done in 10 low performing councils each year for the first two years (2019 and 2020) of HSS Grant for 7 days. The activity will be implemented by 2 officers from each council and will be supported by 2 regional immunization officers from each region. In every council 10 health facilities with high number of unvaccinated children or low performing will be selected.
	Baseline assessment in urban <ul style="list-style-type: none"> <li>• Consultancy fee</li> <li>• Transport cost</li> <li>• Fuel</li> <li>• Daily subsistence allowance.</li> </ul>	The activity involves conduct baseline assessment to total of 19 councils in Dar es salaam (Ilala, Ubungo, Kigamboni, Kinondoni, Temeke), Arusha (Arusha CC, Arusha DC, Meru), Dodoma (Dodoma CC), Mbeya (Mbeya cc, Mbeya DC), Songwe (Tunduma), Mwanza (Ilemela, Nyamagana), Tanga (Tanga CC, Korogwe TC) and Zanzibar (Mjini, Kazikazini, Kati) the assessment will involve national level IVD 1, PORALG 1, Regional 1 and Council level staffs 2. This intervention will be done in collaboration with Academic institution and by staff of the IVD/Postgraduate students.
	Monitoring of sentinel sites surveillance system <ul style="list-style-type: none"> <li>• Daily subsistence allowance</li> <li>• Fuel</li> <li>• Transport cost</li> </ul>	This activity will be done in 8 sentinel surveillance sites twice a year for 3 years. During this monitoring, the 2 national laboratory personnel and 2 MOH officers and partners will carry out supportive supervision, mentoring, coaching and calibration of laboratory equipment.
	Sentinel site review meetings <ul style="list-style-type: none"> <li>• Daily subsistence allowance</li> <li>• Fuel</li> <li>• Transport cost</li> <li>• Refreshment package</li> </ul>	The program has 8 sentinel sites that are doing surveillance of rotavirus, PBM and CRS in the country. Each sentinel site will bring total of 8 participants
	FRI active case search <ul style="list-style-type: none"> <li>• Daily subsistence allowance</li> <li>• Fuel</li> <li>• Transport cost</li> </ul>	Two councils in ten regions will be supported to conduct active case search twice a years in three years as well.



	Develop immunization mentoring package <ul style="list-style-type: none"> <li>• Daily subsistence allowance</li> <li>• Fuel</li> <li>• Transport cost</li> <li>• Refreshment package</li> </ul>	National level staff and representation of regions and districts will be involved. 10 National staff 3 regional staff and 3 council staff will be used.
	Conduct Mentoring Exercise <ul style="list-style-type: none"> <li>• Daily subsistence allowance</li> <li>• Fuel</li> <li>• Refreshment package</li> </ul>	Training of Mentors who will be used as Mentors to Mentor councils and health facilities on better management of Immunization services. The mentors will come from 10 regions with the 15 low performing councils
	Monitor the Mentoring Programme <ul style="list-style-type: none"> <li>• Daily subsistence allowance</li> <li>• Fuel.</li> </ul>	The mentoring will be done by the Council Mentors on quarterly basis.
	Conduct Monitoring and supportive supervision of CHWs <ul style="list-style-type: none"> <li>• Daily subsistence allowance</li> <li>• Fuel</li> <li>• Transport cost</li> </ul>	The monitoring will done through supervision from the Regional level to health facility level. This exercise will involve personnel from regional (30) and council (30).
	Develop/Update package for community health workers defaulters tracing <ul style="list-style-type: none"> <li>• Daily subsistence allowance</li> <li>• Fuel</li> <li>• Refreshment package</li> </ul>	Will involve National Immunisation personnel, stakeholders and region and district immunisation officers for the first 5 days.
<b>Training</b>	Orient Mentors and disseminate mentoring package <ul style="list-style-type: none"> <li>• Daily subsistence allowance</li> <li>• Fuel</li> <li>• Transport cost</li> <li>• Refreshment package</li> </ul>	n 56 poor performing council, 10 facilities per council, 2 CHW per HF will be oriented for 2 days
	REC regional and council training <ul style="list-style-type: none"> <li>• Daily subsistence allowance</li> <li>• Fuel</li> <li>• Transport cost</li> <li>• Refreshment package</li> </ul>	Training will be conducted in all ten zones including 20 zonal facilitators, 10 national facilitators and 46 regional and 112 council participants.
	Orientation of Defaulter tracking package to community health workers (CHW) <ul style="list-style-type: none"> <li>• Daily subsistence allowance</li> <li>• Fuel</li> <li>• Transport cost</li> <li>• Refreshment package</li> </ul>	56 poor performing council, 10 facilities per council, 2 CHW per HF will be oriented for 2 days

	Immunization newcomers training to immunization supervisors and managers at all levels <ul style="list-style-type: none"> <li>• Daily subsistence allowance</li> <li>• Fuel</li> <li>• Transport cost</li> <li>• Refreshment package</li> </ul>	50 new comers in immunization services (RIVOs and Assistant RIVOs, DIVOs and Assistant DIVOs) and national coordinators) and 10 facilitators
	Immunization performance review sessions at council levels <ul style="list-style-type: none"> <li>• Daily subsistence allowance</li> <li>• Fuel</li> <li>• Transport cost</li> <li>• Refreshment package</li> </ul>	Performance review session will be conducted biannually in 8 regions, each session three days,
<b>Procurement</b>	Bicycles <ul style="list-style-type: none"> <li>• Price per unit</li> </ul>	600 CHVs will be given a monthly salary of \$160 as set by the Ministry.

**Template for Supply Chain (Applicable even if country is not applying for CCEOP):**

<b>Objective 2:</b>	To improve immunisation supply chain performance and efficiency to 90% or above by 2023.
<b>Timeframe:</b>	2019 - 2023
→ <b>Priority geographies/population groups or constraint(s) to coverage and/or equity</b> to be addressed by the objective: → <b>List to match those identified in Section B</b>	All supply chain levels namely at central, regional, council and health facilities.
<ul style="list-style-type: none"> <li>• <b>Describe the tailored intervention to address the particular supply chain constraints</b> and provide evidence of efficacy of the intervention</li> </ul>	
<p><b>2.1 Increasing availability of vaccines through strengthening systems for storage and distribution of vaccines and related supplies to all populations including the hard to reach populations.</b></p> <ul style="list-style-type: none"> <li>• There are delays in delivery of vaccines and supplies from the CVS to RVS and then from councils to health facilities. Such delays have caused stock outs of vaccines in various parts of mainland Tanzania and Zanzibar e.g. as reported in the SARA<sup>88, 89&amp;90</sup>. Thirteen percent (13%) of caregivers reported ever being turned away due to lack of vaccines<sup>91</sup>. The SARA also reports the percentage of health facilities with antigens at the time of the study ranging from 77% for BCG and 80% for DTP-HepB-Hib in 2012<sup>92</sup>. Delays in distribution are due to shortage of means of transport (e.g. vehicles, boats and motorcycles) and the high maintenance costs of vehicles which were purchased in 2006 for the regions. The volume of vaccines being transported has increased as new vaccines have been introduced since 2006; hence, existing vehicles do not have adequate carrying capacity to effectively and efficiently deliver vaccines to districts and health facilities. The limited capacity of vehicles has led to vaccine stock outs at health facility level as can be seen in Figure 8.1 and these tend to cause missed opportunities to vaccination.</li> </ul> <p style="text-align: center;"><b>Figure 8.1: Proportion of health facilities with antigens (SARA 2012&amp;2017)</b></p>	

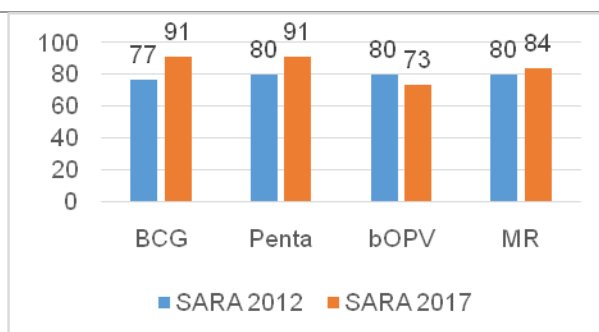
<sup>88</sup> Ifakara Health Institute. (2013). Tanzania service availability and readiness assessment 2012. Dar es Salaam: Ifakara Health Institute.

<sup>89</sup> Ifakara Health Institute. (2017). Tanzania service availability and readiness assessment 2017. Dar es Salaam: Ifakara Health Institute.

<sup>90</sup> MoH. (2015). EPI comprehensive review. Dar es Salaam: Ministry of Health.

<sup>91</sup> MoH. (2015). EPI comprehensive review. Dar es Salaam: Ministry of Health.

<sup>92</sup> SARA 2012, Pages 28-29.



There are 195 districts in Tanzania and 129 vehicles were purchased using HSS1 grant. This implies that 66 districts do not have vehicles. The HSS2 grant will be used to purchase (i) 26 vehicles to replace vehicles which were purchased in 2006; (ii) 36 vehicles for new districts; 33 motor cycles; and 9 boats. This implies that there will still be 20 districts without vehicles. The boats will support the delivery of health services including immunisation in the islands in Zanzibar and mainland Tanzania. A comprehensive fleet assessment, with support from WHO, will be conducted in early 2019 to confirm the gaps in terms of vehicles required including replacement plans.

- Over 50% of DVSSs have limited building space for storage of refrigerators and dry materials such as spare parts and injection materials. This limits the capacity of councils to keep adequate stock for specific supply periods. This intervention will support 30 councils to renovate substandard DVSSs for effective management of vaccines and related supplies for immunisation activities. These councils are as follows: Geita DC, Geita TC, Mbogwe DC, Nyang'wale DC, Mpanda DC, Mpanda MC, Buhigwe DC, Kasulu TC, Kasulu DC, Chunya DC, Busokelo DC, Buchosa DC, Ilemela MC, Ukerewa DC, Nyamagana MC, Wanging'ombe DC, Njombe DC, Kabiti DC, Chalinze DC, Bagamoyo DC, Kalambo DC, Sumbawanga DC, Sumbawanga MC, Msalala MC, Ushelu MC, Shinyanga DC, Bariadi DC, Banadi TC, Itilima DC, Itigi DC, Mkalama DC, Momba DC, Songwe DC and Tunduma TC. This will enable councils and service delivery points to have adequate stores for vaccines and injection materials for specific supply periods.

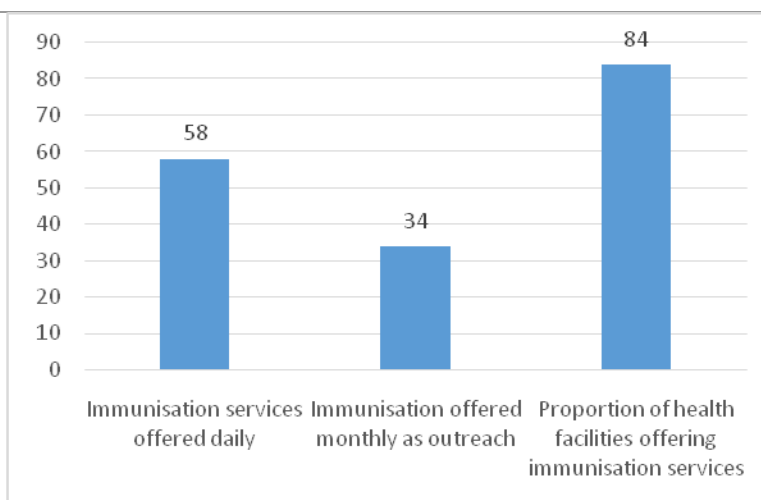
## 2.2 Equip health facilities with sufficient and high-performing cold chain infrastructure to meet the present and future service delivery coverage needs.

- The cold chain storage capacity analysis (See WHO sizing tool) during Tanzania's CCEOP application showed that there will be an increase in volume estimated per fully immunized child based on the country's vaccines introduction plan by 64% at national and subnational levels and 63% at health facility level. Tanzania has requested through plans to cater for this additional capacity need by procuring higher storage capacity equipment (doubling capacity at the facility from roughly 24L per site to over 50L) to replace existing low capacity sub-optimal equipment.
- This intervention will address coverage inequity by equipping sites with no CCE especially in hard to reach areas and councils with immunization coverage of <80%. The priority will be to install the SDD refrigerators in rural and hard to reach health facilities and councils with coverage of <80%<sup>93</sup>. This effort to equip all unequipped sites across councils will improve access to immunization services as currently such sites offer 1 immunization session per month or none. Once these facilities are equipped, they will be able to offer immunisation services at least 5 days a week enabling improved coverage and a significant reduction in missed opportunities. In 2017, only 84% of the health facilities offered immunisation services: 58% of these facilities offered immunization on daily basis while 34% were offering immunization through outreach as can be seen in Figure 8.2 below.

**Figure 8.2: Proportion of health facilities offering immunisation services<sup>94</sup>**

<sup>93</sup>CCRP Plan pages 16-17).

<sup>94</sup> SARA 2017, 56-58.



- The intervention also aims at improving sustainability and effectiveness of the immunization program by reducing logistical disruptions and additional operating expenditures resulting from suboptimal CCE. By replacing old and beyond repair and other suboptimal equipment, disruption to immunization services (e.g. through regular CCE breakdown and shortage of LP Gas) will be minimised. This is expected to improve immunization coverage and raise the coverage levels beyond the target of above 90%. The 2017 CCI report indicates that roughly 81% of CCE are absorption refrigerators, 10.4% (674) are non-functional refrigerators and over 37% (2,012) are over 10 years old. Tanzania has already been awarded CCEOP grant worth US\$11 million which will cover not more than 60% of the initial quantified need of \$20.3 million. Through this intervention, the program intends to address the remaining gaps of CCE requirements in the country and taking into consideration a high quoted service bundle fee. This intervention will ensure there is sufficient cold chain storage capacity to accommodate routine and new vaccine introductions up to 2025.

### 2.3 Strengthen systems for management of CCE and maintenance in a well-functioning state to minimize vaccine wastage and missed opportunities.

- Cold chain assessments conducted in mainland Tanzania and Zanzibar between October 2012 and September 2013 established functionality status at 35.5% and 16% at facility and district levels, respectively. Previous assessments have shown that there is a shortage of skilled cold chain technicians, lack of spare parts and shortage of tool kits for preventive maintenance of CCE. This intervention will build the capacity of cold chain technicians and ensure availability of spare parts and toolkits at all levels of health care. This will improve and maintain high functionality status of the cold chain. Lastly, the 2015 EPI review documented the lack of adequate pre and post services programs for training of cold chain technicians. Over the period 2019-2023, the IVD will increase the number of technicians and, therefore, improve response time and down time of CCE in Tanzania.

### 2.4 Improve temperature monitoring at all levels of the health system.

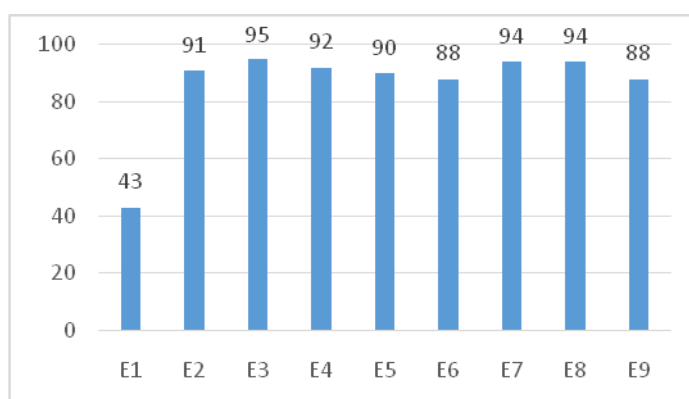
- IVD programme has already purchased 120 RTM devices with support from Nexleaf through JSI covering 7 districts and 113 facilities. The HSS2 grant will be used to cover remaining gap of devices in remaining districts and facilities in the country.
- Untimely and inaccurate reporting of cold chain functionality and temperature performance status delays responses and decision-making processes which ultimately disrupt service provision. This intervention will improve provision of effective service delivery by preventing disruptions to services due to CCE breakdown and prevent vaccine wastages estimated at \$62 million as of 2017 due to freezing. Temperature monitoring studies conducted in Tanzania mainland (2014) and in Zanzibar (2018) revealed that 36% and 17% of the vaccine study shipment stocks are potentially at risk of freezing, respectively. These incidences can go unnoticed and cause vaccine wastages. Timely visibility on temperature alert up to facility level will enable the program to take timely corrective measures. In addition to this, the visibility of stock at all levels of immunization system will guide decisions for timely delivery and redistribution of commodities and avoidance of overstocking and stock outs and, hence, minimize chances of expiry. This intervention will enable the program to have real time visibility of the data to monitor stock availability, CCE functionality and temperature performances and consequently improve the quality of immunization services.

### 2.5 Improve capacity and skills of immunization staff to manage vaccine per EVM standards and reduction of storage and distribution cost.

- This intervention will address key issues identified as weakness in the previous EVM assessment conducted in 2015 for continuous improvement of the supply chain functions. The key issues which have been identified include the vaccine handling at national level was at 43% (Figure 8.3) which is below EVM standard for both mainland Tanzania and Zanzibar, the lack of skills and knowledge by staff who manage vaccines at both MSD

and IVD and that lot release certificates are not always available and attached to shipping documents. IVD is taking over from the MSD the management of the CVS and this intervention aims at building the capacity and skills of immunisation staff to enable them effectively perform their new roles of warehousing, transport management and distribution.

**Figure 8.3: 2015 EVM score<sup>95</sup>**

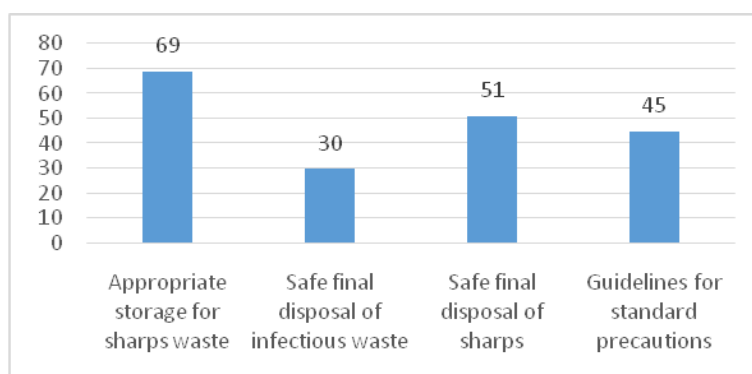


- Over the past 5 years, the number of councils in Tanzania has increased as part of the government effort to move social services closer to communities. This increase has created capacity improvement needs for newly hired Immunization and Vaccine Officers and those who need to upgrade knowledge and skills on vaccine management up to facility level. The need for continuing improvement of knowledge is also important because of the expected increase in the number of vaccines in the programme and the introduction of new technology.

**2.6 Strengthening waste management capacity, skills and infrastructure for immunization and the wider health system**

- Immunisation activities generate a lot of waste such as sharps and infectious non-sharp wastes which can cause direct negative health impacts on the community and the personnel working spaces. The 2017 SARA documents evidence on the gaps for waste management. For instance, only 69% and 45% of the health facilities had appropriate measures for sharp waste storage and guidelines for standard precautions, respectively (See Figure 8.4).

**Figure 8.4: Standard precautions for infection prevention<sup>96</sup>**



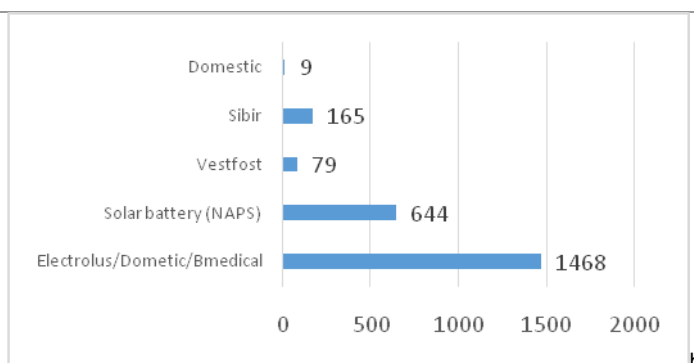
Furthermore, 30% and 51% of these health facilities have safe final disposals of infectious wastes and sharps, respectively.

- In addition, pollution due to inadequate treatment and disposal of obsolete refrigerators, cold boxes and vaccine carriers wastes can cause indirect health effects in the community and negatively impact the environment. As per CCI of 2017, there are over 2,000 pieces of obsolete equipment which need to be safely disposed of as can be seen in Figure 8.5 below.

**Figure 8.5: Number of obsolete CCE**

<sup>95</sup> EVMA 2015, Page 6.

<sup>96</sup> SARA 2017, Pages 36-37.



This intervention will lay ground for smooth deployment of the expected equipment to be procured through CCEOP and also providing healthy working environments for immunization staff at all levels thereby protecting the environment.

- **List priority activities for each of the five supply chain fundamentals:**
- Describe the activities related to supply chain fundamentals – for those planned in years 1-2 and those planned in the outer years (3-5).

→ **These activities should be linked to the latest EVM Improvement Plan and be reflected in the operational work plan & budget**

**1. Continuous Improvement**

• *First two years (Years 1-2)*

- 2.1.1 Support renovation of sub-standard district vaccine stores in districts with inadequate vaccine storage space.
- 2.2.1 Support procurement of CCE for use at district and health facilities.
- 2.2.2 Procure CCE spare parts.
- 2.2.3 Deploy CCE..
- 2.4.1 Procure and install remote temperature monitoring systems at regions, districts and health facilities.
- 2.5.1 Conduct EVMA.
- 2.6.1 Decommission obsolete CCE available at district and health facilities in the country.

3 *Outer years (Years 3-5)*

- 2.1.1 Renovate sub-standard district vaccine stores in districts with inadequate vaccine storage space.
- 2.4.1 Procure and install remote temperature monitoring systems at regions, districts and health facilities.
- 2.4.2 Review, update and print SOP's (including job aids and response protocols).
- 2.5.1 Conduct EVMA.
- 2.6.1 Decommission obsolete CCE available at district and health facilities in the country.
- 2.6.2 Upgrade immunisation management infrastructures.

**2. Management/Leadership**

• *First two years (Years 1-2)*

- 2.1.2 Procure vehicles, boats and motorcycles for distribution of vaccines.
- 2.1.3 Support drivers attend a short course on fleet management and safe transportation of vaccines and related supplies.
- 2.5.2 Conduct vaccine wastage assessment study at all levels of vaccine storage and immunisation service delivery.
- 2.5.3 Conduct training of national immunization officers to meet new roles for warehousing distribution and upgraded temperature monitoring systems.
- 2.5.4 Train immunisation officers and technicians on vaccine management and new technologies at all level.

• *Outer years (Years 3-5)*

- 2.3.1 Train cold chain technicians on repair and maintenance on new technologies.

**3. Data for Management<sup>97</sup>**

• *First two years (Years 1-2)*

- Integrate temperature monitoring data into the EIS platform.
- Develop and install warehouse information management system at IVD.
- Design and implement data-driven review systems for supply chain data including temperature monitoring.

• *Outer years (Years 3-5)*

- Develop and implement Tanzania immunization supply chain mobile application.

**4. Cold Chain Equipment (including maintenance)**

<sup>97</sup> The development and installation of the warehouse information management system has been covered in the HSS2 budget but the other activities are being covered by other partners such as JSI.

- **How will the country ensure that aspects of maintaining the cold chain are addressed (e.g. preventive and corrective maintenance, monitoring functionality, technicians, financing for maintenance, spare part procurement etc.)?**

Four qualified cold chain technicians at national level support corrective maintenance and the repair of refrigerators/fridges in Tanzania. There are two technicians in each region and RIVOs have also been trained in minor repair and maintenance. Out of 195 councils, there are 33 council technicians trained in maintenance and repair of CCE. The remaining councils rely on technical support from regions and central level technicians for more complex repairs. DIVOs have also been trained on minor repair and maintenance at council level.

In order to ensure sustainability of the skills imparted and avoid additional labour costs, all technicians involved in the trainings of cold chain technicians in maintenance and repair of CCE are government employees. The remuneration for these technicians is from either Central or Local Government budgets, hence, costs are low. Tanzania has CCE maintenance guidelines and SoPs which constitute part of newcomers and refresher trainings for health workers and council and regional immunization officers. Quarterly reviews, supportive supervision and mentoring are conducted at all levels to monitor performance in maintenance and ensure that SOPs are adhered to. The procurement of spare parts is usually done through UNICEF–Supply Division except during emergencies when parts are procured locally. Council, central government or partners, mainly CHAI, UNICEF and MCSP finance these procurements. All council and regional Cold Chain Technicians are provided with an equipment maintenance tool-kit supplied with spare parts.

- **What is the frequency of preventive and corrective maintenance that the country commits to (supported by partners)?**

Preventive maintenance of CCE involves regular preventive maintenance done on daily, weekly and monthly basis by health workers at health facility level and immunization officers at council and regional levels. Corrective maintenance is conducted whenever a report comes from the user who escalates broken equipment alert. The number and location of the broken equipment determines strategies for conducting corrective maintenance either through assembled workshops or direct visit at the site.

- **How will the country monitor the completion of preventive and corrective maintenance?**

The key performance indicator for monitoring the effectiveness of repair and maintenance is the proportion of functional CCE at any point in time. The IVD is currently tracking the functionality of CCE through the web-based SMT/CCIT and this is updated on real time basis. On bi-annual basis, the MOHCDGEC conducts a periodic update of the CCI data and analyses it for action and sharing with other stakeholders. The MOHCDGEC will monitor this indicator through the VIMS. VIMS is a comprehensive vaccine information management system which integrates all information on immunization supply, stock management, routine immunization utilization and CCE management. Currently, when repairs are undertaken, the technician fills out a job card, records the date, the actions undertaken, the parts which were replaced (if any), the status of the device at the end of the visit, and any further actions which had been undertaken. The job card is usually taken to the immunization and vaccine officer who is supposed to update functionality status of repaired equipment in the web-based CCIT.

- **Indicate the sources of funding for planned maintenance activities**

CCE maintenance at council level is funded through council comprehensive health plans (CCHP). The funds are usually allocated for transport, daily subsistence allowance for technicians, procurement of spare parts, LP gas cylinders and paying electricity bills. However, funding released for CCE maintenance is in most cases inadequate to meet all the needs within the council. The IVD is engaging PO-RALG through their RCHPs and CCHPs to ensure that each facility budget has adequate funds for procurement of basic spare parts and technician allowances to support repairs in their respective areas. Partners including UNICEF, WHO, CHAI and MCSP have provided funds for procurement and distribution of spare parts and daily subsistence allowance for technicians to perform maintenance and repairs at regional, council and health facilities levels.

- **How will the country dispose of obsolete and irreparable equipment by new equipment?**

Disposal of obsolete equipment follows the Guidelines for Management of Hazardous Wastes (2013) under National Environmental Management Council and other government guidelines. All



unserviceable equipment will be collected from health facilities to the district level and commencement of disposal procedures will start. Equipment at central and regional levels are disposed of by the respective authorities (VETA, an authorized refrigerant reclaimer).

- **System design (all countries should answer) If the country is applying for CCEOP, also indicate how system design considerations impacted the choice of CCE for which the CCEOP support is requested.**

Most health facilities are located in rural, remote areas where access to electricity is a major challenge: 32% of the facilities have electricity and the remaining ones use gas as the main source of power for refrigerators. Therefore, health facilities with no access or irregular electricity availability shall receive SDD fridges depending on their capacity needs. There has been an increase in the number of districts and health facilities. From 2013 to 2016, 50 new councils have been created which is an increase of 14% of the total councils in Tanzania. This trend has also been considered in establishing the number of CCE required.

For sustainability, immunization services are expected to cut down current expenditure for procuring/refilling LPG to run refrigerators at facility level. The averted funds will be used to sustain CCE and maintenance plan through the procurement of new SDD refrigerators for replacement of defective equipment, spare parts and refrigerators for new health facilities. Furthermore, the platform is expected to replace 100% of the outdated absorption refrigerators: this will spare workers' time for other supply chain tasks and reduce maintenance cost. The platform will also lead to the expansion of immunization services which allows reduced burden on health workers allowing more time for support of supply chain tasks.

- **Describe how the sustainability of these activities will be ensured in the future:**

The program continually develops comprehensive multi-year plans and annual plans engaging PO-RALG through their regional, council and health facility plan to ensure that all immunization activities are budgeted with adequate funds. The program has developed minimum checklist for immunization activities to guide the councils and health facilities in their plans.

→ **List indicators to monitor progress toward objective:**

→ **Reflect these in the Grant Performance Framework**

If requesting CCEOP support, include mandatory indicators (please refer to the programming guidance, here: <http://www.gavi.org/support/process/apply/hss/>)

Indicator	Definition	Data Source	Reporting frequency	Baseline (2018)	Target Year (2019)	Target Year (2020)	Target Year (2021)
1. Percentage of existing sites with (non) functional and / or obsolete non - PQS and PQS equipment to be replaced with platform-eligible ILR, SDD or long-term passive devices (including equipping sites with a larger equipment)	<i>Number of existing sites with non-functional and/or obsolete non-PQS and PQS equipment replaced with new non-PQS/PQS equipment/ Number of existing sites with non-functional and/or obsolete non-PQS and PQS equipment multiply by 100</i>	CCIT tool (VIMS)	Biannually	Numerator = 0 Denominator = 4,809 Percentage = 0%	Numerator = 390 Denominator = 4,809 Percentage= 8%	Numerator =1,070 Denominator = 4,809 Percentage =22%	Numerator = 2,450 Denominator = 4,809 Percentage = 51%
2. Percentage of existing sites being equipped with <b>ADDITIONAL</b>	<i>CCE expansion in existing equipped sites:</i>	<i>Sizing tool + CCIT tool (VIMS)</i>	Annually	<i>Numerator = 0 Denominator=80 Percentage=0%</i>	<i>Numerator = 0 Denominator=80 Percentage=0%</i>	<i>Numerator = 80 Denominator=80 Percentage=100%</i>	<i>Numerator = 80 Denominator=80 Percentage=100%</i>



<i>pieces of equipment for new vaccine introduction and/or to serve an increasing population</i>							
3. Percentage of previously unequipped sites (providing immunisation services or not, including existing sites without active devices) and new service sites being equipped with Platform eligible equipment	.CCE extension in unequipped existing and/or new sites:	CCIT tool - (VIMS)	Annually	Numerator = 0 Denominator=567 Percentage=0%	Numerator = 567 Denominator=567 Percentage=100%	Numerator = 567 Denominator=567 Percentage=100%	Numerator = 567 Denominator=567 Percentage=100%
4. Percentage of districts with at least 90% of facilities with full stock availability	Numerator: Number of districts with more than 90% health facilities without vaccine stock out; Denominator: Total number of districts	VIMS	Quarterly	Numerator = Denominator=184 Percentage =	Numerator = Denominator = 184 Percentage =	Numerator = Denominator = 184 Percentage =	Numerator = Denominator = 184 Percentage =
5. Percent of refrigerators with functional prequalified Temperature Monitoring Devices (TMD) (includes both 30DTR and RTMD)	Number of refrigerators with functional prequalified Temperature Monitoring Devices (TMD) (this includes both 30DTR and RTMD)/Total number of refrigerators multiply by 100	VIMS	Quarterly	Numerator = Denominator= Percentage = 100%	Numerator = Denominator= Percentage =	Numerator = Denominator= Percentage =	Numerator = Denominator= Percentage =
6. Percentage of health facilities with CCE having more than 6 temperature alarms during last month	Number health facilities with CCE having more than 6 temperature alarms during last month/Total number of health facilities with CCE	VIMS (Temperature alarm report)	Monthly	Numerator = 6 Denominator=48 Percentage =13%	Numerator = Denominator= Percentage =	Numerator = Denominator= Percentage =	Numerator = Denominator= Percentage =
7. Percentage of districts with no stock of any antigen (i.e. full availability) for the past 3 months	Number of districts with full availability of all antigen for the past 3 months/Total number of districts multiply by 100	VIMS	Quarterly	Numerator = 117 Denominator =184 (Tanzania mainland) Percentage = 64%	Numerator = 148 Denominator=184 Percentage = 80%	Numerator = 157 Denominator=184 Percentage = 85%	Numerator = 166 Denominator=184 Percentage = 90%
8. Percentage of orders delivered on-	Number of Regional vaccine stores	VIMS	Quarterly	Numerator = 0 Denominator= 26 Percentage = 0%	Numerator = 7 Denominator= 26 Percentage = 27%	Numerator = 13 Denominator= 26 Percentage = 50%	Numerator = 20 Denominator= 26 Percentage = 75%

time and in-full (OTIF) from National to the Regional level of supply chain for the past	receiving deliveries on time and in full (OTIF) from National vaccine store/Total number of order from Regional Vaccine Stores multiply by 100.						
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- **Detail TA needs required to support this activity and** clarify how much is not covered by PEF/TCA.

1. Management of supply chain functions (storage and distribution at IVD), [Year 1].
2. Cold chain decommissioning [Years 1 & 2].
3. Scale up of remote temperature monitoring system at facility levels [Year 1-3].
4. EVMA assessment [Year 5].
5. Comprehensive fleet assessment [Year 1].

→ <b>How much HSS and CCEOP budget is allocated to this objective</b>	<b>Years 1-2</b>	<b>US\$ 11,100,170</b>
→ <b>Insert here same figures as in table 2.4. and also reflect these in the budget and planning template</b>	<b>Years 3-5</b>	<b>US\$ 1,067,777</b>

- **Please also provide details on the key cost drivers, inputs and assumptions required for the main activities of this objective, here:**

Key cost drivers.	Inputs	Assumptions
<b>Management</b>	EVM and vaccine wastage assessments. <ul style="list-style-type: none"> <li>• Transport.</li> <li>• Conference package.</li> <li>• Stationery.</li> <li>• Daily subsistence allowance.</li> </ul>	The assessments will include orientation of assessors, data collection, analysis, report writing and dissemination of findings.
	Standard operating procedures <ul style="list-style-type: none"> <li>• Conference package</li> <li>• Printing and dissemination costs</li> </ul>	As part of continuous improvement, the programme will review and update the standard operating procedures to meet global changes and standards.
	Project management team <ul style="list-style-type: none"> <li>• Conference package</li> <li>• Number of meetings per year</li> </ul>	Assumes the roles of monitoring the deployment of equipment to avoid deviations and delays during installation.
	Infrastructures upgrades (district vaccine store and incinerators) <ul style="list-style-type: none"> <li>• Cost per DVS renovation</li> <li>• Cost per incinerator renovation</li> </ul>	District vaccine stores infrastructure need to be upgraded to adequately store incoming refrigerators, injection and vaccines. A total of 30 DVS will be renovated.  Treatment of wastes need to be improved to ensure safe disposal and avoid environmental pollution.
<b>Training</b>	Drivers <ul style="list-style-type: none"> <li>• Cost per driver per course.</li> <li>• Number of courses per driver.</li> </ul>	IVD will take over distribution functions from Medical Stores Department (MSD). Driver will need to be trained to safely transport vaccines and operate refrigerated vehicles, a responsibility previously conducted by MSD.
	Program Officers at IVD vaccine storage <ul style="list-style-type: none"> <li>• Cost per program officer per training.</li> <li>• Number of trainings per program officer.</li> </ul>	IVD will take over vaccine storage and distribution functions from MSD. IVD officers will be trained to safely store and manage vaccines and related supplies.

	Immunization and vaccines officers <ul style="list-style-type: none"> <li>• Cost per officer per training.</li> <li>• Number of trainings per officer.</li> </ul>	IVD will continuously improve knowledge and skills of immunization officers at sub-regional level to use new immunization developments and technologies for general performance improvement.
<b>Procurement</b>	Refrigerators <ul style="list-style-type: none"> <li>• Price per unit</li> <li>• Service bundle cost per unit</li> </ul>	The program will procure 1,000 refrigerators for use at health facilities and district vaccine stores through HSS 2 funds to fill the gap after \$11m CCEOP procurement.
	Cold chain spare parts <ul style="list-style-type: none"> <li>• Price per unit</li> <li>• Number of spare parts per refrigerator</li> </ul>	Spare parts will be procured to enable that technicians carry out maintenance and timely repairs to ensure CCE are maintained and are in a well-functioning state.
	Vehicles <ul style="list-style-type: none"> <li>• Price per vehicle</li> <li>• Number of vehicles</li> </ul>	Vehicles at regional level have depreciated i.e. are beyond economic life of 10 years since they were procured, and have limited capacity to carry vaccines at Regional and Council level.
	Boats <ul style="list-style-type: none"> <li>• Price per boat</li> <li>• Number of boats</li> </ul>	Boats are needed for delivery of supplies and services (outreach and supervision) to facilities located in islands and delta along the shores. They will not only be used for immunisation but also other health services as well.
	Motorcycles <ul style="list-style-type: none"> <li>• Price per motorcycle</li> <li>• Number of motorcycles</li> </ul>	Assumed that some sites are inaccessible by vehicles and thus motorcycles will be used to deliver supplies and services (outreach and supervision) and perform repairs during CCE breakdowns.
	Temperature monitoring devices <ul style="list-style-type: none"> <li>• Price per device</li> <li>• Maintenance and communication fee</li> </ul>	Assumed every cold chain point requires temperature monitoring device to continuously monitor temperature

<b>Objective 3:</b>	To improve data management and utilisation at all levels of the health system.
<b>Timeframe:</b>	2019-2023
→ <b>Priority geographies/population groups or constraint(s) to coverage and/or equity to be addressed by the objective:</b> <ul style="list-style-type: none"> <li>• <b>List to match those identified in Section B</b></li> </ul>	National, regional, council and health facility levels.
<b>Describe the tailored interventions to address this constraint</b> and provide evidence of efficacy of the intervention. Describe the critical national capacities that will be established or strengthened as a result of this investment.	

### **3.1 Strengthen the utilization of Electronic Immunization Systems (EIS) to improve data availability at all levels.**

- Tanzania has introduced EIS that captures and monitors data on routine immunisation, vaccine stocks and cold chain inventory and functionality at all levels. This system is holistic and enhances the effectiveness and efficiency of data collection, reporting and has the capacity to link various data systems. This system is currently being implemented in 4 regions, 33 councils and 1,300 facilities which provide immunisation services. With the current HSS1 grant, the EIS will be expanded to 6 regions by the end of 2018 to make up a total of 10 regions, 76 councils and 2,800 health facilities in Zanzibar/mainland Tanzania. The implementation of the EIS in the 4 regions has demonstrated that it improves timeliness of data submission by facilities, completeness of data and data accuracy<sup>98</sup>. An evaluation has found that health workers rate EIS data as of high quality, and were able to use the data (e.g. to trace defaulters) compared to the situation at baseline<sup>99</sup>. With HSS2 funds, the EIS will be scaled up to the remaining 21 regions and 118 districts both mainland Tanzania and Zanzibar.
- Based on the successful implementation of the EIS in 4 regions, the GoT has decided to scale up the EIS nationwide by December 2019 and has committed resources for the training of health workers, data bundle for internet, equipment replacement and supervision as part of the scale-up of EIS, initial investments in equipment (e.g. tablets, computers and servers), software enhancement and integrations with existing and upcoming national information systems and technical capacity in software development and maintenance beyond GAVI support. With HSS2 support, the EIS will be rolled out in the remaining 21 regions, 118 councils and 3,700 health facilities in mainland Tanzania and Zanzibar. This intervention will address challenges of parallel reporting systems and improve timely availability of data.
- For VPD surveillance and response, there is lack of linkage between case based surveillance system and the laboratory system and this imposes an unnecessary inconsistency of data. In addition, the lack of data sharing between laboratory surveillance information and case-based surveillance system have been causing a delay in responding to VPD's cases<sup>100</sup>. To address this gap, the IVD will develop an integrated reporting system for clinical and laboratory surveillance system to enhance data sharing.
- Health workers at all levels of the health system should be able to use the data in order to realize the full potential of EIS which will be rolled out countrywide. IVD will, therefore, apply continuous quality improvement and change management approaches which will be incorporated in data review meetings, desk reviews and mentorship in order to strengthen quality and use of EIS data for decision making.

### **3.2. Improve immunization data quality for better decision making at all levels**

- There is significant discrepancy between data from DHIS2 and IVD systems<sup>101</sup>. The JRF reports also show that 45% of councils reported over 100% coverage for DTP-3 in 2017<sup>102</sup>; hence, the need to address issues of denominator which impact on data quality. Introducing community module as part of EIS will help address target population challenges by making sure that the correct birth cohort at community level is registered and registered with immunisation services. The CHWs will be given tablets in which they will enter all the children in their village and this will be linked to the health facility EIS. All children who have not been vaccinated will be picked up by the system and followed up by the CHWs. The use of the EIS at community level will address the denominator challenges currently being experienced by the IVD and partners.
- Data quality audits (DQA) in Tanzania are conducted irregularly and recommendations from such audits are often not fully implemented. The 2017 DQA found that the consistency of reporting to district level based on source documents was only 49% and consistency between monthly paper reports and data entered in DHIS2 was 70%<sup>103</sup>. The issue of data quality is also affected by absence of data reviews at subnational level, incomplete reports and delays of submission of data by health facilities to districts<sup>104</sup>. IVD is planning to conduct coverage survey during MR campaign in 2019 as part of assessing community protection and evaluating administrative data reported. This intervention is aimed at improving accuracy, consistency, timeliness and completeness of data at all levels of health system so that it can effectively inform decision-making.

### **3.3 Improve capacity of healthcare workers and managers at national and sub-national levels to use immunization and surveillance data for better decision making**

- The EPI review acknowledges that there is a general lack of knowledge and skills among health workers on data management, analysis and utilisation. Most data that are generated at service delivery points are not used for decision making due to limited capacity in data analysis. Effective decision making at all levels should be informed by data and this can address many health problems including why some children are not being vaccinated. This intervention aims at building the capacity of health workers on data management, analysis and use for planning. In order to ensure

<sup>98</sup> Mott Macdonald. (2017). Evaluation of the Better Immunization Data Initiative. London: Mott Macdonald (Page 25-28).

<sup>99</sup> Kindoli, R. (2017). BID initiative midline evaluation report: immunization data quality and use in Arusha region, Tanzania. Dar es Salaam: PATH Tanzania.

<sup>100</sup> EPI comprehensive review 2015.

<sup>101</sup> EPI comprehensive review 2015.

<sup>102</sup> IVD admin data 2017.

<sup>103</sup> Tanzania DQA report 2017.

<sup>104</sup> EPI comprehensive review 2015.

sustainability, the EPI data management will be incorporated into the HMIS training package for health workers and managers at all levels.

#### 4. Support generation of evidence to inform policy and programming

- The TDHS is conducted every 4-5 years. There is no other national population based survey which looks at immunisation coverage in details. HSS2 funds will be used to conduct one national immunisation coverage survey. WHO recommends the conduct of national immunisation coverage surveys to provide coverage estimates for selected vaccines as well as assessing equity in immunization. An orientation will be conducted on supportive supervision checklist through the ODK platform. This will constitute one way of collecting data on supportive supervision.

List approximately five (5) specific activities to be undertaken to achieve this objective:

→ **Reflect these activities in the budget & planning template**

#### 3.1 Strengthen Electronic Immunization Systems to improve data availability, quality and use.

- 3.1.1 Procure tablets and related electronic devices and accessories required for the EIS.
- 3.1.2 Review and update EIS user and facilitation guides.
- 3.1.3 Scale up of EIS in remaining 21 regions, 118 councils and 3,700 health facilities in mainland Tanzania and Zanzibar.
- 3.1.4 Support EIS maintenance based on user and program needs.
- 3.1.5 Support enhancement of EIS to include community based module and integration with HMIS modules at health facility level to improve and address challenges of parallel reporting systems.
- 3.1.6 Develop and install Warehouse Management Information System for CVS management as part of EIS for end-to-end visibility.
- 3.1.7 Conduct leadership sensitisation for EIS sustainability (including technical, financial and equipment) to local authorities.
- 3.1.8 Review, update, print and disseminate EPI data collection tools (AEFI, Tally sheet, Monthly summary form and performance monitoring chart).
- 3.1.9 Develop and orient integrated VPD surveillance database.
- 3.1.10 Automate selected health facilities to implement EIS/CRVS systems.

#### 3.2 Improve immunization data quality for better decision making at all levels

- 3.2.1 Conduct immunization data reviews and verification including desk reviews for root cause analysis and action planning to increase accountability and data driven solution and feedback at all levels.
- 3.2.2 Conduct Data Quality Self-Assessment (DQS).
- 3.2.3 Conduct annual data cleaning and harmonization meetings.

#### 3.3 Implement continuous improvement of healthcare workers' and managers' skills to use immunization and surveillance data for better decision making

- 3.3.1 Provide in-depth mentorship to regions, councils and health facilities especially those that demonstrate low usage of the EIS.

#### 3.4 Support the generation of evidence to inform policy and programming.

- 3.4.1 Conduct ad hoc surveys and ensure data consistency across sources.
- 3.4.2 Conduct orientation on the integrated supportive supervision checklist through ODK platform (adopt WHO integrated supportive supervision tool in ODK) to immunization managers.
- 3.4.3 Incorporate EPI data management into the HMIS training package for health workers and managers at all levels.

**Update the GPF to propose indicators to monitor progress toward this objective: These provide a means to assess achievement of intermediate results and activity implementation.**

Indicator	Definition	Data Source	Reporting frequency	Baseline (2018)	Target Year (2019)
1. % of regions with functional EIS	1. Number of regions with EIS/Total number of Regions multiply by 100	IVD reports	Quarterly	Numerator = 10 Denominator = 31 Percentage= 33%	Numerator = 31 Denominator = 31 Percentage 100%
2. % of councils with functional EIS	2. Number of councils/Total number of councils multiply by 100	IVD reports	Quarterly	Numerator =77 Denominator = 195 Percentage= 39.5%	Numerator = 195 Denominator=195 Percentage=100%

3. % of councils with DPT3 coverage of more than 100%.	3. Number of councils with DPT3 coverage of more than 100%/Total number of councils multiply by 100.	IVD reports	Annual	Numerator = 88 Denominator=195 Percentage=45%	Numerator = 0 Denominator=195 Percentage=0%
4. Number of health workers trained on how to use EIS.	4. Number of health workers who received EIS training	IVD reports, HRHIS reports	annual	Number: 0	Number: 3,700
5. % of council data review meetings conducted	5. Number of council data review meetings conducted/Total number of meetings planned multiply by 100.	IVD reports	biannual	Numerator: 40 Denominator: 40 Percentage: 100%	Numerator: 40 Denominator: 40 Percentage: 100%

**Technical Assistance:** List the anticipated TA needs and timelines required to support this objective and plans for securing it (e.g., Gavi HSS, PEF/TCA, other sources?)

The following technical assistance will be required:

- Systems design and maintenance [Year 1-3].
- Implementation of DQA [Year 2].
- Change management – to improve and sustain use of EIS [Year 1-5].

**Financing:** Justify any requests for Gavi to support major recurrent costs (e.g. human resources) regardless of transition stage.

→ **Countries in the preparatory and accelerated transition phase are restricted from using Gavi funds for recurrent costs** (please refer to the *Guidance on supporting countries' HR capacity*, available here: <http://www.gavi.org/support/process/apply/additional-guidance/>).

...

How much HSS budget is allocated to this objective:

→ **Reflect the details in the budget and planning template**

Years 1-2

US\$ 3,879,936

Years 3-5

US\$ 3,562,840

Please also provide details on the key cost drivers, inputs and assumptions required for the main activities of this objective, here:

Key cost drivers	Inputs	Assumptions
Procurement	<ul style="list-style-type: none"> <li>• Electronic devices</li> </ul>	<ul style="list-style-type: none"> <li>• Electronic devices will be procured to support scale up of EIS in the remaining 21 regions.</li> </ul>
Trainings/ orientation of health workers on EIS	<ul style="list-style-type: none"> <li>• Conference package</li> <li>• Transport.</li> <li>• Printing.</li> <li>• Stationery.</li> <li>• Subsistence allowances</li> </ul>	<ul style="list-style-type: none"> <li>• Managers and health workers will be capacitated on the use of new technologies and interventions; hence, they will require orientation.</li> </ul>
External professional services	<ul style="list-style-type: none"> <li>• System development and enhancement/consultancy and orientation of users.</li> </ul>	<ul style="list-style-type: none"> <li>• IVD will take over vaccine storage and distribution from MSD; hence, there will be a need to develop a Warehouse Management Information System to support its operations. The inputs for this activity will be system development and orientation to users.</li> <li>• Integrated VPD database will be developed to support case based surveillance and reporting.</li> </ul>

Management	<ul style="list-style-type: none"> <li>● System development and enhancement</li> <li>● Printing</li> <li>● Conference package</li> <li>● Transport</li> <li>● Consultancy and subsistence allowance cost</li> <li>● Stationeries</li> </ul>	<ul style="list-style-type: none"> <li>● New technologies and innovations require periodic reviews, maintenance and enhancement to ensure effective operations and program needs.</li> <li>● To ensure quality and reliability of data, regular reviews and assessments is required. This will increase confidence of reported data to be used for planning and effective decision-making.</li> <li>● For sustainability, local authority will have to own and manage some logistics part to support the systems/interventions. Advocacy to leaders on the importance and best way to sustain this investment will be needed. In addition, integration with already existing platforms under MOHCDGEC will minimize operation costs and ensure sustainability i.e. integration with HMIS/DHIS2 platform.</li> </ul>
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<b>Objective 4:</b>	To strengthen leadership, management and coordination to improve governance and financial sustainability for better immunization outcomes by 2023
<b>Timeframe:</b>	2019-2023
<b>Priority geographies/population groups or constraint(s) to coverage and/or equity</b> to be addressed by the objective: <ul style="list-style-type: none"> <li>• <b>List to match those identified in Section B</b></li> </ul>	<ul style="list-style-type: none"> <li>• Inadequate capacity in financial management and accountability.</li> <li>• Inadequate program monitoring for effective implementation of the plans.</li> <li>• Inadequate capacity of human resources (In terms of numbers, skills and retention).</li> </ul>
<b>Describe the tailored interventions to address this constraint</b> and provide evidence of efficacy of the intervention. Describe the critical national capacities that will be established or strengthened as a result of this investment.	
<p><b>4.1. Improve efficiency and effectiveness of the program financial management and accountability system.</b></p> <ul style="list-style-type: none"> <li>• The 2017 PCA found that there is inadequate capacity in financial management and accountability in the IVD including weak internal and external controls. The IVD, with support from MOHCDGEC, will strengthen financial management and accountability by integrating GAVI HSS and other grants into EPICOR, a GoT financial management system. Accountants in the IVD will then be oriented on how to use the EPICOR. The responsibility to maintain EPICOR will lie with the MoF&amp;P as is the case with other government ministries and departments. In addition to this, the MOHCDGEC will conduct both internal and external audits as scheduled and ensure that audit reports are timely produced and shared with GAVI and other development partners. While audits are independent activities, there is a need that when auditors are visiting regions and districts they should be accompanied by focal persons in the IVD to provide guidance and support; hence the need for DSAs and lunch allowances at different levels especially at regional and district levels.</li> <li>• In addition to weak financial management practices, the 2017 PCA also identified other challenges such as weak assets and stock management practices which need to be urgently addressed. The IVD will conduct annual comprehensive financial analysis and reviews, stocktaking and assets listing for all equipment and materials including those procured using GAVI grants. The activity will increase program accountability and transparency on financial and stock management and reporting for action on identified gaps at all levels. The proposed reviews will also include the status of assets purchased using GAVI funds.</li> <li>• The National Immunization program has the responsibility of program monitoring, formulation of policy and guidelines, setting standards and strategic planning to ensure the program is well managed. Previous reviews have cited insufficient operational costs as one of the factors limiting the functionality of the IVD. As mentioned earlier, the GoT budget adequately funds the purchase of traditional vaccines and provides for co-financing new and underutilised vaccines. In order to ensure effective implementation of programme plans as detailed in this HSS2 proposal, the HSS2 grant will support some of the programme operational activities including procurement of office equipment and communication services. This will ensure the smooth implementation of the programme plans and activities.</li> </ul> <p><b>4.2 Support program management to effectively monitor implementation of program plans.</b></p> <ul style="list-style-type: none"> <li>• In order to improve and sustain the capacity of the immunization program to deliver quality immunization services, the programme will work in collaboration with PORALG and LGAs at all levels of the health system. The last EPI comprehensive review was conducted in 2015. The HSS2 grant will also be used to support the conduct of the EPI comprehensive review in 2020. This review will identify the progress in the implementation of the immunisation programme, the challenges which have been experienced and inform the development of the successor cMYP. The programme in collaboration with PORALG plans to conduct biannual immunization programme review sessions to monitor the progress in the implementation of the EPI programmes at regional level. Participants in these review meetings will be the RMOs, RIVOs and RCHOs. These meetings will be held in January and August of each year. Lastly, support is also being requested for council review meetings which will be facilitated by RIVOs every quarter to review their performance and provide feedback. Best practices and lessons learnt from these sessions will be shared with all councils and incorporated into comprehensive council health plans. Studies have generally shown that these review meetings at different levels of the health system constitute effective tools for improving immunisation performance and the capacity of health staff<sup>105</sup>.</li> <li>• Support is also being requested to facilitate coordination meetings (ICC, NITAG &amp; TWG). Normally participants attending these coordination meetings do not received any DSAs. These meetings will be held either in Dar es</li> </ul>	

<sup>105</sup> See Shimp, L., N. Moammed, L. Oot, E. Mokaya, T. Kiyemba, G. SSebett0 and A. Alminana. (2017). Immunization review meetings: low hanging fruit for capacity building and data quality Improvement? Pan African Medical Journal 27(3):21



Salaam or Dodoma and only those who will be travelling will be eligible to get transport refunds and DSAs. It has also been observed that there is a need for mainland Tanzania and Zanzibar to have high level meetings (attended by the PSs) to discuss immunisation issues affecting the two countries, share progress in the implementation of the GAVI HSS2 grant and prepare for joint reporting to GAVI. The venue for these meetings will rotate between Zanzibar and Tanzania and only those travelling will be entitled to DSAs. During these meetings, participants will also update guidelines for immunisation service delivery for mainland Tanzania and Zanzibar and these shall be disseminated accordingly. A number of guidelines as per thematic areas of the EPI programme will be updated and disseminated and this is necessary because there has been an increase in the number of vaccines and new technologies have been adopted. These new guidelines will be specific to mainland Tanzania and Zanzibar taking into consideration the prevailing social and cultural factors. The policies for immunisation for Zanzibar and mainland Tanzania are outdated and new policies will need to be developed. The new policies and guidelines will then be disseminated at various times.

- The immunisation programme in mainland Tanzania and Zanzibar, as is the case with other disease programmes, experiences critical shortage of staff, high turnover, and unequal distribution of skilled staff<sup>106</sup>. There is also a general lack of knowledge and skills. These gaps affect the effective delivery of health services including immunisation (e.g. cancellation of outreach sessions). There is urgent need that staff at IVD/EPI should be adequately incentivised in order to retain them. Staff at IVD/EPI will receive 20% of their salary as an incentive from HSS2. These incentives will only be paid to staff if the agreed upon targets as detailed in the GPF are reached. Lastly, the cMYPs for Zanzibar and mainland Tanzania expire in 2020 and there will be a need to develop successor cMYPs to guide the implementation of immunisation services for the period 2021-2025. HSS2 funds will support the recruitment of a consultant who will review literature and facilitate the development of the cMYPs. These cMYPs will be printed and disseminated.

#### 4.3 Build the capacity of health workers at all levels of the health system to deliver effective immunisation services

- There are 6 positions that will be filled with support from GAVI: (i) GAVI HSS Coordinator: His/her responsibility will be to coordinate the implementation of the HSS interventions for both Zanzibar and mainland Tanzania and ensure that activities are implemented within the agreed timeframe with GAVI. (ii) Accountant: S/he will be responsible for managing the EPICOR with support from MOHCDGEC and MoF&P. (iii) Fleet Manager: IVD has purchased 129 vehicles using HSS1 funds. There are also plans to purchase an additional 59 vehicles during the implementation of the HSS2 grant. These vehicles need to be effectively managed and HSS2 funds will be used to hire a Fleet Manager whose responsibility will be to maintain vehicles; conduct vehicle telematics (tracking and diagnostics); and manage drivers, speed and fuel. His responsibilities will be aimed at improving efficiency and reduce transportation costs. (iv) Warehouse Manager: the IVD will recruit a Warehouse Manager who will be responsible for managing the CVS. Previously, the MSD managed the CVS but the IVD is taking over this responsibility starting end of 2018. (v) C4D Specialist: The IVD will also hire a C4D specialist who will be responsible for coordinating the design, execution and monitoring and evaluation of behavioural change and social mobilization activities relating to immunisation. (vi) Technical Assistant for Immunisation (Zanzibar): A TA will be hired for Zanzibar who will support the effective implementation of the immunisation programme in Zanzibar. The salaries of the TA for Zanzibar and the GAVI HSS Coordinator will be paid by GAVI for 5 years while for the rest of the positions, GAVI HSS2 funds will only pay salaries for the first 3 years after which the GoT will take over.
- The EPI review identified limited knowledge and skills among health workers (including new health workers) as one of the challenges in the provision of quality immunisation services. In-service training removes health workers from offering services and the training of tutors to offer preservice training on immunisation services is a more sustainable approach. One of the first activities will, therefore, be to update the knowledge and skills of the tutors from training institutes on the use of the preservice curriculum on immunisation which has already been developed by the MOHCDGEC and MCSP. The training of the tutors from health training institutions is key as this will capacitate them to train health workers on immunisation and related services, hence, creating a new workforce with skills and knowledge on immunization. There will be a pool of TOTs who will be trained to provide the various training needs of the program. This will release national program Officers from the training activity and enable them time for other important activity. The TOTs will be used for MLM, Refresher trainings and Newcomers training and other related activities. The HSS2 grant will also be used to train 120 middle level managers on MLM. The MLM training will target RMOs, RIVOs, RRCHCOs, DRCHCOs, DIVOs and DMOs. The last MLM training was conducted in Tanzania in 2015/2016.
- There are a number of studies which have been proposed in this PSR to inform the development of interventions. These studies will be conducted by postgraduate students including staff of the MOHCDGEC/IVD as part of capacity building at masters and PhD level. The proposal is that 2 students will pursue their PhDs while 4 will pursue their masters' degrees and these shall be undertaken at local universities in Tanzania such as University

<sup>106</sup> Zanzibar cMYP, mainland Tanzania cMYP and the 2015 comprehensive EPI review.

of Dar es Salaam and Muhimbili University of Health and Allied Sciences. In addition to these courses at postgraduate level, the HSS2 grant will also be used to support EPI staff to attend short courses in leadership and management and this will target management of IVD mainly to build their capacity in these areas as well as a source of motivation. There are international meetings on new vaccines and the immunisation programme (e.g. meetings on surveillance, EPI managers meetings, supply chain, WHA) which staff from IVD/MOHCDGEC need to attend. Attending these meetings is important as it provides EPI staff knowledge and skills and it strengthens their capacity in areas of leadership and management of the programme.

- There are 56 poor performing districts in Tanzania including urban areas. The HSS2 grant will support some staff from poor performing districts to visit districts which are performing quite well in the immunisation programme in order to learn factors contributing to their high performance. In addition to this, there are a number of NGOs in Tanzania which are implementing very innovative interventions e.g. the implementation of the My Home My Village by MCSP which has led to improvement in immunisation coverage in Kagera, Shinyanga, Tabora and Simiyu regions. The HSS2 grant will also support some staff from the national level to visit countries implementing interventions which have led to improved immunisation coverage. This intervention will therefore be important as it will cross learning and sharing of best practices and eventually contribute to an increase in immunisation coverage.
- The GoT has introduced a Direct Health Facility Financing (DHFF) system whereby funds are sent directly to health facilities. It has employed assistant accountants to manage funds at health facility level. These assistant accountants will manage financial resources from both government and development partners including GAVI. With GAVI HSS2 funds, these accountants will be oriented on how to manage GAVI and other funds from development partners. In this proposal, resources have been dedicated to the conduct of microplanning at health facility level. Assistant accountants will also be oriented about the need to dedicate resources to microplanning, as this will constitute a sustainable way of financing microplanning activities. A ToT will be held at zonal levels after which the assistant accountants will be oriented for 2 days.
- The IVD will also update various guidelines (e.g. service delivery, demand creation, supply chain and data management) and upload them on the e-learning platform currently being run by the IVD with support from CHAI. While it is important to target all the officers working on immunisation and related issues, the effective delivery of E-learning is hampered by the lack of computers and internet in most health facilities in Tanzania. This e-learning approach will run on a quarterly basis and will target all vaccine managers at regional and district levels, tutors in health training institutions, data managers and immunisation focal persons. This will ensure that these officers are kept updated in a more sustainable way and reaching more people. The use of E-learning for continuous capacity building of healthcare workers is cost effective and time efficient. This will be run on a pilot basis over the next 4-5 years and lessons learnt will be used to strengthen the e-learning program. The HSS2 grant will be used to strengthen the capacity of the IVD to run/manage the e-learning platform. –The e-learning courses targeting immunisation managers at regional and district level will be mandatory and will eventually result into a reduction number of classroom costs. Over the next 5 years, the E-learning will not replace the classroom trainings which have been planned in this HSS2 grant but complimenting starting with immunisation managers but anyone can use this. This intervention will be implemented in conjunction with PO-RAG.

**List approximately five (5) specific activities to be undertaken to achieve this objective:**

→ **Reflect these activities in the budget & planning template**

#### **4.1 Improve efficiency and effectiveness of the program financial management and accountability system:**

- 4.1.1 Integrate IVD/GAVI grant into EPICOR system.
- 4.1.2 Conduct internal audit of the immunization program at all levels.
- 4.1.3 Conduct external audits of the immunisation programme at all levels.
- 4.1.4 Conduct comprehensive financial data analysis and reviews including program stock taking and assets listing.
- 4.1.5 Conduct high-level Ministry of Health coordination meetings between mainland Tanzania and Zanzibar to enhance immunisation service delivery and joint resource mobilisation.
- 4.1.6 Update immunisation policy guidelines for mainland Tanzania and Zanzibar.
- 4.1.7 Disseminate immunisation policy guidelines – Zanzibar.
- 4.1.8 Disseminate immunisation policy guidelines – mainland Tanzania.
- 4.1.9 Conduct quarterly immunisation Inter-Agency Coordinating Committee (ICC) meetings.
- 4.1.10 Conduct biannual National Immunisation Technical Advisory Group (NITAG) meetings.
- 4.1.11 Conduct biannual National Polio Eradication Expert Committee and measles elimination verification committee meetings.
- 4.1.12 Conduct quarterly Immunisation Technical Working Group (TWG) meetings.
- 4.1.13 Conduct quarterly Immunisation Technical Working Group (TWG) sub-committee meetings.

4.1.14 Develop, print and disseminate a costed IVD comprehensive multi-year plan (cMYP) for the period 2021-2025.

#### 4.2 Support program management to effectively monitor implementation of program plans

4.2.1 Conduct biannual immunisation evaluation meetings at national level (National, RMOs, RIVOs and RCHCOs).

4.2.2 Support programme operations for smooth implementation of programme plans and activities.

4.2.3 Conduct district immunisation performance evaluation meetings (EPI parliament – national coordinators, RIVOs and DIVOs).

4.2.4 Provide performance-based incentives for national (IVD/EPI) staff to promote staff retention.

4.2.5 Support an EPI comprehensive review in 2020 at all levels.

#### 4.3 Build capacity of health workers in the health system to deliver effective immunisation services.

4.3.1 Recruit 6 officers for IVD new positions (Warehouse manager, GAVI HSS Coordinator, Fleet Manager, M&E Specialist, C4D Specialist and TA for Zanzibar).

4.3.2 Orient tutors in health training institutions on preservice immunisation curricula.

4.3.3 Conduct refresher training for health care workers to update their knowledge and skills in the provision of immunisation services.

4.3.4 Conduct MLM training for immunisation managers at national, regional and district levels.

4.3.5 Support IVD staff to attend short courses in leadership and management.

4.3.6 Support IVD/MOHCDGEC staff to pursue postgraduate programmes to improve performance.

4.3.7 Support IVD staff to attend meetings such as World Health Assembly, surveillance, service delivery, EPI managers meetings and new updates on immunisation.

4.3.8 Undertake exchange programmes for learning best practices in immunisation services both within and outside Tanzania.

4.3.9 Orient assistant accountants at health facility level and health facility governing committee in financial management.

4.3.10 Update the e-learning module and upload in the e-learning platform.

4.3.11 Conduct supportive supervision national, regional and district levels.

**e the GPF to propose indicators to monitor progress toward this objective:** These provide a means to assess achievement of intermediate results and activity implementation.

Indicator	Definition	Data Source	Reporting frequency	Baseline (2018)	Target Year (2019)	Target Year (2020)	Target Year (2021)
1. % of scheduled meetings conducted as per IVD schedule and minutes of the meetings compiled and filed.	1. Numerator is the number of high-level Coordination Forums ICC, NITAG, NPEC, TWG meetings conducted and the denominator is the total number of meetings scheduled.	Meeting minutes	quarterly	Numerator = 0 Denominator = 36	Numerator = 32 Denominator = 36	Numerator =32 Denominator = 36	Numerator = 32 Denominator = 36
2. Percentage of vacant positions filled in the national EPI team as planned for mainland and Zanzibar	Numerator is the number of employees hired to fill the vacant positions as per plan: and the denominator is the total staff number required at the program level	Payroll and staffing level guideline	Bi- Annual	Numerator =39 Denominator 88 Percentage= 44.32%	<b>Numerator = 59</b> <b>Denominator=88</b> <b>Percentage=67.05%</b>	<b>Numerator = 74</b> <b>Denominator=88</b> <b>Percentage=84.09%</b>	<b>Numerator = 88</b> <b>Denominator=88</b> <b>Percentage=100%</b>

3. <b>Performance review sessions at the district, regional, and national levels conducted as scheduled in at all levels</b>	Numerator is the total number of Annual immunization and EPI parliament sessions biannual performance review sessions at the regions and three annual sessions at the districts level conducted. and the denominator is the total number of sessions scheduled	Sessions Reports	Biannual, Annual,	<i>Numerator = 0 Denominator=162 Percentage=0%</i>	<i>Numerator = 113 Denominator=1162 Percentage=700%</i>	<i>Numerator = 146 Denominator=162 Percentage=90%</i>	<i>Numerator = 162 Denominator=162 Percentage=100%</i>
4. <b>Number of Staff who received refresher training</b>	Numerator is the number of staff who attended the training and denominator is the total who are scheduled for training	Training report, IVD training database, HRHIS	annual		<i>Numerator = 1633 Denominator =1633 Percentage =100%</i>		<i>Numerator = 1633 Denominator = 1633 Percentage =100%</i>
5 <b>Number of Audits conducted</b>	Number of audit reports timely submitted (October 31st and April 30th each year) Numerator number of reports and denominator frequency of submission	Internal Audit Reports	Semi annual	<i>Numerator =2 Denominator =2</i>	<i>Numerator =2 Denominator=2</i>	<i>Numerator = 2 Denominator=2</i>	<i>Numerator = 2 Denominator=2</i>
6. <b>External Audit timely conducted</b>	<b>Audit report submitted by the 31st December each year</b>	Audit Report	Annual	<i>Numerator = 1 Denominator=1</i>	<i>Numerator = 1 Denominator= 1</i>	<i>Numerator = 1 Denominator=1</i>	<i>Numerator = 1 Denominator=1</i>
7. <b>Number of accountants assistant, HFIC and HFGC on financial management system</b>	Numerator is the number of health centre staff accounting, HFGC and HFic oriented, and denominator is total number to be trained in a year	Training Report; Training database	annual	0	<i>Numerator = 240 Denominator= 300 Percentage = 80%</i>	<i>Numerator = 240 Denominator=300 Percentage = 80%</i>	
8. <b>Program financial report prepared</b>	<b>Annual Financial Report approved by the Permanent Secretary</b>	Approved Financial Report	Annual	<i>Numerator = 1 Denominator= 1</i>	<i>Numerator = 1 Denominator=1</i>	<i>Numerator = 1 Denominator= 1</i>	<i>Numerator = 1 Denominator= 1</i>
<b>Number of districts which have received at least one visit by IVD TWG</b>	<b>Number of districts supervised as the numerator and denominator</b>	Supervision reports	Bi annual	<i>Numerator=</i> <i>Denominator=</i>	<i>Numerator</i> <i>Denominator</i>	<i>Numerator</i> <i>Denominator</i>	<i>Numerator</i> <i>Denominator</i>

	is total number of districts							
Reflect these in the Grant Performance Framework								
<p><b>Technical Assistance:</b> List the anticipated TA needs and timelines required to support this objective and plans for securing it (e.g., Gavi HSS, PEF/TCA, other sources?)</p> <ul style="list-style-type: none"> <li>• Training on EPICOR System [Year 1].</li> <li>• E-learning [Year 1-5].</li> <li>• Comprehensive EPI review [Year 2]</li> <li>• Dissemination of PSE materials [Year 1]</li> </ul>								
<p><b>Financing:</b> Justify any requests for Gavi to support major recurrent costs (e.g. human resources) regardless of transition stage.</p> <p>→ <b>Countries in the preparatory and accelerated transition phase are restricted from using Gavi funds for recurrent costs</b> (please refer to the <i>Guidance on supporting countries' HR capacity</i>, available here: <a href="http://www.gavi.org/support/process/apply/additional-guidance/">http://www.gavi.org/support/process/apply/additional-guidance/</a>).</p>								
<ol style="list-style-type: none"> <li>1. The program has experienced staff shortages over the past five years with high labour turnover rates for the period 2014 to 2018. Currently, the total staffing level is only 41% of the need as identified in the Government Staffing level guideline for IVD. The Program has already requested the Ministry of Health to allocate staff to fill the gap. The current need to support the program operations is 88 personnel (technical and support staff). Taking into consideration that the allocation will take a bit of time and not all staff positions can be filled in the same year, the program has requested 6 new staff to be covered by the HSS2 grant for three years whilst working on to be integrated into the civil service. For 2018, the Government has already allocated three accountants working with IVD. An additional 2 staff members will be hired in the first year of the grant and the expectation is that the GoT will continue to fill vacant positions during the implementation of the programme.</li> <li>2. The EPI review and EVMA 2015 reports have indicated a number of problems and challenges found in the implementation of immunization services at regional, district and health facility levels and to address such challenges, enough supportive supervision is required as an important activity for coaching and mentoring of immunization coordinators and vaccinators. It is through timely supportive supervision that the programme can identify strengths and opportunities for sustainability and weaknesses for future improvement. The programme is planning to reach at least 54 districts with supportive supervision and the days allocated for the task will involve both supervision and mentorship for health workers in the low performing districts and health facilities.</li> <li>3. Performance review sessions which have been conducted have provided evidence of the increase in political buy in for supporting immunization services since they bring decision makers on board. The working sessions are chaired by the Regional Administrative Secretaries (RAS) as such decisions and actions to improve the provision of services and performance are addressed during the session and at the same time awareness on the program is being raised at the highest decision making level of the region. The sessions have also increased accountability at the level of the service providers and managers and have also been advocating for increase of resource allocation for the immunization program at the council level. Forty per cent of health facilities within the district are targeted for data and performance review at the council level to address data challenges as well as improve data use at the point of generation. The new direct health facility funding model calls for review sessions at council level to tap the gains observed in regional performance review sessions.</li> <li>4. To increase program accountability on financial management and reporting which were identified as a gap in the Program Capacity Assessment report (2017), the program intends to conduct comprehensive financial analysis and reviews, two internal audits annually as per the government financial regulations, the audit will be conducted in all regions divided in two tranches. This will also be followed by an external audit once a year. Timely audits will also improve transparency in management and use of funds allocated at all levels for the system as well as timely addressing any challenges that the program may come across thereof.</li> <li>5. It is important to provide performance based incentives to deficient available IVD staff to motivate and retain them. For the past two years, the programme has experienced high labour turnover and loss of staff with</li> </ol>								

high capacity looking for greener pastures. To increase immunization coverage beyond 90%, the staff at IVD/EPI need to be motivated in order to retain them. Performance based incentive will be provided once the targets as set in the GPF have been met.		
<b>How much HSS budget is allocated to this objective:</b> → <b>Reflect the details in the budget and planning template</b>	1-2	<b>US\$ 4,721,797</b>
	3-5	<b>US\$ 4,315,607</b>
<b>Please also provide details on the key cost drivers, inputs and assumptions required for the main activities of this objective, here:</b>		
<b>Cost drivers.</b>	<b>Inputs</b>	<b>Assumptions</b>
<b>Capacity building and governance</b>	<ul style="list-style-type: none"> <li>• Transport.</li> <li>• Conference package.</li> <li>• Stationery.</li> <li>• Daily subsistence allowance.</li> <li>• Salaries.</li> <li>• Gratuity.</li> </ul>	<p>Most activities will involve human resource and training:</p> <ul style="list-style-type: none"> <li>• Refresher trainings on routine immunization services delivery including new technologies and other updates for Mainland Tanzania and Zanzibar will be conducted twice in the 5-year period.</li> <li>• Newcomers' training will be conducted to immunization supervisors and managers at all levels. A total of 50 newcomers will be oriented.</li> <li>• IVD/EPI staff members will pursue postgraduate studies (2 at PhD and 4 at Masters) to strengthen the capacity deliver immunization services as well as improve their capacity to utilise research data.</li> <li>• 600 accounts assistants at health facility level, 600 health facility in charge and 600 health facility governing committee will be oriented in financial management.</li> <li>• Internal audits of the immunization program at all levels will be conducted twice a year in all regions both in mainland Tanzania and Zanzibar</li> <li>• External audits of the immunization program at all levels will be conducted once a year in both Mainland and Zanzibar.</li> <li>• It is assumed that immunization performance review sessions at regional level will be conducted biannually and immunization performance review at council levels will be done three times in a year.</li> <li>• Annual immunisation evaluation meetings which involves IVD/EPI National level and all RMO and RIVO will be held to evaluate immunization</li> </ul>

		progress in the country.
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Please add additional objective boxes as necessary.

<b>Objective 5:</b>	<b>To improve community participation and utilization of immunization services particularly in rural, urban slums and hard to reach areas by 2023.</b>
<b>Timeframe:</b>	2019-2023
<b>Priority geographies/population groups or constraint(s) to coverage and/or equity to be addressed by the objective:</b>	<ul style="list-style-type: none"> <li>• Low performing councils.</li> <li>• Geographical areas with hard to reach, urban areas, migrant pastoralists, seasonal farmers and fishing communities.</li> </ul>
<ul style="list-style-type: none"> <li>• <b>List to match those identified in Section B</b></li> </ul>	
<p><b>Describe the tailored interventions to address this constraint</b> and provide evidence of efficacy of the intervention. Describe the critical national capacities that will be established or strengthened as a 2 result of this investment.</p>	
<p><b>5.1 Increase community participation in immunization programmes.</b></p> <ul style="list-style-type: none"> <li>• Tanzania, despite having high immunization coverage of &gt;90% at national level, has large numbers of under/unvaccinated children. These children are mainly from the poor households, households where mothers/caregivers are less educated<sup>107</sup>, nomadic populations, fishing and farming communities<sup>108</sup> and urban areas. Community engagement needs to be strengthened and specific strategies should be developed and implemented to address equity barriers and challenges among these population groups. Some community members particularly males are not fully involved in immunization activities, hence, contributing to low coverage<sup>109</sup>. Increasing male participation in immunisation programmes is important because men are decision makers and sometimes they act as barriers to women and children accessing health services including immunisation.</li> <li>• The involvement of communities especially in health services including immunization is limited in both mainland Tanzania and Zanzibar leading to large numbers of unvaccinated children mainly due to suboptimal communication or linkage between communities and health The GoT and CSOs have been using VHVs to link their communities to health facilities to facilitate access and utilization of health services including immunization. In order to strengthen community linkage to health services, the GoT has established a new cadre of CHWs. Under Objective 1, CHWs will be recruited, trained and provided with bicycles to facilitate their work. These CHWs will visit households and conduct one to one discussions with mothers/fathers of under five children and girls eligible for HPV and create awareness about the importance of immunisation and other health services. The use of the house-to-house approach in creating awareness about immunisation programme has been used in Tanzania as well and has been found quite successful<sup>110</sup> in training defaulters and improving coverage. These CHWs will work very closely with community leaders (Objective 1) to create awareness about health services including immunisation<sup>111</sup>. A total of 600 CHWs will be recruited (see Objective 1) provided with bicycles and other working tools in order to facilitate their working environment.</li> <li>• In order to improve immunization uptake, it is also important to consolidate immunization services within community systems. This will be facilitated through implementation of the African vaccination week. The theme highlights collective actions needed to ensure that every person is protected against VPDs. It urges greater actions on the role that everyone can play. The approach will enhance opportunity to reach a large number of children, facilitate defaulter tracing and improve awareness at village level eventually promoting utilization of immunization services. This activity will also engage recognition of good performers and individual efforts across health care providers, VHVs and community immunization champions. Successful implementation of this comprehensive approach will necessitate engagement of all key stakeholders at ward level to address immunization issues. These activities will be coordinated by social welfare officers/community development officers of the MOHCDGEC who are well versed with what happens at community level.</li> </ul>	

<sup>107</sup> TDHS 2015/2016.

<sup>108</sup> UNICEF Equity in immunization coverage assessment 2016.

<sup>109</sup> Zewde, 2016.

<sup>110</sup> Mbabazi, N. (Not Dated). H2H tracing of routine immunisation defaulters: experiences of Uganda and Tanzania. XXX: American Red Cross.

<sup>111</sup> This has already been costed in Objective 1.

## 5.2. Strengthen behavioural change communication (SBCC) initiatives including availability of key messages in local language.

- The messages on immunization targeting mothers and caretakers of un/under-vaccinated under five children in urban slums, migrant, remote and marginalized communities need to be designed and tailored with culturally sensitive social and behaviour change interventions. The SBCC Resource Centre in the MOHCDGEC in conjunction with the IVD will develop, update, review and print information, education and communication (IEC) materials on immunization. These materials will be kept in electronic format and will be disseminated through innovative technologies such as social networks where the majority of young people will have access to immunization information in urban areas. The print materials like factsheets, leaflets, brochures and posters will be distributed during African vaccination week and through school health platforms where children will receive and take them to their parents to raise awareness about the immunisation programme particularly in councils and cities with low immunisation coverage.
- Schools constitute one of the primary sites through which children and youth learn about the factors that influence their health including the role of immunization. On joining schools, children are expected to show evidence that they are vaccinated but in most cases, this is not done<sup>112</sup>. This is mainly because teachers' understanding of immunization is limited. At school level, teachers and students will be oriented on the importance of immunisation and school health clubs on immunization services will be established<sup>113</sup>. Such an approach will contribute towards promotion of positive attitude towards immunization as well as dissemination of immunization messages. With this activity, the IVD will build capacity of health promotion coordinators at regional and council levels on immunization services to support coordination of demand creation supervision activities including school health immunization platforms.
- IVD will also develop a Memorandum of Understanding with mobile phone companies. Comprehensive immunization messages will be developed and disseminated through mHealth application in the Health Education Unit in MOHCDGEC. Mobile phone companies have high subscription rates and through this platform, many people will be reached with messages on immunisation. The major cost will be the development of immunisation messages which can be sent through the mhealth application. Through the integrated supportive supervision visits, the supervisors will track utilization of mHealth application and address key challenges.

## 5.3 Strengthen advocacy effort to increase awareness on immunization at all levels

- In Tanzania, the immunization program contributed significantly to the reduction in child mortality; consequently to the achievement of MDG 4. The programme has led to the decrease in the prevalence of VPDs with polio being on the verge of being eradicated. These impacts of the program need to be disseminated widely to stakeholders including parliament, MoF&P, other government ministries, CSOs/NGOs, media personnel and traditional and religious leaders. The program will engage CSOs to advocate for immunisation in the social and political spheres to ensure that the development of policies to prioritise immunisation. The creation of awareness among policy makers has previously led to securing adequate financial resources for purchase of traditional vaccines and ensuring that Tanzania fulfils the co-financing arrangements with GAVI. This intervention is, therefore, aimed at continued creation of awareness among policy makers at different levels in order to advocate for more domestic resources for the immunisation programme especially for operational expenses.
- The role of mass media particularly the radio and TV spots on creation of awareness and improving vaccination coverage in several countries has been documented in a number of studies mainly in India and Philippines where media campaigns was credited for increasing knowledge on vaccination and raising percentage of fully vaccinated children. With this intervention, the IVD will engage media personnel at national and zonal levels to facilitate dissemination of immunization messages through multiple channels in both national and community or local media. A strong relationship with journalists and editors in the country will be built to extend their understanding of and capacity to report on immunization and other child health issues. The IVD will also create routine systems for media monitoring and reward the better reporters in immunization events such as in African immunization week.
- Community mobilization efforts to increase awareness on immunization need to be strengthened further to all influential people in communities, who will also act as vehicles to disseminate immunization information to the communities. A range of effective communication tools including factsheets on immunization will be developed and disseminated to influential people in the communities including religious leaders, local or clan leaders, community leaders and media channels in local language. These tools will promote the value and benefits of

<sup>112</sup> National School Health Policy Guidelines 2018.

<sup>113</sup> National School Health Programme Strategic Plan 2018-2022.



timely and complete vaccination to strengthen efforts to improve immunization coverage. Stakeholders at all levels will be involved to support community mobilization activities for immunization services and defaulter tracing.

#### **5.4 Engage CSOs in creating demand for immunization.**

- There are a number of CSOs that are working in the health sector including on immunisation issues. Most NGOs/CSOs work at community level and can therefore play an important role in creating awareness about the importance of immunisation. The MoHCDGEC will conduct a mapping exercise in order to identify CSOs working in low performing districts including urban areas, among nomadic and fishing communities. These CSOs will be oriented on how they can contribute to creation of demand for immunisation services in the geographical spaces where they work. They will also be called upon to mobilise resources for immunisation as currently not many CSOs in Tanzania are engaged in immunisation services. Furthermore, the CSOs will use their existing community structures established to help in immunization activities including immunization promotion, health education, reaching un/under-vaccinated children and working on vaccine rumours and misconceptions; hence, promote acceptance and utilization of vaccines.

**List approximately five (5) specific activities to be undertaken to achieve this objective:**

→ ***Reflect these activities in the budget & planning template***

#### **5.1 Strengthen community participation in immunization programmes.**

- 5.1.1 Support implementation of the African vaccination week.
- 5.1.2 Strengthen school health platform to disseminate immunization messages to parents and community.
- 5.1.3 Support sensitization of urban slums population in utilisation of immunisation services.

#### **5.2 Strengthen behavioural change communication initiatives including availability of key messages in local language.**

- 5.2.1 Develop and disseminate SBCC materials for targeted communities in low performing councils, urban slums, fishing communities and nomadic populations.
- 5.2.2 Disseminate immunisation information through community radios/TV spots (airtime).
- 5.2.3 Incorporate, update and disseminate comprehensive information messages in the mHealth application.
- 5.2.4 Develop and support implementation of male strategy involvement in immunisation services.

#### **5.3 Strengthen advocacy effort to increase awareness on immunization at all levels.**

- 5.3.1 Conduct advocacy meetings with members of parliamentarian and Ministry of Finance and engage them to support securing financial resources for strengthening immunisation services.
- 5.3.2 Sensitise the private sector on engagement and support of immunisation services.

#### **5.4 Engage CSOs in creating demand for immunization.**

- 5.4.1 Engage CSOs namely RED Cross, Lions Club, NGOs and religious leaders in identification and supporting of CHVs in the implementation of immunisation services.
- 5.4.2 Conduct media seminars.

**Update the GPF to propose indicators to monitor progress toward this objective:** These provide a means to assess achievement of intermediate results and activity implementation.

→ **Reflect these in the Grant Performance Framework**

Indicator	Definition	Data Source	Reporting freq	2018 (Baseline)	2019	2020	2021	2022	2023
1. African vaccination week launched	Number of launches	Activity reports	Annually	0	1	1	1	1	1
2. % of teachers oriented on immunisation.	Number of teachers oriented/Total number of teachers targeted multiply by 100.	Training reports/Data base	Twice	<b>Numerator=0 Denominator=3080 %=0%</b>	<b>Numerator=1540 Denominator=3080 %= 50%</b>	<b>Numerator=3080 Denominator=3080 %=100%</b>			
3. Number of sensitization events conducted in urban areas.	Number of sensitisation meetings in urban areas	Activity reports	Annually for three years	<b>Number: 12</b>	<b>Number: 12</b>	<b>Number: 12</b>			
5. Number of IEC materials updated, pre tested, printed and distributed	# of immunization IEC materials updated, printed & distributed	Activity reports	Annually	<b>Number:</b>	<b>Number:</b>				
6. Number of radio and TV spots broadcasted	Number of radio/TV spots	IVD activity reports	Quarterly:	<b>Number:</b>	<b>Number:</b>	<b>Number:</b>	<b>Number:</b>	<b>Number:</b>	<b>Number:</b>

7. Immunization messages updated and incorporated in RCH m-health application	Immunisation messages updated and incorporated in mHealth.	IVD activity reports	Annually	-	√				
8. Male involvement strategy developed	Male involvement strategy developed.	IVD activity report	Annually		√				
9. Number of advocacy meetings conducted with parliamentarians, government officials and development partners	Number of advocacy meetings conducted with parliament committee for health, education and social services.	IVD activity Report	Annually	0	4	4	4	4	4
9. Number of meetings with CSOs/NGOs	Number of meetings with CSOs	Meeting reports	Annually	0	1	1	1	1	1

<b>Technical Assistance:</b> List the anticipated TA needs and timelines required to support this objective and plans for securing it (e.g., Gavi HSS, PEF/TCA, other sources?)		
<ul style="list-style-type: none"> <li>• Communication for Development (C4D).</li> </ul>		
<b>Financing:</b> Justify any requests for Gavi to support major recurrent costs (e.g. human resources) regardless of transition stage. → <b>Countries in the preparatory and accelerated transition phase are restricted from using Gavi funds for recurrent costs</b> (please refer to the please refer to the <i>Guidance on supporting countries' HR capacity</i> , available here: <a href="http://www.gavi.org/support/process/apply/additional-guidance/">http://www.gavi.org/support/process/apply/additional-guidance/</a> ).		
<b>How much HSS budget is allocated to this objective:</b> → <b>Reflect the details in the budget and planning template</b>	1-2	US\$ 832,334
	3-5	US\$ 1,276,959
<b>Please also provide details on the key cost drivers, inputs and assumptions required for the main activities of this objective, here:</b>		

Key cost drivers	Inputs	Assumptions
Radio/TV spots	Air time	Well-structured broadcast schedule through local/community Radio/TV spots will be used to disseminate key immunization information and available services for community awareness and demand creation.
Procurement  Printing	Printing machine for SBCC Materials  Printing IEC materials for the national program	Printing machine will be procured to support printing of SBCC Materials. The printing of IEC materials will be cheaper than commissioning printing houses to do the printing.  Updated immunization IEC materials will be printed to for creation of awareness about immunisation and other child health issues.
Develop/update/review, pre-test, and distribute SBCC Materials	<ul style="list-style-type: none"> <li>• Conference package</li> <li>• Transport.</li> <li>• Subsistence allowances</li> </ul>	MOH technical staff in collaboration with development partners through a well-designed working session will convene to review, update & pre-test immunization SBCC materials which will be used countrywide.
Advocacy meetings	<ul style="list-style-type: none"> <li>• Conference package</li> <li>• Transport.</li> <li>• Subsistence allowances</li> </ul>	Advocacy meetings at different levels will help to support securing financial resources for strengthening immunization services as well as supporting demand creation of immunization services.
Orientation of school health teachers	<ul style="list-style-type: none"> <li>• Transport.</li> <li>• Subsistence allowances</li> <li>• Refreshments</li> </ul>	School health teachers will be oriented at council level on immunization and they will thereafter orient their students using school health platform to disseminate immunization messages to parents and community.

	<ul style="list-style-type: none"> <li>• Stationaries</li> </ul>	
Support urban immunization sensitization efforts	<ul style="list-style-type: none"> <li>• Transport.</li> <li>• Subsistence allowances</li> <li>• Refreshments</li> <li>• Cost for events supplies e.g. stage, events, security</li> <li>• PA system.</li> </ul>	<p>Implementation of urban immunization promotion will facilitate demand creation in four low performing town councils.</p> <p>IVD will establish and support cities with low immunization performance to conduct this activity on annual basis. The intention of this activity is to increase utilization of immunization services and advocate for integration of RMNCH services in urban setting.</p>
African Vaccination Week	<ul style="list-style-type: none"> <li>• Transport.</li> <li>• Subsistence allowances</li> <li>• Refreshments</li> <li>• Cost for events supplies e.g. stage, events, security</li> <li>• PA system</li> </ul>	<p>This event will be conducted in all regions countrywide to ensure full involvement and contribution of all stakeholders. The activity is also intended to:</p> <ul style="list-style-type: none"> <li>• Highlight the need and importance for everyone to get vaccinated.</li> <li>• Update community members on immunization services /schedule throughout the life course</li> <li>• Advocate for government and all stakeholders to allocate sufficient resources to immunization</li> </ul> <p>At national level, the commemoration will be done in one of the councils selected from poor performing Region. Celebrations will happen in close connection with the ongoing implementation of the integrated immunization services.</p> <p>From the evidence, commemoration of African vaccination week will facilitate utilization of immunization services</p>
Male involvement strategy	<ul style="list-style-type: none"> <li>• Transport.</li> <li>• Subsistence allowances</li> <li>• Conference costs</li> </ul>	<p>The male involvement strategy will be developed and will facilitate to influence male to participate in immunization services. A meeting will be held with stakeholders to develop the strategy.</p>

## Part E: Signatures – Endorsement of the Programme Support Rationale

### Government signature form

The Government of (country) 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 the portfolio as outlined in this Programme Support Rationale (PSR):

The Government of (country) commits itself to the continued development of 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 Government of (country) will fulfill the co-financing commitments set out in this PSR as expressed in doses or the equivalent dollar amount in Part A above.

*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.<sup>114</sup>*

Minister of Health (or delegated authority)		Minister of Finance (or delegated authority)	
<b>Name</b>	Mrs. Umyy Mwalimu	<b>Name</b>	Dr. Philip I. Mpango
<b>Date</b>	1 <sup>st</sup> September 2018	<b>Date</b>	1 <sup>st</sup> September 2018
<b>Signature</b>		<b>Signature</b>	

<sup>114</sup> 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.

**Annex 1: List of low performing districts in Tanzania and Zanzibar (2017)**

SN	Region	District	Trend of DTP3 Coverage (%)			Number of Unimmunized Children (2017)	Trend of DTP3 Vaccinations			Trend of DTP1/DTP3 Dropout rate (%)		
			2015	2016	2017		2015	2016	2017	2015	2016	2017
1	Dar es salaam	Ubungo MC	NA	NA	56	18498	NA	NA	23754	NA	NA	6
2	Dar es salaam	Temeke MC	94	89	70	18228	49390	50216	42047	10	3	11
3	Dar es salaam	Ilala MC	86	81	71	17930	40630	40706	43077	6	0	7
4	Kilimanjaro	Moshi DC	110	88	59	7803	9830	11027	11161	2	-2	-1
5	Dar es salaam	Kinondoni MC	81	62	90	4857	55430	45399	41609	0	2	8
6	Morogoro	Morogoro DC	109	101	65	4168	8071	7854	7490	12	15	15
7	Kilimanjaro	Same DC	97	79	66	3741	6896	6880	7222	7	8	7
8	Morogoro	Kilosa DC	82	79	80	3685	14280	14392	14701	4	6	14
9	Tabora	Uyui DC	98	100	79	3622	15673	16837	13538	18	14	18
10	Pwani	Rufiji DC	95	94	58	3313	8185	8456	4575	4	7	5
11	Kilimanjaro	Rombo DC	106	85	69	3281	7325	7655	7322	1	-3	2
12	Mwanza	Kwimba DC	91	90	89	1968	15592	15663	15668	7	11	15
13	Kigoma	Kasulu TC	92	87	81	1647	7626	7604	7113	-4	4	12
14	Mwanza	Ilemela MC	100	88	91	1316	13541	14096	13465	9	4	8
15	Dodoma	Kondoa DC	91	79	88	1023	10275	9065	8811	5	5	4
16	Tanga	Korogwe DC	91	96	90	985	8653	9614	9105	13	8	6
17	Morogoro	Ulanga DC	93	102	87	844	9749	5789	5492	19	13	15
18	Pwani	Kisarawe DC	77	88	81	813	3095	3698	3192	4	4	8
19	Mbeya	Mbeya CC	101	91	95	771	15536	14826	15442	9	11	14
20	Kagera	Muleba DC	98	103	97	732	21642	23929	22944	1	2	0
21	Ruvuma	Mbinga DC	86	91	93	682	12047	13305	8618	20	9	20

22	Kigoma	Kigoma DC	107	98	94	494	9019	8640	8406	5	1	2
23	Mara	Bunda DC	75	120	95	450	10296	9904	8881	25	1	7
24	Ruvuma	Songea MC	101	94	95	438	8120	7910	7879	4	12	10
25	Ruvuma	Namtumbo DC	108	101	95	427	8543	8426	7930	12	6	10
26	Lindi	Lindi MC	107	124	95	141	3207	3846	2925	1	14	7
27	Geita	Nyang'hwale DC	96	100	99	87	6483	7070	6228	6	9	14
28	Tabora	Nzega DC	97	101	100	58	19609	21585	17579	13	7	11
29	Songwe	Momba DC	106	89	100	30	12450	7502	7389	10	11	14
30	Shinyanga	Kahama TC	90	89	101	-84	11399	11514	10093	-2	9	17
31	Tanga	Handeni DC	91	103	102	-175	12764	15116	11708	11	4	6
32	Tabora	Sikonge DC	103	106	104	-277	7493	8123	5902	23	14	24
33	Tabora	Igunga DC	103	109	102	-335	16646	18521	17762	17	15	19
34	Mara	Rorya DC	113	109	103	-350	12264	12112	11544	8	11	8
35	Singida	Ikungi DC	110	110	104	-466	11899	12517	11875	9	2	5
36	Tabora	Kaliua DC	99	102	103	-554	15715	17099	17621	21	20	23
37	Manyara	Hanang DC	101	97	105	-565	11360	11520	12665	12	8	14
38	Mara	Bunda TC	NA	102	117	-824	NA	5881	5634	NA	13	14
39	Simiyu	Itilima DC	135	105	108	-1003	17980	16049	13819	-1	11	14
40	Mara	Tarime TC	145	148	143	-1238	4703	4917	4132	11	12	23
41	Geita	Mbogwe DC	110	109	115	-1239	9689	10055	9496	18	15	16
42	Mwanza	Nyamagana MC	103	101	108	-1248	15285	16463	17016	11	7	9
43	Morogoro	Malinyi DC	NA	101	127	-1276	NA	5509	6068	NA	21	15
44	Rukwa	Kalambo DC	133	117	114	-1308	12136	11294	10430	4	6	9
45	Shinyanga	Kishapu DC	106	97	119	-2124	14685	13642	13400	-4	7	6
46	Katavi	Nsimbo DC	116	114	142	-2355	8120	8012	8009	10	10	10
47	Geita	Geita DC	95	108	109	-2358	26944	31645	29366	14	16	16



48	Katavi	Mpanda DC	116	125	130	-2391	10041	10957	10270	16	12	14
49	Shinyanga	Shinyanga MC	103	117	139	-2597	8431	9784	7393	-9	1	6
50	Tanga	Kilindi DC	96	139	130	-2933	8957	13661	12806	32	20	8
51	Mbeya	Chunya DC	110	126	146	-3030	12753	15525	9423	11	10	14
52	Shinyanga	Msalala DC	97	90	131	-3161	15513	14866	13236	-2	4	7
53	Shinyanga	Ushetu DC	115	107	134	-3860	15139	17049	15140	3	-2	9
54	Geita	Bukombe DC	115	129	142	-3974	11730	13754	13535	21	12	19
55	Rukwa	Nkasi DC	108	132	134	-4225	14653	17265	16575	9	7	4
56	URBAN WEST	West	62	57	86	1728	9619	9215	10498	6	9	13

**Annex 2: Districts for EIS scaling up under HSS2**

<b>Zones</b>	<b>Regions</b>	<b>Districts</b>	<b>Sr. No. Districts</b>	<b>Sr. No. Regions</b>
Eastern Zone	Pwani			1
		Bagamoyo DC	1	
		Chalinze DC	2	
		Kibaha DC	3	
		Kibaha TC	4	
		Kibiti TC	5	
		Kisarawe DC	6	
		Mafia DC	7	
		Mkuranga DC	8	
		Rufiji DC	9	
Southern Zone	Lindi			2
		Kilwa DC	10	
		Lindi MC	11	
		Lindi DC	12	
		Liwale DC	13	
		Nachingwea DC	14	
		Ruangwa DC	15	
Southern Zone	Ruvuma			3
		Tunduru DC	16	
		Songea DC	17	
		Namtumbo DC	18	
		Mbinga DC	19	
		Songea MC	20	
		Nyasa DC	21	
		Mbinga TC	22	
		Madaba DC	23	
Southern Highlands Zone	Iringa			4
		Iringa MC	24	
		Mafinga TC	25	
		Iringa DC	26	
		Mufindi DC	27	
		Kilolo DC	28	
Southern Highlands Zone	Mbeya			5
		Busokelo DC	29	
		Chunya DC	30	
		Kyela DC	31	
		Mbarali DC	32	

		Mbeya CC	33	
		Mbeya DC	34	
		Rungwe DC	35	
Central Zone	Singida			6
		Ikungi DC	36	
		Iramba DC	37	
		Itigi DC	38	
		Manyoni DC	39	
		Mkalama DC	40	
		Singida DC	41	
		Singida MC	42	
Western Zone	Tabora			7
		Nzega DC	43	
		Igunga DC	44	
		Uyui DC	45	
		Urambo DC	46	
		Tabora MC	47	
		Sikonge DC	48	
		Kaliua DC	49	
		Nzega TC	50	
Southern Highlands Zone	Rukwa			8
		Sumbawanga DC	51	
		Nkasi DC	52	
		Kalambo DC	53	
		Sumbawanga MC	54	
Southern Highlands Zone	Katavi			9
		Mpanda TC	55	
		Mpanda DC	56	
		Nsimbo DC	57	
		Mlele DC	58	
		Mpimbwe DC	59	
Western Zone	Kigoma			10
		Buhigwe DC	60	
		Kakonko DC	61	
		Kasulu DC	62	
		Kasulu TC	63	
		Kibondo DC	64	
		Kigoma DC	65	
		Kigoma MC	66	
		Uvinza DC	67	

Western Zone	Shinyanga			11
		Kahama TC	68	
		Kishapu DC	69	
		Msalala DC	70	
		Shinyanga DC	71	
		Shinyanga MC	72	
		Ushetu DC	73	
Western Zone	Simiyu			12
		Bariadi DC	74	
		Bariadi TC	75	
		Busega DC	76	
		Itilima DC	77	
		Maswa DC	78	
		Meatu DC	79	
Lake Zone	Kagera			13
		Karagwe DC	80	
		Bukoba DC	81	
		Muleba DC	82	
		Biharamulo DC	83	
		Ngara DC	84	
		Bukoba MC	85	
		Missenyi DC	86	
		Kyerwa DC	87	
Lake Zone	Mara			14
		Bunda DC	88	
		Bunda TC	89	
		Butiama DC	90	
		Musoma DC	91	
		Musoma MC	92	
		Rorya DC	93	
		Serengeti DC	94	
		Tarime DC	95	
		Tarime TC	96	
Northern Zone	Manyara			15
		Simanjiro DC	97	
		Kiteto DC	98	
		Babati DC	99	
		Hanang DC	100	
		Mbulu TC	101	
		Mbulu DC	102	
		Babati TC	103	

Southern Highlands Zone	Songwe			16
		Mbozi DC	104	
		Momba DC	105	
		Ileje DC	106	
		Songwe DC	107	
		Tunduma TC	108	
UNGUJA	URBAN WEST	Urban	109	17
		West	110	
	NORTH UNGUJA	North A	111	18
		North B	112	
	SOUTH UNGUJA	Central	113	19
		South	114	
PEMBA	SOUTH PEMBA	Mkoani	115	20
		Chake	116	
	NORTH PEMBA	Wete	117	21
		Micheweni	118	