

Application Form for Gavi NVS support

Submitted by

The Government of

United Republic of Tanzania

Date of submission: **18 May 2017**

Deadline for submission:

- i. **3 May 2017**
- ii. 3 May 2017
- iii. 1 September 2017

Select Start and End Year of your Comprehensive Multi-Year Plan (cMYP)

Start Year

2016

End Year

2020

Form revised in 2016

(To be used with Guidelines of December 2016)

Note: Please ensure that the application has been received by Gavi on or before the day of the deadline.

Gavi
GRANT TERMS AND CONDITIONS

FUNDING USED SOLELY FOR APPROVED PROGRAMMES

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

AMENDMENT TO THE APPLICATION

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

RETURN OF FUNDS

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

SUSPENSION/ TERMINATION

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

ANTICORRUPTION

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

AUDITS AND RECORDS

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

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

CONFIRMATION OF LEGAL VALIDITY

The Country and the signatories for the Country confirm that its application, and Annual Progress Report, are accurate and correct and form legally binding obligations on the Country, under the Country's law, to perform the programmes described in its application, as amended, if applicable, in the APR.

CONFIRMATION OF COMPLIANCE WITH THE Gavi TRANSPARENCY AND ACCOUNTABILITY POLICY

The Country confirms that it is familiar with the Gavi Transparency and Accountability Policy (TAP) and complies with the requirements therein.

USE OF COMMERCIAL BANK ACCOUNTS

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

ARBITRATION

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

. The languages of the arbitration will be English or French.

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

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

1. Type of Support requested

Please specify for which type of Gavi support you would like to apply to.

Type of Support	Vaccine	Start Year	End Year	Preferred second presentation[1]
Routine New Vaccines Support	HPV quadrivalent, 1 dose(s) per vial, LIQUID	2018	2020	HPV bivalent, 2 dose(s) per vial, LIQUID

[1] Gavi may not be in a position to accommodate all countries first product preferences, and in such cases, Gavi will contact the country and partners to explore alternative options. A country will not be obliged to accept its second or third preference, however Gavi will engage with the country to fully explore a variety of factors (such as implications on introduction timing, cold chain capacity, disease burden, etc.) which may have an implication for the most suitable selection of vaccine.

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3. Executive Summary

Please provide a summary of your country's proposal, including the following the information:

- For each specific request, NVS routine support or NVS campaign :
 - The duration of support
 - The total amount of funds requested
 - Details of the vaccine(s), if applicable, including the reason for the choice of presentation
 - Projected month and year of introduction of the vaccine (including for campaigns and routine)
- Relevant baseline data, including:
 - DTP3 and Measles coverage data (as reported on the WHO/UNICEF Joint Reporting Form)
 - Target population from Risk Assessments from Yellow Fever and Meningitis A
 - Birth cohort, targets and immunisation coverage by vaccines
- Country preparedness
 - Summary of planned activities to prepare for vaccine launch, including EVM assessments, progress on EVM improvement plans, communication plans, etc.
 - Summary of EVM assessment and progress on EVM improvement plan
- The role of the Coordination Forum (ICC/HSCC or equivalent) and stakeholders' participation (e.g. government, key donors, partners, key implementers, CSOs) in developing this proposal

Tanzania Mainland has 26 regions subdivided in 183 councils while Zanzibar has 5 regions subdivided in 11 districts. Majority of Tanzanians are farmers, fishermen and pastoralists. Nomadic populations are also found in the northern, western and Lake Zones. Immunization services are provided countrywide and are free of charge in both public and private health facilities in the whole country.

According to the latest Population and Housing Census of 2012, Tanzania Mainland had a population of 43,625,354 comprised of 21,239,313 males and 22,386,041 females with an average annual growth rate of 2.7%. The projected population by 2015 was 48,858,342. The crude birth rate is 41.6 per 1,000 populations and life expectancy at birth is 63 years for women and 60 years for men respectively. Less than one third (29%) of the population resides in urban areas whereas the majority (71%) of population are rural dwellers.(Tanzania Bureau of Statistics, 2013)

In 2015 the targets for under one year was 1,810,396 under five was 9,600,159, under fifteen was 23,450,004 and the birth cohort was 1,949,962. The immunization coverage by vaccines were as follows; DTP3 98%, OPV3 96%, HepB3 98%,Hib3 98%, PCV3 95%, Rota 2 98%, TT2+ 94% , Measles and Rubella 1st dose was 103% and 2nd dose was 57% .

HPV vaccine will be introduced country wide in 1st April 2018. The routine immunization services will be the strategy used to deliver HPV vaccine in Tanzania. Health Facilities will be the main point of provision of the vaccine as other antigens in the routine immunization. Eligible girls may be vaccinated either at health facility, outreach posts or schools. In the first year of introduction 2018 eligible girls will be 9 to 14 years of age. In subsequent years single age cohort of 9 years old girls will be vaccinated.

The HPV quadrivalent (Gardasil) vaccines will be used because have already been registered by TFDA and have been used in Kilimanjaro region during demonstration.

The total amount requested by Government of Tanzania is \$ **1,719,890** as introduction grant of HPV into routine immunization for 9 years girls and \$ **2,222,287** as operation cost for introduction of HPV vaccine into routine immunization to multi cohort age 10-14 years girls for a period of five years. The remaining financial gap will be mobilized within in country.

Several activities will be done prior introduction of HPV vaccine which includes;

- Development of micro plan
- Development ,print and distribution of HPV vaccine guideline
- Development, print and distribution of IEC materials, media and airing sport
- Advocacy meeting at National level
- Conducting high level stakeholder's meeting committee
- Extended PHC meeting (Regional and district)
- Sensitization of CHW , girls and Community,
- Media seminars
- Training of supervisors at national, regional and district level
- Training of health workers and teachers
- Ordering receiving and distribution of HPV vaccine

With introduction of new vaccine e.g HPV vaccine, EVM assessment is very important to ensure good storage and distribution practice within the country. EVM assessment was conducted in 2015 the overall score was 87% which is slightly higher compare to EVM assessment conducted in 2012 by 2%.The following were key recommendations of EVM assessment;

- Lot release certificates should accompany all vaccine batches and copies filed together VARs
- Products Arrival Forms should be completed for each consignment injection safety materials and copies submitted to UNICEF
- A formal contingency plan should be developed to deal with unexpected vaccine arrivals
- Zanzibar status as Central Store should be reclassified if they no longer receive vaccines direct from manufactures.
- A temperature mapping study should be conducted for each cold room, a reports produced and archived.
- Data generated by temperature loggers on refrigerated vehicles should be downloaded periodically and filed for future reference.
- Standard operating procedures for key vaccine management areas should be developed and issued to all vaccine stores. These should be based on generic WHO EVM SOPs.
- Zanzibar CVS cold chain capacity to be increased to meet demand for new vaccine- IPV and HPV

EVM assessment was followed by development of improvement plan to address the recommendations. The progress on improvement plan was;

- MSD staff have been provided with SOP to handle VARs and Lot release certificate monthly supportive supervision to MSD are ongoing and quarterly spot check
- Implemented product arrival form for injection safety material filled at MSD as SOPs
- Contingency plan for unexpected vaccine arrivals not yet developed
- Discussion between MOH Zanzibar and UNICEF supply division is ongoing to reach consensus of all traditional vaccine to be delivered in Zanzibar.
- Temperature mapping study is in the process of developing study protocol and electronic data loggers (BeyondWireless fringePhone™) devices for temperature mapping devices installed in all WICR.
- New cold room 30m3 have been installed in Zanzibar CVS to meet demand for new vaccine.

Several HPV stakeholders were full involved in the whole process of introduction of HPV in Tanzania. Ministry of health in collaboration with Ministry of Education, Ministry of finance with support of partners e.g WHO,UNICEF,CHAI,PATH, professional association (MEWATA,AGOTHA,PAT) and Civil society group worked together in implementation of HPV demonstration and also in development of this proposal.

Inter -Agency Coordinating Committee review and endorse this proposal.

4. Signatures

4.1. Signatures of the Government and National Coordinating Bodies

4.1.1. Government and the Inter-Agency Coordinating Committee for Immunisation

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

HPV quadrivalent, 1 dose(s) per vial, LIQUID routine introduction

The Government of United Republic of Tanzania commits itself to developing national immunisation services on a sustainable basis in accordance with the Comprehensive Multi-Year Plan presented with this document. The Government requests that the Gavi and its partners contribute financial and technical assistance to support immunisation of children as outlined in this application.

Table(s) 6.2.4 in the NVS Routine section of this application shows the amount of support in either supply or cash that is required from the Gavi. Table(s) 6.2.3 of this application shows the Government financial commitment for the procurement of this new vaccine (NVS support only).

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

The payment for the first year of co-financed support will be around **October 2018** for **HPV quadrivalent, 1 dose(s) per vial, LIQUID**.

Please note that this application will not be reviewed or recommended for approval by the Independent Review Committee (IRC) without the signatures of both the Minister of Health and Minister of Finance or their delegated authority. These signatures are attached as DOCUMENT NUMBER : 1 and 2 in Section 10. Attachments.

Minister of Health (or delegated authority)		Minister of Finance (or delegated authority)	
Name	UMMY A. MWALIMU	Name	DK PHILIP MPANGO
Date		Date	
Signature		Signature	

Proof of involvement of the Ministry of Education will also be required for HPV Routine Support. The Ministry of Education will either have to be involved in the ICC process (preferred option) and, for countries choosing schools as a location for vaccinations, or choosing a school link strategy, the Minister of Education (or delegated authority) must provide its signature. The signature is attached as DOCUMENT NUMBER : 3 in Section 10. Attachments.

Minister of Education (or delegated authority)	
Name	
Date	
Signature	

This report has been compiled by (these persons may be contacted in case the Gavi Secretariat has queries on this document):

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4.1.2. National Coordination Forum (Interagency Coordinating Committees (ICCs), Health Sector Coordinating Committees (HSCCs), and other equivalent bodies)

To be eligible for support, Gavi asks countries to ensure a *basic* functionality of their Coordination Forum (ICC/HSCC or equivalent body). Countries can demonstrate this by adhering to the requirements listed in section 5.2 of the General Guidelines. The information in this section and a set of documents submitted along with this application will help the Independent Review Committee (IRC) to assess adherence.

Profile of the Coordination Forum

Name of the Forum	National Immunization Coordinating Committee
Organisational structure (e.g., sub-committee, stand-alone)	National ICC is stand-alone committee under the chairmanship of the Permanent Secretary. Member of I

The Terms of Reference for the Coordination Forum is attached as DOCUMENT NUMBER : 4. The Terms of Reference should include all sections outlined in Section 5.2 of the General Guidelines..

Please describe the role of the Coordination Forum and stakeholders' participation (e.g. government, key donors, partners, key implementers, CSOs) in developing this proposal:

The roles of the National ICC are to;

1. Foster solid partnerships by coordinating all inputs and resources available from inside and outside the country in order to maximize resources for the good of the child.
2. Support the EPI Programme to mobilize resources, both within the country and externally, for use in the programme such as Gavi funds.
3. Assist the Immunization Programme in enhancing transparency and accountability by reviewing use of funds and other resources at regular intervals. This should be a process that enhances and motives both the ICC and the government to continue resource mobilization for EPI.
4. Review and endorse work plans such as the Country Multi Year Plans (cMYPs), EPI annual plans, and Supplemental Immunization Activities (SIAs) plans of action, Surveillance plans, and Introduction of New Vaccines etc.

Support and encourage as much information-sharing and feedback as possible, not only at the national level, but also with the implementing levels within the country and interested partners outside the country.

Stakeholds participation

HPV introduction in Tanzania started as Demonstration Project. Decision of starting demonstration involved all the Immunization and Cervical Cancer Prevention stakeholders in different forums before submission to the National ICC for the final decision. Decision for national wide introduction involved all the stakeholders.

EPI Technical Working Group which involves the MoH IVD Team and Immunization Partners and Cervical Program worked together in the preparation of the application development through the sub committees (Logistics, Social mobilization, Operations and Programme Management)

Other Stakeholders such as Government (Health and Local Government), PATH, WHO, CHAI, UNICEF, MEWATA, Red Cross, AMREF, TAMWA, AGOTA, Pediatrics Association, TPHA were fully involved in the application

4.1.3. Signature Table for the Coordination Forum (ICC/HSCC or equivalent body)

We the members of the ICC, HSCC, or equivalent committee [1] met on the **26/01/2017** to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached. The minutes from the meeting endorsing the proposal and of the meetings of the past 12 months are attached as Document number 5. The signatures endorsing the proposal are attached as Document number 7 (please use the list for signatures in the section below).

Function	Title / Organisation	Name	Please sign below to indicate the attendance at the meeting where the proposal was endorsed	Please sign below to indicate the endorsement of the minutes where the proposal was discussed
Chair	Permanent Secretary	Dr. Mpoki M. Ulisubisya		
Secretary	National IVD Manager	Dr. Dafrossa Lyimo		
Members	WHO Representative	Dr Richard Banda		
	UNICEF Representative	Ms Maniza zamani		
	USAID	Raz Stevenson		
	KFW	Pascal Kanyinyi		
	Red cross	Bertha Mlay		
	CHAI	Dr. Esther Mtumbuka		
	Pediatric Association	Dr Kandi Muze		
	AMREF	Dr Julieth Kabengula		

By submitting the proposal we confirm that the quorum has been met. **Not selected**

The minutes from the meeting endorsing the proposal and of the meetings of the past 12 months are attached are attached as DOCUMENT NUMBER : 6.

4.2. National Immunization Technical Advisory Group (NITAG)

Has a NITAG been established in the country ? **Not selected**

In the absence of a NITAG, countries should clarify the role and functioning of the advisory group and describe plans to establish a NITAG. This document is attached as **(Document Number: 8)**

5. Immunisation Programme Data

5.1 Background information

Please complete the table below, using the most recent data from available sources. Please identify the source of the data, and the date and attach the source document, where possible. The following documents should be referred to and/or attached:

- Comprehensive Multi-Year Plan for Immunisation (cMYP) (or equivalent plan). Please attach as DOCUMENT NUMBER 9.
- New Vaccine Introduction Plan(s) / Plan of Action. Please attach as DOCUMENT NUMBER 12.
- New Vaccine Introduction Checklist, Activity List and Timeline. Please attach as DOCUMENT NUMBER 12.
- Effective Vaccine Management (EVM) assessment. Please attach as DOCUMENT NUMBER 20.
- Two most recent annual WHO/UNICEF Joint Reporting Forms (JRF) on Vaccine Preventable Diseases.
- Health Sector Strategy documents, budgetary documents, and other reports, surveys etc, as appropriate.

- In the case of Yellow Fever and Meningitis A mass preventive campaigns, the relevant risk assessments. Please attach as DOCUMENT NUMBER 24 and DOCUMENT NUMBER 25.

Please use the most recent data available and specify the source and date.

	Figure	Year	Source
Total population	49,461,216.00	2016	National Bureau of Statistic
Birth cohort	1,970,811.00	2016	National Bureau Statistic
Infant mortality rate (per 1000)	43.00	2015	Tanzania Demographic Health Survey
Surviving infants[1]	1,852,322.00	2016	National Bureau of Statistic
GNI per capita (US\$)	932.00	2016	World Bank
Total Health Expenditure (THE) as a percentage of GDP	7.00	2013	World Bank
General government expenditure on health (GGHE) as % of General government expenditure	11.00	2013	WHO National Health Account

[1] Surviving infants = Infants surviving the first 12 months of life

5.1.1 Lessons learned

Routine New Vaccines Support

If new or under-used vaccines have already been introduced in your country, please give details of the lessons learned from previous introduction(s) specifically for: storage capacity, protection from accidental freezing, staff training, cold chain, logistics, coverage and drop-out rates, wastage rate, etc., and suggest action points or actions taken to address them. Please refer to previous Post Introduction Evaluations (PIE), if applicable. If they are included in the Introduction Plan, please cite the section only. If this information is already included in NVIP/POA, please reference the document and in which section/page this information can be found.

Lessons Learned	Action Points
<p>Tanzania has experience of introduction of new and used vaccine since 2009. Of the recent years the following were introduced;</p> <ul style="list-style-type: none"> • PCV and Rota in 2013 • Measles 2nd dose at 18 months in 2014 • Measles Rubella vaccines in 2014 • HPV as demonstration project in 2014 <p>Detailed lesson learnt are in documented in the Introduction Plan section 3.</p> <p>Storage capacity</p> <ul style="list-style-type: none"> • Cold chain capacity is sufficient to accommodate the additional dose. <p>Vaccine Management</p> <ul style="list-style-type: none"> • The cold chain were maintained and monitored using the available temperature monitoring devices <p>Distribution of vaccines</p> <ul style="list-style-type: none"> • The introduction of new vaccine did not increase frequency of vaccine distribution at any level as the new vaccines were distributed at the same time with other vaccines. <p>Staff training</p> <ul style="list-style-type: none"> • Limited skill at regional and district level for preventive maintenance and repair of equipment 	<ul style="list-style-type: none"> • Currently the cold chain capacity is adequate. However, will continue to monitor the situation accordingly. • Programme continue to monitor availability, functionality and use of temperature monitoring devices and are in use. • New vaccines will be distributed along with other antigens. • Training on preventive maintenance at regional and district level were conducted for regional and district

especially for new cold rooms

level officers

5.1.2 Health planning and budgeting

Please provide information on the planning and budgeting cycle in your country

The planning for the country financial year starts in March up to the end of June. The budget cycle covers the period of July up to the end of June in the next year.

Please indicate the name and date of the relevant planning document for health

Health Sector Strategic Plan IV (HSSP IV) covering a period of July 2015 to June 2020

Is the cMYP (or updated Multi-Year Plan) aligned with the proposal document (timing, content, etc.)

Yes, The cMYP is aligned with HSSP IV. Immunization is part of the HSSP IV with clear indicators on immunization.

Please indicate the national planning budgeting cycle for health

The budgeting cycle for health is aligned with the country financial cycle (July to June of the following year)

Please indicate the national planning cycle for immunization

The planning cycle for Immunization is January to December

5.1.3 Coverage and equity

Please describe any health systems bottlenecks or barriers to access, utilisation and delivery of immunisation services at district level (or equivalent), for example geographic, socio-economic and/or gender-related barriers. Please indicated if there are specific populations of concern. If available, please provide subnational coverage and equity data highlighting geographic, socio-economic, gender-related, or other barriers and any other relevant categories of vulnerable or high-risk populations.

Tanzania doesn't have significant barriers in most of the districts because all the communities and sub communities are clearly identified with Community Leaders who are recognized by the administrative system.

The Tanzania Demographic and Health Survey 2015 – 16 indicated that;

- Basic vaccination coverage does not differ substantially by the sex of the child: Males were 76.9% and Females 73.5%
- Some differences between urban and rural residence were marked
- Larger differences were observed at the zonal level; the percentage of children with all basic vaccination coverage ranges from a high of 83% in Central, Southern Highlands, and Eastern zones to a low in Southwest Highland zone (67%) and Western zone (66%)
- Mothers' educational level and wealth status were positively correlated with basic vaccination coverage of their children. For example, 68% of children whose mothers had no education received all basic vaccinations, as compared with 76% of those children whose mothers had primary education and 81% of those whose mothers had secondary education or higher

Barriers to immunization services in some of the districts are geographical especially communities living in the small islands and hard to reach areas because of accessibility and also some of the nomads who move because of their cattle to search water and grazing areas. The majority of unvaccinated and under vaccinated children in the country are in these communities. The District Councils are aware of the hard to reach areas, and they provide mobile services using vehicles, boats and small planes. Nomadic communities are served with outreach or mobile services once identified in the health facility catchment area.

During introduction preparations and planning these barriers and mitigation actions will be identified in the detailed micro-plans, which are supported by the health facilities and affected community leaders. Tailored Periodic Intensified Routine Immunization services are conducted with financial challenges in some of districts.

Please explain how the proposed NVS support (activities and budget) will be used to improve coverage and equity of routine immunisation with reference to specifically identified health systems bottlenecks and/or specific populations of concern. For countries that will be receiving Gavi HSS and/or CCEOP funding concurrently with NVS funds, please also highlight how NVS funds will support/complement/leverage specific activities or investments included in those other grants.

The coverage and equity will be improved through both social mobilization and detailed micro planning to reach hard to reach area;

- Use of the community leaders including the religious leaders in the social mobilization through their village committees
- Local radios has good communication network will be used to send the message
- Children will be used to share the message to the community
- Detailed micro plans will be developed to ensure all communities and sub villages are reached through the existing administrative structure
- The use of town criers will intensified in all urban and rural areas
- Existing outreach and mobile services will be used and expand numbers depending on the geographical areas.

Please describe what national surveys take place routinely in country to assess gender and equity related barriers. Highlight whether this application includes any activities to assess gender and equity related barriers.

The Tanzania Demographic and Health Survey 2015 – 16 indicated that;

- Basic vaccination coverage does not differ substantially by the sex of the child: Males were 76.9% and Females 73.5%
- Some differences between urban and rural residence were marked
- Larger differences were observed at the zonal level; the percentage of children with all basic vaccination coverage ranges from a high of 83% in Central, Southern Highlands, and Eastern zones to a low in Southwest Highland zone (67%) and Western zone (66%)

This application will include activities to adress gender and equity through reaching every child strategy and social mobilization

Please indicate if sex disaggregated data is collected and used in immunisation routine reporting systems.

The sex disaggregated data is collected at Health Facility level and captured in DHIS2

Is the country currently in a situation of fragility (e.g. insecurity, conflict, post-conflict, refugees/and or displaced persons and recent, current or potential environmental disaster, such as flooding, earthquake or drought or others)? If Yes, please describe how these issues may impact your immunisation programme, planning for introduction of routine vaccines or campaigns and financing of these activities.

The United Republic of Tanzania is peaceful country without insecurity; however in case potential environmental disaster Immunization services are given higher priority in those areas. The use of mobile or outreaches are quickly instituted to support in these instances

5.1.4 Data quality

To support country efforts to strengthen the availability, quality and use of vaccination coverage data for strengthened programme management, Gavi requires that countries applying for all types of Gavi support to undertake routine monitoring of vaccination coverage data through an annual desk review; conduct periodic (once every five years or more frequently where appropriate) in-depth assessments of routine administrative vaccination coverage data; conduct periodic (at least once every five years) nationally representative vaccination coverage surveys; and develop and monitor plans for improving vaccination coverage data quality

as a part of their own core work plans.

5.1.5 HPV specific facts

Countries applying for HPV that have already conducted a demonstration or pilot programme, should include details on specific lessons learned for HPV vaccine delivery.

Key programmatic areas	Lessons Learned	How these areas have been addressed in a National Plan
Preparation & planning	<p>Good coordination with various stakeholders</p> <p>Early and fully involvement of health and education departments at all levels in the micro plans helped in smooth implementation of demonstration project and better utilization of resource.</p> <p>Registration of eligible girls both in school and out of schools made delivery of vaccine easy and able to trace those who missed and also for second dose</p> <p>Early training of health workers and teachers before the introduction of new vaccines with reference materials (user guides) increased their knowledge hence able to provide health education to parent and girls.</p> <p>Timely development and distribution of IEC materials to the lower level was guaranteed.</p> <p>Non-inclusion of HPV outreach to school in CCHP</p>	<p>Joint planning and involvement of stakeholders has been included in the National Plan at all levels.</p> <p>Development of guideline for HPV introduction and IEC material will be developed and distributed timely to the lower level.</p> <p>Health facilities will plan the outreaches in schools together with the school and the outreach at schools will be included in the Comprehensive Council Health plans</p>
Communication & social mobilization	<p>Community engagement especially use of the Community Leaders enable to send the messages to the community easily.</p> <p>Use of the local radios to disseminate messages, teacher parent meeting increase acceptability among parents</p> <p>Advocacy and sensitization of politician, High level (first lady launch HPV vaccine) religious leaders</p> <p>Community engagement through Community Health Workers to identify those out of school</p>	<p>This is part of the national plan especially the first year as part introduction of new vaccines</p>
Delivery strategies	<p>Using the campaign mode is very expensive and not sustainable. Using the routine immunization mode by intensifying vaccination is specific month is cheap and is sustainable</p>	<p>Delivery strategy will be routine immunization with intensified in April and November. Mixed strategy Health facility and outreach in school and community will be used to make sure all eligible girls are reached.</p>
Coverage	<p>HPV vaccine was generally carried out smoothly with very good acceptance overall by all stakeholders including parent, school and religious group. HPV coverage was high for both campaign and routine mode of delivery of HPV vaccine but campaign mode was higher than routine mode. The campaign mode resulted in coverage of 93% for 1st dose and 92.6% for 2nd dose while routine mode the coverage was 89% for 1st</p>	<p>Use of school as outreach will be advocated to get girls at shortest period to increase coverage</p> <p>Outreach to the community will be conducted to reach hard to reach girls</p>

	<p>dose and 78% for 2nd doses. Limited HPV vaccine dropout was observed among in school girls. For girls who missed their 1st dose in round one action was taken to identify them so that may receive it in round two during campaign mode. The coverage for out of school was 65%. Using school as outreach post ensure that more girls are reached on the shortest time</p>	
Reporting & monitoring	<p>Campaign mode the data is not captured in the RI administrative data however monitoring is easy for short period. Routine Immunization mode the data is easily captured in the administrative data, defaulter tracing can be easily done to schools and community for those missed during intensified period. Monitoring is done integrated with other antigens.</p>	<p>Data management tools already have been updated to include HPV Vaccine HPV vaccination monthly monitoring will be done through routine immunization data management tools. Performance monitoring chart for HPV vaccine will be available in all Health Facilities to monitor both two doses vaccination.</p>
Sustainability	<p>Routine immunization is sustainable and easily to be integrated with other adolescent interventions at schools. Delivery of vaccine using campaign mode was expensive, \$ 11 compare to routine mode, \$2 per fully immunized girl (vaccine exclusive)</p>	<p>Each has Health Facility will develop their own micro plan to ensure girls are reached using the REC approach</p>

For each district in which the demonstration/ pilot programme was implemented, please complete the following:

District Information	
Name of the district	Mwanga DC
Size of target population of the district	140,730
Describe how the district is divided into rural and urban areas:	About 80% of the district is rural and mountainous.
Delivery strategy(ies) used (e.g. school based, health centre based, campaign)	<p>First year was campaign mode from April 2014 to March 2015 Second year was routine immunization mode using both fixed and outreach services which included schools from April 2015 to March 2016</p> <p>Coverage for first year; 1st dose was 92.5% and 2nd dose was 93% Coverage for second year; 1st dose was 81% and 2nd dose was 82%</p>
District Information	
Name of the district	Moshi DC
Size of target population of the district	501,260
Describe how the district is divided into rural and urban areas:	About 60% of the district is rural and 40% is urban
Delivery strategy(ies) used (e.g. school based, health centre based, campaign)	<p>First year was campaign mode from April 2014 to March 2015 Second year was routine immunization mode using both fixed and outreach services which included schools from April 2015 to March 2016 First year was campaign mode and second was routine immunization mode using both fixed and outreach services which included schools</p> <p>Coverage for first year; 1st dose was 93.6% and 2nd dose was 93% Coverage for second year; 1st dose was 100% and 2nd dose was 103%</p>
District Information	
Name of the district	Siha DC
Size of target population of the district	126,780
Describe how the district is divided into rural and urban areas:	About 90% of the district is rural and mountainous
Delivery strategy(ies) used (e.g. school based, health centre based, campaign)	<p>First year was campaign mode from April 2014 to March 2015 Second year was routine immunization mode using both fixed and outreach services which included schools from April 2015 to March 2016 First year was campaign mode and second was routine immunization mode using both fixed and outreach services which included schools</p> <p>Coverage for first year; 1st dose was 95.3% and 2nd dose was 94% Coverage for second year; 1st dose was 76% and 2nd dose was 55%</p>
District Information	
Name of the district	Moshi Municipal Council
Size of target population of the district	198,507
Describe how the district is divided into rural and urban areas:	About 95% of the district is urban
Delivery strategy(ies) used (e.g. school based, health centre based, campaign)	<p>First year was campaign mode from April 2014 to March 2015 Second year was routine immunization mode using both fixed and outreach services which included schools from April 2015 to March 2016 First year was campaign mode and second was routine immunization mode using both fixed and outreach services which included schools</p> <p>Coverage for first year; 1st dose was 91.2% and 2nd dose was 92% Coverage for second year; 1st dose was 136% and 2nd dose was 120%</p>

District Information	
Name of the district	Same DC
Size of target population of the district	290,618
Describe how the district is divided into rural and urban areas:	About 85% of the district is rural and mountainous
Delivery strategy(ies) used (e.g. school based, health centre based, campaign)	<p>First year was campaign mode from April 2014 to March 2015 Second year was routine immunization mode using both fixed and outreach services which included schools from April 2015 to March 2016</p> <p>Coverage for first year; 1st dose was 95.6% and 2nd dose was 95% Coverage for second year; 1st dose was 94% and 2nd dose was 66%</p>
District Information	
Name of the district	Rombo DC
Size of target population of the district	281,092
Describe how the district is divided into rural and urban areas:	Most of the district is rural, about 90%
Delivery strategy(ies) used (e.g. school based, health centre based, campaign)	<p>First year was campaign mode from April 2014 to March 2015 Second year was routine immunization mode using both fixed and outreach services which included schools from April 2015 to March 2016</p> <p>Coverage for first year; 1st dose was 91.5% and 2nd dose was 92% Coverage for second year; 1st dose was 58% and 2nd dose was 44%</p>
District Information	
Name of the district	Hai DC
Size of target population of the district	226,772
Describe how the district is divided into rural and urban areas:	80% of the district is rural
Delivery strategy(ies) used (e.g. school based, health centre based, campaign)	<p>First year was campaign mode from April 2014 to March 2015 Second year was routine immunization mode using both fixed and outreach services which included schools from April 2015 to March 2016</p> <p>Coverage for first year; 1st dose was 92.5% and 2nd dose was 93% Coverage for second year; 1st dose was 87% and 2nd dose was 73%</p>

5.2. Baseline and Annual Targets for Routine Vaccines

For HPV, Gavi supports the vaccination of girls aged 9-14 years, based on the following cohorts:

- Routine cohort – countries are required to identify a single year cohort of girls to be immunised on a routine basis. (e.g. 9 years old)
- Additional multi-age cohort – in the first year of introduction (or initial year of each phase, if country choose phased introduction), countries also have the option to immunise additional girls within the recommended age groups (e.g. 10-14 years), that are older than the routine cohort.

Note: Countries may choose proxy age of girls based on a school grade (e.g. grade 5 corresponds to approximately 10 year olds). However, grades usually have a range of different aged girls so it is important to keep in mind that girls under 9 years should not be vaccinated, and doses for girls older than 14 years are not provided by Gavi.

Please specify the chosen age for the routine cohort HPV vaccination: e.g. 9 years

If relevant, please specify the chosen age range for the additional multi-age cohort in the year of introduction: e.g. 10, 11, 12, 13, 14 years

From :

10 years

To :

14 years

Will a phased introduction approach be adopted?

No

If a phased approach will be adopted, please provide an explanation for this approach.

N/A

Please refer to cMYP pages to assist in filling-in this section. For HPV, please also refer to Annex 3 of the HPV Guidelines.

The Base year information should be completed for the year in which the application is being completed.

Table 5.2: Baseline NVS routine figures

Number	Base Year	Baseline and Targets		
	2016	2018	2019	2020
Total births	1,892,716	1,996,302	2,050,202	2,105,558
Total infants' deaths	81,387	85,841	88,159	90,539
Total surviving infants	1,811,329	1,910,461	1,962,043	2,015,019
Total pregnant women	1,892,716	1,996,302	2,050,202	2,105,558
Target population (routine cohort) vaccinated with OPV3[1]	1,720,763	1,814,938	1,863,941	1,914,268
OPV3 coverage[2]	95 %	95 %	95 %	95 %
Target population (routine cohort) vaccinated with DTP1[1]	1,756,989	1,853,147	1,903,181	1,954,568
Target population (routine cohort) vaccinated with DTP3[1]	1,720,763	1,814,938	1,863,941	1,914,268
DTP3 coverage[2]	95 %	95 %	95 %	95 %

Wastage[3] rate in base-year and planned thereafter (%) for DTP	10	10	10	10
Wastage[3] factor in base-year and planned thereafter for DTP	1.11	1.11	1.11	1.11
Routine Cohort				
Number of girls in the routine cohort		716621	735970	755841
Target population (routine cohort) vaccinated with 1st dose of HPV	0	680,799	699,172	718,049
Target population (routine cohort) vaccinated with 2nd dose of HPV	0	644,959	662,373	680,257
HPV quadrivalent coverage 1st dose	0 %	95 %	95 %	95 %
HPV quadrivalent coverage 2nd dose	0 %	90 %	90 %	90 %
Additional multi-age cohort				
Number of girls in the additional multi-age cohort	0	3422859		
Target population (additional multi-age cohort) vaccinated with 1st dose of HPV quadrivalent	0	3251716		
Target population (additional multi-age cohort) vaccinated with 2nd dose of HPV	0	3080573		
HPV quadrivalent coverage[2]	0%	95%	0%	0%
HPV quadrivalent coverage 2nd dose	0%	90%	0%	0%
First Presentation: HPV quadrivalent, 1 dose(s) per vial, LIQUID ROUTINE COHORT + ADDITIONAL MULTI-AGE COHORT				
Wastage[3] rate in base-year and planned thereafter (%)	5	5	5	5
Wastage[3] factor in base-year and planned thereafter (%)	1.05	1.05	1.05	1.05
Maximum wastage rate value for HPV quadrivalent, 1 dose(s) per vial, LIQUID	5 %	5 %	5 %	5 %
Second Presentation: HPV bivalent, 2 dose(s) per vial, LIQUID ROUTINE COHORT + ADDITIONAL MULTI-AGE COHORT				
Wastage[3] rate in base-year and planned thereafter (%)	5	5	5	5
Wastage[3] factor in base-year and planned thereafter (%)	1.05	1.05	1.05	1.05
Maximum wastage rate value for HPV bivalent, 2 dose(s) per vial, LIQUID	10 %	10 %	10 %	10 %
MCV Cohort				
Target population (routine cohort) vaccinated with 1st dose of MCV	1,720,763	1,814,938	1,863,941	1,934,418
MCV coverage[2]	95 %	95 %	95 %	96 %
Annual DTP Drop out rate				
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	2 %	2 %	2 %	2 %

[1] Indicate total number of children vaccinated with either DTP alone or combined

[2] Number of infants vaccinated out of total surviving infants

[3] The formula to calculate a vaccine wastage rate (in percentage): $[(A - B) / A] \times 100$. Whereby: A = the number of doses distributed for use according to the supply records with correction for stock balance at the end of the supply period; B = the number of vaccinations with the same vaccine in the same period.

5.2.1 Description of routine and additional multi-age cohorts

Provide the percentage of primary school enrolment

Primary school enrollment is 97%

Provide the percentage of secondary school enrolment

Secondary school enrollment is 90%

Provide the average age of entry for secondary school

Average age of entry for secondary school 14 years

Please provide a source for the enrolment data (e.g., national statistics office, MOE, recent census, school registers, etc.)

Source of enrollment data: President Office Regional Administration and Local Government Authority; Government Portal Content Committee, Last Reviewed on : 2015-11-24 12:14:08;
<http://www.tanzania.go.tz/home/pages/1219>

Please provide a source for the enrolment data (e.g., national statistics office, MOE, recent census, school registers, etc.)

Source of enrollment data: President Office Regional Administration and Local Government Authority; Government Portal Content Committee, Last Reviewed on : 2015-11-24 12:14:08;
<http://www.tanzania.go.tz/home/pages/1219>

5.2.2 HPV specific targets

Girls to be vaccinated with HPV should be within the WHO-recommended target population of 9-14 years old girls

Please specify the source of data that was used to estimate the number of girls in the routine and, if relevant, additional multi-age cohorts and reported in the above table under "Target population (routine cohort) vaccinated with HPV" and "Target population (additional multi-age cohort) vaccinated with HPV"

Source of data used to estimate number of girls for routine and additional multi age cohort was from projection of National Bureau of Statistics (NBS) census 2012.

Data for HPV target from UNESCO and UNFPA have been triangulated and no significant different was found although data Projections from National Bureau of Statistics (NBS) census 2012 was slightly higher .Therefore NBS data was used and these data already available at district, regional and national level.

5.3. Targets for Preventive Campaign(s)

No NVS Prevention Campaign Support this year

5.4. Targets for One time mini-catchup campaign(s)

No One time mini-catchup campaign this year

6. New and Under-Used Vaccines (NVS Routine vaccines)

6.1. Assessment of burden of relevant diseases (if available)

If already included in detail in the Introduction Plan or Plan of Action, please cite the section only.

Disease	Title of the assessment	Date	Results
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6.1.1 HPV burden specific information

Has the country undertaken an assessment of the burden of cervical cancer? If so, describe the burden, and when and how the assessment was done. If not, countries may report on Globocan data (available on the WHO HPV information Centre website at <http://www.who.int/hpvcentre/en>).

Cervical cancer is a leading cause of morbidity and mortality in Tanzania for women. Tanzania is one of the countries with the highest cervical cancer burden in the world and the highest in Eastern Africa. The annual incidence for cervical cancer is 50.9 cases per 100,000 and mortality of 37.5 women per 100,000. In the past 5 years, 80% of the cases were reported at the advanced stage. Among those with advanced cases, the chance for survival is less than 21%. In Tanzania, about 35,000 women develop cancer each year, but only 20% manage to reach to Ocean Road cancer institute for diagnosis and treatment. Women with HIV are twice as likely to develop cervical cancer if not prevented properly.

Source: National Cancer Control Strategy 2008

Describe the existing cervical cancer prevention and control activities.

The existing cervical cancer prevention and control activities are as follows:

- Primary prevention,
 - Behaviour change – This is done with promotion of behaviour changes by creating demand for vaccination and early diagnosis of cervical cancer at the individual level or broader-level.
 - Vaccination of adolescent girls before they become sexually active. – The country has done a HPV demonstration in Kilimanjaro to girls who are 9-13 years from 2014-2016. In 2018, the country is planning to scale up HPV intervention throughout the country.
- Secondary prevention
 - Screening of women aged 30 to 50 years – The country in collaboration with other stakeholders (WAMA, MEWATA) is raising awareness and conduct screening of women age 30-50 years old.
 - Treatment of pre-cancer lesion – Currently, treatment of pre-cancer and cancer is conducted at Ocean Road Cancer Institute, as well as Kilimanjaro Christian Medical Centre (KCMC).
- Tertiary care

Diagnosis and treatment invasive cancer and palliative care for cervical cancer patients

Has the country developed a strategy for establishing or strengthening a national comprehensive approach to cervical cancer prevention and control? **Yes**
If Yes, please attach and refer to section [10. Attachments](#). (Document N°15,16)

If No, are there plans for the country to develop such a roadmap or strategy in the future? Please describe- when, who will be leading the development of the plan, and which agencies will be involved.

N/A

6.1.2 Description of province/ region profile

Countries are required to attach a description of the profile for each province/ region, using the template provided by Gavi

Please attach the relevant documents "HPV Region/ Province profile " template provided by Gavi and attach as a mandatory document in the Attachment section. Document number **16**)

6.1.3 Delivery strategies for HPV vaccine

Please provide information on each of the following **delivery strategies** that will be:

- Using outreach to schools as a location for vaccinations
- Using health facilities as a location for vaccinations
- Using community outreach as locations for vaccinations

- Campaign

Using schools as a location for vaccinations

Please describe why this delivery strategy has been chosen for the selection region/ district(s). Will this delivery strategy be used for every year? If so, please describe how this strategy will be financed in future years.

Schools will be used as location for vaccination as other outreaches in all districts. Reaching Every Child approach will be used to reach eligible girls whereby outreach will be conducted in schools and communities depending on health facility micro plan. Those girls which miss the dose mop up will be done to school.

Experience from HPV demonstration 2ND year showed that most of eligible girls are in school and doing outreach in school eligible girls are reached easily and give opportunity identify missed girls to be vaccinated.

Periodic Intensification of Routine Immunization will be done twice a year in each districts in specified months. In the first year because of wide age group to be involved April and November have been identified to make sure eligible girls are reached.

Using schools as outreach point through reaching every child approach and implementing Periodical Intensification of routine immunization twice a year is cheaper compare to campaign mode. District councils have been sensitized to include strategy in their CCHP.

Please specify whether girls will be vaccinated by selection of a specific age or a specific school grade

The girls will be vaccinated based on selection of specific age examples girls of 9 years

Please complete table 6.1.3a vaccination by specific age or table 6.1.3b by specific school grade, depending on above choice

Table 6.1.3 a: Vaccination by specific age

Routine Cohort	
Specific age chosen	9 years
Target population of girls in chosen age	716621
Girls of chosen age enrolled in schools	642348

Additional multi-age cohort	
Specific age-range chosen	Start 10 years End 14 years
Target population of girls in chosen age	3422859
Girls of chosen age range enrolled in schools	2462870

Table 6.1.3 b: Vaccination by specific school grade

Routine Cohort		
School grade	Average age of girls on school grade	Number of girls in grade
	9 years	

Additional multi-age cohort		
School grade	Average age of girls on school grade	Number of girls in grade
	9 years	

If you are vaccinating by grade, provide information on how you will ensure girls under 9 or over 14-years will not be vaccinated

N/A

Please describe when vaccinations will be scheduled (school year, holidays, examinations), where vaccinations will be administered, who will do vaccinations, how will the vaccine logistics be assured when using schools as a location for vaccination.

Vaccination will take place during school days when the schools are open, not during examination time. HPV vaccination will be intensified when school are open six month apart in April and November to reach majority of eligible girls in these months therefore increase coverage. Vaccination will be administer in school and health workers from the facility in the catchment area will conduct the vaccination session. the logistics during vaccination will be done by health worker but planning for the outreach in schools will be done in collaboration between teachers and health workers

Will additional personnel need to be hired in order to vaccinate the introduction year multi-age cohorts? If so, how will this be financed?

No additional personnel is needed as existing health works and school teachers will be used to deliver the services in schools. What is expected to increase is number of outreaches. The allowances for out reaches in schools for first year is part of introduction grants and in subsequent year will be incorporated in CCHPs

Please describe the strategy to capture girls who may miss the initial vaccination session or any of the remaining doses

School health teachers will be used to register eligible girls in schools. These registers will be used to identify the girls who missed the initial vaccination and remaining doses. After identification of those who missed the dose teacher will communicate with health facility. Both approach will be used revisit schools (mop up to school or teacher send them to health facility.

Will the vaccination strategy need to be adapted for at private or religious schools? If so, please elaborate.

The same vaccination delivery strategy will be used in both government and Private/religious schools where schools will be used as outreach of the health facility in the catchment area. The vaccination schedules will be planned by health workers in collaboration with school teachers in which all the activities will be stipulated in the micro plans.

Social mobilization will start earlier in private school and religious schools which will involve sensitization of girls, teacher parent meeting, religious leader will be used to sensitize in religious schools. Teacher from private school will be train before HPV introduction.

Using health facilities as a location for vaccination

Please describe why this approach has been chosen for the selection region/ district(s). Will this approach be used every year?

Routine immunization services are provided daily on working days. HPV will be part of routine immunization vaccine provided daily at health facility. The HPV vaccine will be available throughout a year and will be provided with other antigen. The approach will be used every year. REC approach will be used to provide vaccine at fixed post (Health facility) for those girls of out of school live close to health facility and for those who missed vaccination in school.

Will additional personnel need to be hired in order to vaccinate the introduction year multi-age cohorts? If so, how will this be financed?

No additional personnel will be required.

Please provide details of demand generation activities to encourage girls to come to the health facility?

School Health Programme will be used to educate the girls on the value of the HPV. The same will be done to the community through parents, community leaders and religious leaders. Leaf lets with HPV vaccination and cervical screening linking with cervical cancer will be used sensitize the community and girls. Influential people (celebrity, politician, religious leader, village leader) in the community will be used to sensitize community.

Please provide details on how the country plans to link with schools. Some examples of how schools can be leveraged to increase HPV vaccine uptake include facilitating sensitization and mobilization of parents/communities, identification/validation of the target population (i.e. use of school enrolment lists), and assisting with vaccination call/recall mechanisms. If the country does not plan to link with schools please provide a justification for this decision (i.e. low school enrolment).

Health facility micro plan will be developed together between health facility, school and communities to ensure girls are reached in all schools in the health facilities catchment area. The micro plan will indicate each school within health facility catchment area the strategy to be used either girls come to health facility or outreach to be conducted and specific date for HPV vaccination for each school will be agreed by schools , community and health facilities.

Describe if/how this delivery strategy will increase coverage, particularly amongst “hard to reach”/ vulnerable girls.

In the hard to reach communities without schools community leaders will be fully involved in detailed micro plan development to reach these communities.

Community health worker will be used to identify these girls and will be responsible for defaulter tracing like other Antigen.

Reaching Every Child Approach will be used to deliver HPV vaccine whereby the girls who live far from health facilities e.g more than five kilometer will be vaccinated through outreach in the community and for those girls who live nearby will be vaccinated at health facility

Social mobilization activities will be conducted in hard to reach area which include village meeting, house to house sensitization using Red cross and community health worker and tradition dance will be used to sensitize community. Rotary club have been used in social mobilization in MR campaign will be part of social mobilization during HPV introduction.

Describe what follow-up mechanism will be used to ensure girls receive their second dose.

During the sensitization of the 1st dose the message will be communicated on the importance to have the second dose after six months. Sensitization for the 2nd dose will be done to remind the girls and parent to make sure the girls complete the dose which will include teacher parent meeting, sensitization to girls

The detailed micro plan which will be done by health facility in collaboration with community will show each outreach at village and the date agreed with community leader and intensified approach will be used. Registration of girls will be done by Community Health worker before introduction and will use it to make follow up of girls to make sure they receive vaccine and complete 2nd dose

Using community venues as locations for vaccinations

Please describe why this approach has been chosen for the selection region/ district(s).

Community venue as locations for vaccination will be used in all regions in Tanzania to make sure all eligible girls for HPV vaccine are not missed. This approach will vaccinate out of school girls and hard to reach girls. The district with low school enrollment and hard to reach area more effort will be made to conduct community outreach to reach out of school girls. The venue for community vaccination will be the existing outreach post for routine immunization which are village office, market or any public office accessible to all village members. Usually these venue are prepared by community and make them ready for vaccination on the day agreed between health facility and community. Sensitization of community will be done before the date to remind the community to be ready for vaccination.

Will this approach be used for every year? If so, please describe how this strategy will be financed in future years.

This approach will be used every year. Currently community is also used as outreach for routine immunization, so HPV vaccine will also be provided in this outreach as for a other vaccines. The fund for outreach will be included in existing Comprehensive Council Health Plans (CCHPs)

Please describe how your community health care workers/ volunteers will be involved with this strategy

Community health workers will be involved starting from micro plan development, registration of eligible out of school and hard to reach girls. Every village has Community health worker and they know everybody in the village therefore they will map and register these girls and bring them to health facility or to outreach site in their Village. Community health workers will also take part during social mobilization and vaccination exercise

Will additional personnel need to be hired in order to vaccinate the introduction year multi-age cohorts? If so, how will this be financed?

There is no additional personnel needed for this exercise, the existing health workers will be used in the HPV vaccine delivery. Outreach allowance will be incorporated in the CCHPs to cover the outreach cost

Where in the community will the girls be vaccinated? E.g. schools, fixed outreach sites, streets, parks, malls, markets

The eligible community girls will be vaccinated at fixed outreach sites. these outreach sites are always planned in collaboration between community dwellers and health workers in the given area

What interventions will be established to increase community based acceptance and increase community support?

Regular existing village meeting will be used as a forum for educating the parents on HPV Vaccine. The facility OIC are the secretary for the meeting that involve both community and health facility staffs. The village leaders and influential people will also be used to sensitize the communities on the importance of HPV vaccine. Religious leaders will also used to promote HPV vaccine in the churches and mosques. CSOs, professional association (MEWATA) , NGO, women affected with cervical cancer will be used to increase community awareness.

Lions club , RED CROSS will be used in social mobilization and house to house sensitization of community

Existing medias i.e local radios will also be used to ensure the message on HPV vaccine reaches the general community. IEC materials (i.e Posters and leaflets) will be used to increase community awareness

Please provide details of demand generation activities e.g. awareness building and information dissemination via community or education sector and/or mass media, including through youth clubs and street theatre

Demand generation activities including building awareness and information dissemination will be done through existing media and use of meetings, IEC materials that promote HPV vaccines will be used so as to educate the general community on HPV vaccines. During the HPV Vaccine launching, there will be forum to educate the community in which street theatre (traditional dancing) will also be incorporated so as to increase knowledge on HPV. The existing youth centers and information centers will also be used to educate the young people on HPV

Describe if/how this delivery strategy will increase coverage, particularly amongst “hard to reach”/ vulnerable girls?

Using the community as a venue for vaccination will reach the unreachable ones. Involvement of the community dwellers will improve the understanding of HPV and out of school and hard to reach / vulnerable eligible girls will be reached thus increases vaccination coverage

In Tanzania context, there are categories of girls who are typically hard to reach with health services in this age group. Below are these categories and are relevant strategies for ensuring high coverage

- The girls will be reached through outreach in the community and there will be special social mobilization targeted to this group through community health workers and health facility working with these communities to ensure care givers are receiving education and information about HPV and other health services as well as screening girls for eligibility for the vaccine
- **Geographical i.e islands, mountainous: e.g regions with island Kigoma, Kagera, Pwani and regions with mountaneous are Tanga, Iringa, Mbeya, Kilimanjaro. T**
- he programme for reaching these hard to reach girls will be built on what has been done in other existing vaccination and health services outreaches. In particular are social mobilization will be targeted to ensure distinct information around HPV vaccine and which girl will be eligible for the vaccine. In addition community meeting spaces like churches/mosques and community meetings will be attended to increase awareness on HPV vaccine
- **Seasonal barriers like during rain season:** Districts will work with Health facilities and communities to ensure micro plans are appropriately address the challenges of seasonal barriers and outreaches and mobile clinics are scheduled around them while considering the two doses schedules for HPV and preventing drop out

Describe what follow-up mechanism will be used to ensure girls receive their second dose.

Registration of out of school girls will be done prior to actual vaccination. The registers will be used to identify those eligible ones and will also be used to follow up those eligible for second dose. Community health workers will be used to follow up those missed their appointment and those defaulted

Using campaigns to deliver HPV vaccines

Please describe why this approach has been chosen for the selection region/ district(s).

N/A

What type of campaign will be used for HPV vaccine delivery e.g. Child Health Days/ Weeks, Measles Rubella or tetanus containing vaccines, supplementary immunisation activities, health education activities? If the campaign is planned to be standalone, please explain why?

N/A

How will this campaign impact routine service delivery? For example, will health facility personnel be used for this campaign?

N/A

Will additional personnel need to be hired in order to vaccinate the introduction year multi-age cohorts? If so, how will this be financed?

N/A

What location(s) will be used to deliver vaccinations during the campaign?

N/A

Will this delivery strategy be used for every year? If so, please describe how this strategy will be financed in future years.

N/A

Describe if/how this delivery strategy will increase coverage, particularly amongst “hard to reach”/ vulnerable girls?

N/A

6.1.4 Social Mobilisation

Please complete the table below to provide details on the types of information and/ or materials that will be used/ disseminated, to which audience, by which mechanism and the frequency of each.

Types of information or materials	Audience receiving material	Method of delivery	Who delivers	Frequency & Timing
e.g., leaflet, poster, banner, handbook, radio announcement, etc.	e.g., girls, parents, teachers, health workers, district officials, community groups, etc.	e.g., parent meetings, radio, info session at school, house visit, etc.	e.g., teachers, health workers, district official, etc.	e.g., daily, weekly, twice before programme starts; day of vaccination, two weeks before programme begins, etc.
1. Health Education Girls twice before outreach starts;	1. Girls 2. Community	1. Health Education session to schools 2. Radio programme	1. Teachers and health workers 2. District Officials	1. Two weeks before outreach start and last one day before vaccination 2. Twice a week, with daily intensification in two weeks prior to outreach
2. Radio Programme – Local radios	3. Girls, Teachers, CHW, community and parents 4. Community, schools, health facilities	3. During the Health Education session to schools and communities 4. Posted at Public areas	3. Teachers, CHWs and Health workers 4. Teachers, Health workers and community Health workers	3. Distributed during Health education two weeks and prior to vaccination 4. Two weeks prior to vaccination
3. Leaflet	5. Teachers and Community Health Workers	5. Meeting	5. Health workers	5. A week prior to Health Education session and coordinate with MOE for subsequent refreshers
4. Posters	6. Community leaders and religious leaders 7. Parents	6. Meeting 7. Parents meeting	6. Health Workers	6. Two weeks prior to Health Education to community 7. During parent meeting
5. Sensitization of Teachers and Community Health Workers	8. Districts and regional technical, political and other influential leaders 9. Journalist	8. Meetings 9. Media seminar	7. Teachers and Health Workers 8. Immunization focal person 9. Immunization focal person	8. Twice a year coordinated with existing PHC meeting 9. one month before introduction of
6. Community Leaders sensitization				
7. Parent meeting				
8. PHC meetings				
9. Media				

Please describe a crisis communication plan to response to rumors and misconceptions to HPV vaccination.

In Tanzania there is established Primary Health care committees at region, district, ward and village which deal with advocacy and social mobilization of health intervention including immunization. One of their term of reference is to respond to rumors and misconception related to immunization services which will include HPV.

Member of these committee are administrators, politician, religious leaders and influential community leaders. Regional and district are chaired by Regional and district commissioners and in ward and village are chaired by ward and village executive officers. These member will be sensitized on HPV vaccine and provided with frequent asked question and answers

These committee address localized rumors and misconception in their area and if it is not solved the case is refer to the next level for further intervention to make sure rumor are solved. If rumors and misconception are in wider area the district and regional national committees take responsibility.

TWG subcommittee on social mobilization will be developed to plan social mobilization activities including how to respond to rumor .These sub-committee will include media people, communication officer and health education promotion officers.

6.1.5 Adolescent health integration

Irrespective of the strategies, provide a description of existing health services and/or health education currently being provided to young adolescents (both girls and/or boys) within the 9-14 year old age group and indicate and potential synergy by integrating with HPV vaccination:

a. For health services (this can include: what health services are provided, to which age/sex group, whether it's mandatory or voluntary, regularly or ad-hoc, in school or out of school, who provides these (government, NGOs), how often, what is the uptake in the community, how is it perceived by the community.)

Health services provided currently to adolescents both boys and girls include deworming, vision screening and dental care. These intervention will be given with HPV vaccine. The Government is responsible in provision of these services in schools and it is voluntary. Most of these services are generally well accepted by community.

b. For health education (this can include: the topic, whether it is national, sub-national, in school or out of school, who provides the education, how often, is it in the school curriculum, are there NGOs providing these? How is it perceived by the community? Has there been an evaluation and if so, how was it evaluated and what were the findings?)

Currently Health education is provided at community, Schools and health facilities. Health education material will be updated to include HPV vaccine information and distributed before introduction.

Depends at the level of health education, different people do provide health education. At health facility, health workers do provide health education. Health workers also provide health education in schools and communities. They also provide health education in information center for youths. Community health workers do provide health community level while school health teachers do health education at school level. In HPV demo, the community have appreciated and perceived it positively.

c. For improving adolescent immunization platform (this can include integration with: other vaccines provided to adolescents (e.g. measles-rubella, tetanus containing vaccines or Dengue), broader health education services)

Currently no vaccine is provided to adolescent targeted with HPV.

6.1.6 CSO engagement

Please describe how and which CSOs will be included in the delivery of HPV vaccines e.g. demand generation activities, increase coverage of "hard to reach" girls.

CSOs are critical for Tanzania health services for example they provide 43% of medical services. HPV programme will continue to leverage upon CSO activities as it has done on the other Vaccination services. In addition CSOs such as FBOs, professional and community associations/organizations and advocacy groups will be called upon to build buy in and support for successful HPV introduction including to help identify HPV champions and sensitization of the community.

CSOs will be particularly critical in reaching hard to reach girls specifically those out of schools and in pastoralist communities and bridging the equity gaps.

Example of CSOs are;

- Twaweza
- REDCROSS,
- Lions Club
- Catholic relief services

6.1.7 Key stakeholder and technical partner roles and responsibilities

Please complete the Gavi provided template, to define the respective roles and responsibilities of all in-country stakeholders and technical partners.

Please attach the relevant documents and refer to section [10. Attachments](#). (Document N°17)

6.2. Requested vaccine (HPV quadrivalent, 1 dose(s) per vial, LIQUID)

As reported in the cMYP, the country plans to introduce HPV quadrivalent, using HPV quadrivalent, 1 dose(s) per vial, LIQUID.

When is the country planning to introduce this vaccine? April 2018

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

Please summarise the cold chain capacity (at central and other levels) and readiness to accommodate new vaccines, taking into consideration training, cold chain equipment and other logistical requirements. If cold chain expansion is required, state how it will be financed, and when it will be in place. The Independent Review Committee requires assurance that the cold chain is ready or will be ready for the routine introduction of the new vaccine, and evidence/plans need to be provided. All proposals that include Gavi- financing for cold chain equipment intended for vaccine storage shall need to procure equipment pre-qualified by WHO under their Performance Quality and Safety (PQS) program. The purchase of non-PQS equipment will only be considered on an exceptional basis, with justification and advance agreement from Gavi.

Central Vaccine Store (CVS) in Dar es Salaam serve both Tanzania Mainland and Zanzibar. The Store currently has sufficient positive storage capacity of 135,000 litres and negative storage capacity of 14,000 litres for the current used vaccines. The incoming HPV vaccines will consume 96,000 litres making positive balance of 39,000litres. In addition four new WICR are expected to be installed with total capacity of 53,000 litres. The CVS has capacity to accommodate vaccines for six months reducing the shipment and handling costs.

All Regions in Tanzania are equipped with Walking-in Cold Rooms with different sizes depending on the population with enough storage capacity to store three months vaccines with 25% buffer stock. There are a total of 27 WICR with capacity of 264,000 litres. All regions have standby generators. Also Zanzibar has enough positive storage capacity with a new 30m3 at Central Store and two new WICR with capacity of 10m3 each in Unguja and Pemba

6.2.1. Vaccine Prices

Vaccine	Presentation	2017	2018	2019	2020
HPV quadrivalent, 1 dose(s) per vial, LIQUID	1	4.55	4.55	4.55	4.55

6.2.2. Co-financing information

The co-financing requirement applies to vaccines for the routine cohort (i.e. the cohort that will be routinely vaccinated on an annual basis for the routine immunisation programme). However, Gavi will fully finance vaccines for the additional multi-age cohort during the introduction year.

If you would like to co-finance an amount higher than the minimum, please provide information in Your co-financing row.

Country group	Initial self-financing phase		
	2018	2019	2020
minimum co-financing per dose	0.20	0.20	0.20
your co-financing per dose (please change if higher)	0.20	0.20	0.20

6.2.2.1. Specifications of vaccinations with new vaccine for routine cohort

	Source		2018	2019	2020
Number of girls in routine cohort to be vaccinated with the first dose	Table 5.2	#	680,799	699,172	718,049
Number of girls in routine cohort to be vaccinated with the second dose	Table 5.2	#	644,959	662,373	680,257
Immunisation coverage with the second dose	Table 5.2	%	90%	90%	90%

Country co-financing per dose	Table 6.2.2	\$	0.2	0.2	0.2
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6.2.2.2. Specifications of vaccinations with new vaccine for additional multi-age cohort

	Source		2018	2019	2020
Number of girls in the additional multi-age cohort to be vaccinated with the first dose	Table 5.2	#	3,251,716	0	0
Number of girls in the additional multi-age cohort to be vaccinated with the second dose	Table 5.2	#	3,080,573	0	0
Immunisation coverage with the second dose	Table 5.2	%	90.00%	0	0

6.2.3 Portion of supply for routine cohort to be procured by the country (and cost estimate, US\$)

		2018	2019	2020
Number of vaccine doses	#	57,079	58,620	60,337
Number of AD syringes	#	0	0	0
Number of re-constitution syringes	#	0	0	0
Number of safety boxes	#	0	0	0
Total value to be co-financed by the Country [1]	\$	348,021	287,821	295,581

[1] The co-financing amount for initial self-financing countries indicates costs for the vaccines and any freight charges. The total co-financing amount does not contain the costs and fees of the relevant Procurement Agency, such as contingency buffer and handling fees. Information on these extra costs and fees will be provided by the relevant Procurement Agency as part of the cost estimate to be requested by the Country.

6.2.3.1 Portion of supply for routine cohort to be procured by Gavi (and cost estimate, US\$)

		2018	2019	2020
Number of vaccine doses	#	1,268,679	1,302,925	1,337,969
Number of AD syringes	#	1,841,148	1,508,035	1,548,752
Number of re-constitution syringes	#	0	0	0
Number of safety boxes	#	20,253	16,589	17,037
Total value to be co-financed by Gavi	\$	7,811,041	6,459,299	6,618,094

6.2.3.2 Portion of supply for additional multi-age cohort to be procured by Gavi (and cost estimate, US\$)

		2018	2019	2020
Number of vaccine doses	#	3,896,675	662,373	680,257
Number of AD syringes	#	4,286,343	728,611	748,283
Number of re-constitution syringes	#	0	0	0
Number of safety boxes	#	47,150	8,015	8,232

6.2.4 New and Under-Used Vaccine Introduction Grant

Calculation of Vaccine Introduction Grant for the HPV quadrivalent, 1 dose(s) per vial, LIQUID

Year of New Vaccine Introduction	Girls in routine cohort (From Table 5.2)	Share per Girls in routine cohort in US\$	Total in US\$
2018	716,621	2.40	1,719,890

The Grant will be based on a maximum award of \$2.4 per girl in the routine cohort with a minimum starting grant award of \$100,000

Please describe how the Gavi Vaccine Introduction Grant will be used to facilitate the timely and effective implementation of critical activities in advance of and during the introduction of the new vaccine (refer to the cMYP and the Vaccine Introduction Plan).

Gavi Vaccine Introduction Grants will be used to facilitate the timely and effective implementation of the following critical activities prior introduction;

- Development of detailed macro and micro plan
- Development, print and distribution of HPV vaccine guideline and IEC materials
- Advocacy meeting at National, regional and district levels
- Extended PHC meeting (Regional and district)
- Sensitization of girls, parents and CHW
- Social mobilization and community sensitization through airing radio/TV spot and media seminars
- Training of health workers, teachers and supervisors at national, regional and district levels

Please complete the 'Detailed budget for VIG / Operational costs' template provided by Gavi and attach as a mandatory document in the Attachment section.

Detailed budget attached as Document No. 22,23.

Where Gavi support is not enough to cover the full needs, please describe other sources of funding and the expected amounts to be contributed, if available, to cover your full needs.

Other sources of funding and expected amount to be contributed includes

1. GoT \$ 48,500
2. CHAI \$ 68,000
3. UNICEF \$ 78,000
4. WHO \$ 72,629

6.2.5. New and Under-Used Operational support

Calculation of Operational Support for the HPV quadrivalent, 1 dose(s) per vial, LIQUID

Year of New Vaccine Introduction	Girls in additional multi-age cohort (From Table 5.2)	Share per Girls in additional multi-age cohort in US\$	Total in US\$
2018	3,422,859	0.65	2,224,858

Please describe how the Gavi Operational support will be used to reach the additional multi-age cohorts? How will these funds be used to strengthen routine activities e.g. reinforcing routine outreach activities, additional personnel, additional demand generation activities?

Note: These funds can be used over a longer period than the introduction year in order to strengthen routine immunisation. For example to reinforce routine outreach activities in difficult to access districts.

The funds will be used to conduct outreaches as the number of outreach will increase to vaccinate eligible

girls in additional multi cohort 10-14 years for HPV vaccines especial in hard to reach area. Funds also will be used in social mobilization of the community to create demand of HPV vaccine

Detailed budget attached as Document No. 22,23.

Where Gavi support is not enough to cover the full needs, please describe other sources of funding and the expected amounts to be contributed, if available, to cover your full needs.

Some funds will be budgeted in the comprehensive council health plan (CCHP). These funds will be used for such activities as distribution of vaccines and supporting outreach services.

6.2.6. Technical assistance

Please describe any particular area(s) the Ministry would require technical assistance to support the introduction of **HPV quadrivalent**.

No technical assistance is needed

7. NVS Preventive Campaigns

No NVS Prevention Campaign Support this year

8. NVS Follow-up Campaigns

8.3 Epidemiology and disease burden data

No NVS Follow-up Campaign Support this year

9. Procurement and Management

9.1 Procurement and Management of New and Under-Used Vaccines Routine

Note: The PCV vaccine must be procured through UNICEF to be able to access the price awarded by the Advance Market Commitment (AMC).

a) Please show how the support will operate and be managed including procurement of vaccines (Gavi expects that most countries will procure vaccine and injection supplies through UNICEF or PAHO's Revolving Fund):

Vaccines and related materials in the country are procured through UNICEF. Gavi usually transfer the fund to UNICEF Supply Division office in Copenhagen directly. Government Co-financing share are transferred to UNICEF SD before December of the respective year. The operation of the support will follow the same procedures.

b) If an alternative mechanism for procurement and delivery of vaccine supply (financed by the country or the Gavi) is requested, please document

- A description of the mechanism and the vaccines or commodities to be procured by the country
- Assurance that vaccines will be procured from the WHO list of pre-qualified vaccines, indicating the specific vaccine from the list of pre-qualification. For the procurement of locally-produced vaccines directly from a manufacturer which may not have been prequalified by WHO, assurance should also be provided that the vaccines purchased comply with WHO's definition of quality vaccines, for which there are no unresolved quality problems reported to WHO, and for which compliance is assured by a fully functional National Regulatory Authority (NRA), as assessed by WHO in the countries where they are manufactured and where they are purchased.

Not Applicable

c) If receiving direct financial support from Gavi (such as operational support for campaigns or VIG activities), please indicate how the funds should be transferred by Gavi.

The operation fund from Gavi should be directly transferred to the Ministry of Finance and Planning of the United Republic of Tanzania, which is the principal recipient

d) Please indicate how the co-financing amounts will be paid (and who is responsible for this)

The Ministry of Health, Community Development, Gender, Elderly and Children will budget funds for co-financing of HPV. After parliamentary approval, the Ministry of Finance will disburse the funds to the Ministry of Health who will transfer it to UNICEF SD in Copenhagen. Co-financing funds are usually ring fenced in the budget. Payment is done in tranches, and all funds are usually paid before the deadlines.

e) Please describe the financial management procedures that will be applied for the management of the NVS direct financial support, including procurement.

All financial support from GAVI and other development partners will follow Government financial management procedures. The Permanent Secretary of the Ministry of Health is the accounting officer of the Ministry. The Ministry of Health have Accounts and Auditors sections responsible for operational management of MOH finances, where by the office of the Chief Auditor General is responsible for auditing all financial aspects of their ministry of health, as external auditors. Procurement of all items related to vaccine introduction will follow the normal Government procurement procedures.

f) Please outline how coverage of the introduced vaccine will be monitored, reported and evaluated (refer to cMYP and Introduction Plan)

There is a system of data collection and monitoring at all levels. At health facilities, there are tally sheet and performance monitoring charts for monthly self-monitoring immunization coverage. The Facility Health Monthly reporting forms incorporates all reports of immunization, and are submitted to district level before 5th date of each month. From the Councils to National level. there is a District Vaccines Data Management Tool

(DVD-MT) and DHIS-2 for monthly coverage monitoring at district and regional level. The country will also start using Vaccines Management Information System (VIMS) from January 2017. Evaluation of immunization coverage is annually done by a team of immunization officers and stakeholders from all regions and national level.

Vaccine Ledgers, web based Stock management Tool (SMT) and CCIT tools are used for vaccine stock management at all levels.

g) If applying for measles second dose, does the country wish to have the support in cash or in-kind? **N/A**

9.2 Procurement and Management for NVS Preventive Campaign(s)

No NVS Prevention Campaign Support this year

9.3 Product Licensure

For each of the vaccine(s) requested, please state whether manufacturer registration and/or national vaccine licensure will be needed in addition to WHO prequalification and, if so, describe the procedure and its duration. In addition, state whether the country accepts the Expedited Procedure for national registration of WHO-prequalified vaccines.

Note that the necessary time for licensure should be factored into the introduction timeline and reflected in the Vaccine Introduction Plan or Plan of Action.

HPV quadrivalent 1 dose vaccine is already registered for use in Tanzania by the National Regulatory Authority (Tanzania Food And Drugs Authority). For the bivalent vaccines the registration will be needed but as the vaccine is prequalified by WHO the process of registration is expected to be easier.

For each of the vaccine(s) requested, please provide the actual licensure status of the preferred presentation and of any alternative presentations, if required.

The HPV vaccines, regardless of the presentation, will be registered by TFDA provided it is WHO prequalified. The HPV quadrivalent (Gardasil) vaccines have already been registered by TFDA and does not need re-registration

Please describe local customs regulations, requirements for pre-delivery inspection, special documentation requirements that may potentially cause delays in receiving the vaccine. If such delays are anticipated, explain what steps are planned to handle these.

TFDA, Tanzania Revenue Authority (TRA) and Tanzania Bureau of Standards (TBS) are responsible for inspection of the vaccines and related supplies at the port.

Vaccines and other related supplies are cleared by the Medical Stores Department (MSD). The Government have fast tracking mechanism that ensures Vaccines are cleared within 72 hours after arrival at the port, provided the copies of Parking Lists, Airway Bill, Commercial invoices and Certificate of release have been submitted to MSD within 14 working days. For sea deliveries like syringes, safety boxes and other items, documents should be submitted within 30 days.

Please provide information on NRA in the country, including status (e.g. whether it is WHO-certified). Please include points of contact with phone numbers and e-mail addresses. UNICEF will support the process by communicating licensing requirements to the vaccine manufacturers where relevant.

Tanzania Food and Drug Authority (TFDA) is the NRA for Tanzania and it is WHO prequalified with ISO-9001:2008.

The Address is:

Director General,

Tanzania Food and Drug Authority,

Off Mandela road, Mabibo - External,

P. O. Box 77150,

Dar es Salaam, Tanzania

Tel: +255 22 2450512/2450751/2452108

Fax: +255 22 2450793

Mobile: +255 685 701 735 or +255 777 700 002

E-mail: info@tfda.go.tz

website: ww.tfda.or.tz

9.4 Waste management

Countries must have a detailed waste management and monitoring plan as appropriate for their immunisation activities. This should include details on sufficient availability of waste management supplies (including safety boxes), the safe handling, storage, transportation and disposal of immunisation waste, as part of a healthcare waste management strategy. Please describe the country's waste management plan for immunisation activities (including campaigns).

Immunization waste management is done at all primary health facilities in Tanzania. Every facility is monthly supplied with adequate and standard safety boxes used for handling and storage of used syringes and needles. Most facilities are disposing full-used safety boxes by incineration on site.

10. List of documents attached to this proposal

10.1. List of documents attached to this proposal

Table 1: Checklist of mandatory attachments

Document Number	Document	Section	File
Endorsements			
1	MoH Signature (or delegated authority) of Proposal	4.1.1	SIGNATURES FOR MOH.pdf File desc: Date/time : 27/01/2017 12:27:50 Size: 810 KB
2	MoF Signature (or delegated authority) of Proposal	4.1.1	MOF signature HPV application.pdf File desc: Date/time : 24/04/2017 11:51:24 Size: 998 KB
3	MoE signature (or delegated authority) of HPV Proposal	4.1.1	SIGNATURE FOR PORALG.pdf File desc: Date/time : 24/04/2017 10:58:45 Size: 341 KB
4	Terms of Reference for the Coordination Forum (ICC/HSCC or equivalent) including all sections outlined in Section 5.2 of the General Application Guidelines (Note: countries applying before May 2017 can submit their existing Terms of Reference)	4.1.2	TOR FOR ICC.pdf File desc: Date/time : 30/01/2017 09:11:40 Size: 235 KB
5	Minutes of Coordination Forum meeting endorsing Proposal	4.1.3	Minutes 82 ICC MEETING.zip File desc: Date/time : 30/01/2017 09:12:37 Size: 842 KB
6	Signatures of Coordination Forum members in Proposal	4.1.3	SIGNATURES FOR ICC MEMBERS.pdf File desc: Date/time : 27/01/2017 10:34:42 Size: 1 MB
7	Minutes of the Coordination Forum meetings from the past 12 months before the proposal	4.1.3	Minutes ICC Meeting.zip File desc: Date/time : 30/01/2017 09:13:31 Size: 1 MB
8	Role and functioning of the advisory group, description of plans to establish a NITAG	4.2.1	NITAG PAPER.docx File desc: Date/time : 27/01/2017 09:43:44 Size: 22 KB
25	Risk assessment and consensus meeting report for Yellow Fever, including information required in the NVS guidelines on YF Risk Assessment process	5.1	YELLOW FEVER ASSESSMENT IN TANZANIA.pdf File desc: Date/time : 30/01/2017 09:10:08 Size: 230 KB

26	List of areas/districts/regions and targets to be supported for meningitis A mini catch up campaigns		Tanzania Meningitis Risk Assessment REPORT 2016.pdf File desc: Date/time : 27/01/2017 10:38:47 Size: 828 KB
30	For countries applying for measles/rubella support that are not yet financing the measles monovalent component of MCV1, ICC minutes committing to finance from 2018 onwards.		CO-FINANCING DOC.pdf File desc: Date/time : 27/01/2017 12:43:04 Size: 1 MB
Planning, financing and vaccine management			
9	Comprehensive Multi Year Plan - cMYP	5.1	IVD cMYP 2016-2020.doc File desc: Date/time : 27/01/2017 11:04:14 Size: 4 MB
10	cMYP Costing tool for financial analysis	5.1	costing cMYP.xlsx File desc: Date/time : 27/01/2017 11:27:44 Size: 3 MB
11	M&E and surveillance plan within the country's existing monitoring plan	5.1.4	Tanzania 2017 Surveillance plan .pdf File desc: Date/time : 30/01/2017 12:37:09 Size: 923 KB
12	New vaccine introduction plan (NVIP), New Vaccine Introduction Checklist and Activity List & Timeline for routine vaccines or Plan of Action (PoA) for campaign vaccines	5.1	National HPV Introduction Plan PDF Final.pdf File desc: Date/time : 24/04/2017 12:10:43 Size: 1 MB
15	HPV Region/ Province profile	6.1.1	HPV Application Region Profile FINAL.xlsx File desc: Date/time : 24/04/2017 11:05:49 Size: 47 KB
16	HPV Key Stakeholder Roles and Responsibilities	6.1.1,6.1.2	HPV Application Stakeholder roles.xlsx File desc: Date/time : 27/01/2017 11:27:44 Size: 23 KB
19	EVM report	9.3	Tanzania EVM report 15 June 2015 (1).pdf File desc: Date/time : 27/01/2017 11:27:44 Size: 1 MB
20	Improvement plan based on EVM	9.3	EVMA Improvement Plan, TANZANIA by December 2015.pdf File desc: Date/time : 27/01/2017 11:27:44 Size: 419 KB
21	EVM improvement plan progress report	9.3	EVMA Improvement Plan 2017 TANZANIA.pdf File desc: Date/time : 24/04/2017 11:14:15 Size: 241 KB

22	Detailed budget template for VIG / Operational Costs	6.x,7.x.2, 6.x.2	Tanzania HPV budget Final.zip File desc: Date/time : 24/04/2017 11:58:36 Size: 113 KB
23	Risk assessment and consensus meeting report for MenA. If the DPT was used instead, please include this.	6.x,7.x.2, 6.x.2,8.x.3	Tanzania Meningitis Risk Assessment REPORT 2016.pdf File desc: Date/time : 27/01/2017 11:37:29 Size: 828 KB
32	Data quality assessment (DQA) report	5.1.4	Tanzania EPI review Data assessment 29jul2015.pdf File desc: Date/time : 27/01/2017 11:42:39 Size: 1 MB
36	Strategy for establishing or strengthening a national comprehensive approach to cervical cancer prevention and control		National Cervical Cancer Prevention and Control Strategic Plan2011-2015.pdf File desc: Date/time : 27/01/2017 11:42:39 Size: 3 MB

Table 2: Checklist of optional attachments

Document Number	Document	Section	File
13	Introduction Plan for the introduction of RCV / JE / Men A / YF into the national programme	8.x.3	No file loaded
14	Annual EPI Plan with 4 year forward view for measles and rubella		No file loaded
17	Evidence of commitment to fund purchase of RCV (in place of the first dose of MCV) / JE for use in the routine system	5.1.6, 6.1.7	No file loaded
18	Campaign target population documentation	8.x.1, 6.x.1	No file loaded
24	Risk assessment and consensus meeting report for Yellow Fever, including information required Section 5.3.2 in the General Guidelines on YF Risk Assessment process	8.1,5.1	No file loaded
27	National Measles (& Rubella) elimination plan if available		No file loaded

28	A description of partner participation in preparing the application	4.1.3	No file loaded
31	Minutes of NITAG meeting with specific recommendations on the NVS introduction or campaign	4.2	No file loaded
33	DQA improvement plan	5.1.4	No file loaded
34	Plan of Action for campaigns	8.1, 8.x.4	No file loaded
35	Other		No file loaded
37	Evidence of self-financing MCV1	5.1.5	No file loaded
38	For countries applying for measles/rubella support that are not yet financing the measles monovalent component of MCV1, a signed letter from the Minister of Health and the Minister of Finance committing to finance from 2018 onwards.		No file loaded
39	Epidemiological analysis/evidence	8.2.3	No file loaded
40	Post Campaign Coverage Survey report for MR catch-up applications	5.1.x	No file loaded
41	cMYP addendum on measles and rubella		No file loaded

11. Annexes

Annex 1 - NVS Routine Support

Annex 1.1 - NVS Routine Support (HPV quadrivalent, 1 dose(s) per vial, LIQUID)

Table Annex 1.1 A: Rounded up portion of supply that is procured by the country and estimate of relative costs in US\$

		2018	2019	2020
Number of vaccine doses	#	57,079	58,620	60,337
Number of AD syringes	#	0	0	0
Number of re-constitution syringes	#	0	0	0
Number of safety boxes	#	0	0	0
Total value to be co-financed by the Country [1]	\$	348,021	287,821	295,581

Table**Annex** Rounded up portion of supply that is procured by Gavi and estimate of relative costs in US\$**1.1 B**

Rounded up portion of supply for the routine cohort that is procured by Gavi and estimate of relative costs in US\$

		2018	2019	2020
Number of vaccine doses	#	1,268,679	1,302,925	1,337,969
Number of AD syringes	#	1,841,148	1,508,035	1,548,752
Number of re-constitution syringes	#	0	0	0
Number of safety boxes	#	20,253	16,589	17,037
Total value to be co-financed by Gavi	\$	7,811,041	6,459,299	6,618,094

Rounded up portion of supply for the additional cohort that is procured by Gavi and estimate of relative costs in US\$

		2018	2019	2020
Number of vaccine doses	#	6,648,904	0	0
Number of AD syringes	#	7,313,795	0	0
Number of re-constitution syringes	#	0	0	0
Number of safety boxes	#	80,452	0	0

Table**Annex** Summary table for vaccine HPV quadrivalent, 1 dose(s) per vial, LIQUID**1.1 C**

	Source		2018	2019	2020
Number of girls in the additional multi-age cohort to be vaccinated with the first dose	Table 5.2	#	3,251,716	0	0
Number of girls in the additional multi-age cohort to be vaccinated with the second dose	Table 5.2	#	3,080,573	0	0
Immunisation coverage with the second dose	Table 5.2	%	90%	0	0

Table Annex 1.1 D: Estimated numbers for HPV quadrivalent, 1 dose(s) per vial, LIQUID, associated injection safety material and related co-financing budget (page 1)

		Formula	2018		
			Total	Government	Gavi
A	Country co-finance	V	4.31 %		
B	Number of children to be vaccinated with the first dose	Table 5.2	680,799	29,311	651,488
B1	Number of children to be vaccinated with the second dose	Table 5.2	644,959		
C	Number of doses per child	Vaccine parameter (schedule)	1		
D	Number of doses needed	B + B1	1,325,758	57,079	1,268,679
E	Estimated vaccine wastage factor	Table 5.2	1.05		
F	Number of doses needed including wastage	D x E	1,392,046	59,933	1,332,113
G	Vaccines buffer stock	Buffer on doses needed = (D - D of previous year) x 25% Buffer on wastages = ((F - D) - (F of previous year - D of previous year)) x 25%, = 0 if negative result G = [buffer on doses needed] + [buffer on wastages]	348,012	14,984	333,028
I	Total vaccine doses needed	Round up((F + G) / Vaccine package size) * Vaccine package size	1,740,100	74,918	1,665,182
J	Number of doses per vial	Vaccine parameter	1		
K	Number of AD syringes (+ 10% wastage) needed	(D + G) x 1.10	1,841,148	0	1,841,148
L	Reconstitution syringes (+ 10% wastage) needed	(I / J) x 1.10	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	(K + L) / 100 x 1.10	20,253	0	20,253
N	Cost of vaccines needed	I x vaccine price per dose (g)	7,917,455	340,874	7,576,581
O	Cost of AD syringes needed	K x AD syringe price per unit (ca)	75,031	0	75,031
P	Cost of reconstitution syringes needed	L x reconstitution price per unit (cr)	0	0	0
Q	Cost of safety boxes needed	M x safety box price per unit (cs)	9,334	0	9,334
R	Freight cost for vaccines needed	N x freight cost as of % of vaccines value (fv)	165,991	7,147	158,844
S	Freight cost for devices needed	(O+P+Q) x freight cost as % of devices value (fd)	0	0	0
T	Total fund needed	(N+O+P+Q+R+S)	8,167,811	348,021	7,819,790
U	Total country co-financing	I x country co-financing per dose (cc)	348,020		
V	Country co-financing % of Gavi supported proportion	U / (N + R)	4.31 %		

Table Annex 1.1 D: Estimated numbers for HPV quadrivalent, 1 dose(s) per vial, LIQUID, associated injection safety material and related co-financing budget (page 2)

		Formula	2019		
			Total	Government	Gavi
A	Country co-finance	V	4.31 %		
B	Number of children to be vaccinated with the first dose	Table 5.2	699,172	30,102	669,070
B1	Number of children to be vaccinated with the second dose	Table 5.2	662,373		
C	Number of doses per child	Vaccine parameter (schedule)	1		
D	Number of doses needed	B + B1	1,361,545	58,620	1,302,925
E	Estimated vaccine wastage factor	Table 5.2	1.05		
F	Number of doses needed including wastage	D x E	1,429,623	61,551	1,368,072
G	Vaccines buffer stock	Buffer on doses needed = (D - D of previous year) x 25% Buffer on wastages = ((F - D) - (F of previous year - D of previous year)) x 25%, = 0 if negative result G = [buffer on doses needed] + [buffer on wastages]	9,395	405	8,990
I	Total vaccine doses needed	Round up((F + G) / Vaccine package size) * Vaccine package size	1,439,100	61,959	1,377,141
J	Number of doses per vial	Vaccine parameter	1		
K	Number of AD syringes (+ 10% wastage) needed	(D + G) x 1.10	1,508,035	0	1,508,035
L	Reconstitution syringes (+ 10% wastage) needed	(I / J) x 1.10	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	(K + L) / 100 x 1.10	16,589	0	16,589
N	Cost of vaccines needed	I x vaccine price per dose (g)	6,547,905	281,910	6,265,995
O	Cost of AD syringes needed	K x AD syringe price per unit (ca)	61,456	0	61,456
P	Cost of reconstitution syringes needed	L x reconstitution price per unit (cr)	0	0	0
Q	Cost of safety boxes needed	M x safety box price per unit (cs)	7,646	0	7,646
R	Freight cost for vaccines needed	N x freight cost as of % of vaccines value (fv)	137,279	5,911	131,368
S	Freight cost for devices needed	(O+P+Q) x freight cost as % of devices value (fd)	0	0	0
T	Total fund needed	(N+O+P+Q+R+S)	6,754,286	287,821	6,466,465
U	Total country co-financing	I x country co-financing per dose (cc)	287,820		
V	Country co-financing % of Gavi supported proportion	U / (N + R)	4.31 %		

Table Annex 1.1 D: Estimated numbers for HPV quadrivalent, 1 dose(s) per vial, LIQUID, associated injection safety material and related co-financing budget (page 3)

		Formula	2020		
			Total	Government	Gavi
A	Country co-finance	V	4.31 %		
B	Number of children to be vaccinated with the first dose	Table 5.2	718,049	30,984	687,065
B1	Number of children to be vaccinated with the second dose	Table 5.2	680,257		
C	Number of doses per child	Vaccine parameter (schedule)	1		
D	Number of doses needed	B + B1	1,398,306	60,337	1,337,969
E	Estimated vaccine wastage factor	Table 5.2	1.05		
F	Number of doses needed including wastage	D x E	1,468,222	63,354	1,404,868
G	Vaccines buffer stock	Buffer on doses needed = (D - D of previous year) x 25% Buffer on wastages = ((F - D) - (F of previous year - D of previous year)) x 25%, = 0 if negative result G = [buffer on doses needed] + [buffer on wastages]	9,650	417	9,233
I	Total vaccine doses needed	Round up((F + G) / Vaccine package size) * Vaccine package size	1,477,900	63,772	1,414,128
J	Number of doses per vial	Vaccine parameter	1		
K	Number of AD syringes (+ 10% wastage) needed	(D + G) x 1.10	1,548,752	0	1,548,752
L	Reconstitution syringes (+ 10% wastage) needed	(I / J) x 1.10	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	(K + L) / 100 x 1.10	17,037	0	17,037
N	Cost of vaccines needed	I x vaccine price per dose (g)	6,724,445	290,160	6,434,285
O	Cost of AD syringes needed	K x AD syringe price per unit (ca)	63,115	0	63,115
P	Cost of reconstitution syringes needed	L x reconstitution price per unit (cr)	0	0	0
Q	Cost of safety boxes needed	M x safety box price per unit (cs)	7,852	0	7,852
R	Freight cost for vaccines needed	N x freight cost as of % of vaccines value (fv)	125,622	5,421	120,201
S	Freight cost for devices needed	(O+P+Q) x freight cost as % of devices value (fd)	0	0	0
T	Total fund needed	(N+O+P+Q+R+S)	6,921,034	295,581	6,625,453
U	Total country co-financing	I x country co-financing per dose (cc)	295,580		
V	Country co-financing % of Gavi supported proportion	U / (N + R)	4.31 %		

Annex 2 - NVS Routine – Preferred Second Presentation

Annex 2.1 - NVS Routine Support (HPV bivalent, 2 dose(s) per vial, LIQUID)

Table Annex 2.1 A: Rounded up portion of supply that is procured by the country and estimate of relative costs in US\$

		2018	2019	2020
Number of vaccine doses	#	57,079	58,620	60,337
Number of AD syringes	#	0	0	0
Number of re-constitution syringes	#	0	0	0
Number of safety boxes	#	0	0	0
Total value to be co-financed by the Country [1]	\$	348,021	287,821	295,581

Table Annex 2.1 B: Rounded up portion of supply that is procured by Gavi and estimate of relative costs in US\$

Rounded up portion of supply for the additional cohort that is procured by Gavi and estimate of relative costs in US\$

		2018	2019	2020
Number of vaccine doses	#	1,268,679	1,302,925	1,337,969
Number of AD syringes	#	1,841,148	1,508,035	1,548,752
Number of re-constitution syringes	#	0	0	0
Number of safety boxes	#	20,253	16,589	17,037
Total value to be co-financed by Gavi	\$	7,811,041	6,459,299	6,618,094

Table Annex 2.1 B: Rounded up portion of supply that is procured by Gavi and estimate of relative costs in US\$ ADDITIONAL COHORTS

		2018	2019	2020
Number of vaccine doses	#	644,959	662,373	680,257
Number of AD syringes	#	709,455	728,611	748,283
Number of re-constitution syringes	#	0	0	0
Number of safety boxes	#	7,805	8,015	8,232

Table Annex 2.1 C: Summary table for vaccine HPV bivalent, 2 dose(s) per vial, LIQUID

	Source		2018	2019	2020
Number of girls in the additional multi-age cohort to be vaccinated with the first dose	Table 5.2	#	0	0	0
Number of girls in the additional multi-age cohort to be vaccinated with the second dose	Table 5.2	#	0	0	0
Immunisation coverage with the second dose	Table 5.2	%	0	0	0

Table Annex 2.1 D: Estimated numbers for HPV bivalent, 2 dose(s) per vial, LIQUID, associated injection safety material and related co-financing budget (page 1)

		Formula	2018		
			Total	Government	Gavi
A	Country co-finance	V	4.31 %		
B	Number of children to be vaccinated with the first dose	Table 5.2	680,799	29,311	651,488
B1	Number of children to be vaccinated with the second dose	Table 5.2	644,959		
C	Number of doses per child	Vaccine parameter (schedule)	1		
D	Number of doses needed	B + B1	1,325,758	57,079	1,268,679
E	Estimated vaccine wastage factor	Table 5.2	1.05		
F	Number of doses needed including wastage	D x E	1,392,046	59,933	1,332,113
G	Vaccines buffer stock	Buffer on doses needed = (D - D of previous year) x 25% Buffer on wastages = ((F - D) - (F of previous year - D of previous year)) x 25%, = 0 if negative result G = [buffer on doses needed] + [buffer on wastages]	348,012	14,984	333,028
I	Total vaccine doses needed	Round up((F + G) / Vaccine package size) * Vaccine package size	1,740,100	74,918	1,665,182
J	Number of doses per vial	Vaccine parameter	2		
K	Number of AD syringes (+ 10% wastage) needed	(D + G) x 1.10	1,841,148	0	1,841,148
L	Reconstitution syringes (+ 10% wastage) needed	(I / J) x 1.10	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	(K + L) / 100 x 1.10	20,253	0	20,253
N	Cost of vaccines needed	I x vaccine price per dose (g)	7,917,455	340,874	7,576,581
O	Cost of AD syringes needed	K x AD syringe price per unit (ca)	75,031	0	75,031
P	Cost of reconstitution syringes needed	L x reconstitution price per unit (cr)	0	0	0
Q	Cost of safety boxes needed	M x safety box price per unit (cs)	9,334	0	9,334
R	Freight cost for vaccines needed	N x freight cost as of % of vaccines value (fv)	165,991	7,147	158,844
S	Freight cost for devices needed	(O+P+Q) x freight cost as % of devices value (fd)	0	0	0
T	Total fund needed	(N+O+P+Q+R+S)	8,167,811	348,021	7,819,790
U	Total country co-financing	I x country co-financing per dose (cc)	348,020		
V	Country co-financing % of Gavi supported proportion	U / (N + R)	4.31 %		

Table Annex 2.1 D: Estimated numbers for HPV bivalent, 2 dose(s) per vial, LIQUID, associated injection safety material and related co-financing budget (page 2)

		Formula	2019		
			Total	Government	Gavi
A	Country co-finance	V	4.31 %		
B	Number of children to be vaccinated with the first dose	Table 5.2	699,172	30,102	669,070
B1	Number of children to be vaccinated with the second dose	Table 5.2	662,373		
C	Number of doses per child	Vaccine parameter (schedule)	1		
D	Number of doses needed	B + B1	1,361,545	58,620	1,302,925
E	Estimated vaccine wastage factor	Table 5.2	1.05		
F	Number of doses needed including wastage	D x E	1,429,623	61,551	1,368,072
G	Vaccines buffer stock	Buffer on doses needed = (D - D of previous year) x 25% Buffer on wastages = ((F - D) - (F of previous year - D of previous year)) x 25%, = 0 if negative result G = [buffer on doses needed] + [buffer on wastages]	9,395	405	8,990
I	Total vaccine doses needed	Round up((F + G) / Vaccine package size) * Vaccine package size	1,439,100	61,959	1,377,141
J	Number of doses per vial	Vaccine parameter	2		
K	Number of AD syringes (+ 10% wastage) needed	(D + G) x 1.10	1,508,035	0	1,508,035
L	Reconstitution syringes (+ 10% wastage) needed	(I / J) x 1.10	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	(K + L) / 100 x 1.10	16,589	0	16,589
N	Cost of vaccines needed	I x vaccine price per dose (g)	6,547,905	281,910	6,265,995
O	Cost of AD syringes needed	K x AD syringe price per unit (ca)	61,456	0	61,456
P	Cost of reconstitution syringes needed	L x reconstitution price per unit (cr)	0	0	0
Q	Cost of safety boxes needed	M x safety box price per unit (cs)	7,646	0	7,646
R	Freight cost for vaccines needed	N x freight cost as of % of vaccines value (fv)	137,279	5,911	131,368
S	Freight cost for devices needed	(O+P+Q) x freight cost as % of devices value (fd)	0	0	0
T	Total fund needed	(N+O+P+Q+R+S)	6,754,286	287,821	6,466,465
U	Total country co-financing	I x country co-financing per dose (cc)	287,820		
V	Country co-financing % of Gavi supported proportion	U / (N + R)	4.31 %		

Table Annex 2.1 D: Estimated numbers for HPV bivalent, 2 dose(s) per vial, LIQUID, associated injection safety material and related co-financing budget (page 3)

		Formula	2020		
			Total	Government	Gavi
A	Country co-finance	V	4.31 %		
B	Number of children to be vaccinated with the first dose	Table 5.2	718,049	30,984	687,065
B1	Number of children to be vaccinated with the second dose	Table 5.2	680,257		
C	Number of doses per child	Vaccine parameter (schedule)	1		
D	Number of doses needed	B + B1	1,398,306	60,337	1,337,969
E	Estimated vaccine wastage factor	Table 5.2	1.05		
F	Number of doses needed including wastage	D x E	1,468,222	63,354	1,404,868
G	Vaccines buffer stock	Buffer on doses needed = (D - D of previous year) x 25% Buffer on wastages = ((F - D) - (F of previous year - D of previous year)) x 25%, = 0 if negative result G = [buffer on doses needed] + [buffer on wastages]	9,650	417	9,233
I	Total vaccine doses needed	Round up((F + G) / Vaccine package size) * Vaccine package size	1,477,900	63,772	1,414,128
J	Number of doses per vial	Vaccine parameter	2		
K	Number of AD syringes (+ 10% wastage) needed	(D + G) x 1.10	1,548,752	0	1,548,752
L	Reconstitution syringes (+ 10% wastage) needed	(I / J) x 1.10	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	(K + L) / 100 x 1.10	17,037	0	17,037
N	Cost of vaccines needed	I x vaccine price per dose (g)	6,724,445	290,160	6,434,285
O	Cost of AD syringes needed	K x AD syringe price per unit (ca)	63,115	0	63,115
P	Cost of reconstitution syringes needed	L x reconstitution price per unit (cr)	0	0	0
Q	Cost of safety boxes needed	M x safety box price per unit (cs)	7,852	0	7,852
R	Freight cost for vaccines needed	N x freight cost as of % of vaccines value (fv)	125,622	5,421	120,201
S	Freight cost for devices needed	(O+P+Q) x freight cost as % of devices value (fd)	0	0	0
T	Total fund needed	(N+O+P+Q+R+S)	6,921,034	295,581	6,625,453
U	Total country co-financing	I x country co-financing per dose (cc)	295,580		
V	Country co-financing % of Gavi supported proportion	U / (N + R)	4.31 %		

Annex 3 - NVS Preventive campaign(s)

No NVS Prevention Campaign Support this year

Annex 4

Table Annex 4A: Commodities Cost

Vaccine	Presentation	2017	2018	2019	2020
HPV quadrivalent, 1 dose(s) per vial, LIQUID	1	4.550	4.550	4.550	4.550

Supply	Form
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Note: WAP - weighted average price (to be used for any presentation: For DTP-HepB-Hib, it applies to 1 dose liquid, 2 dose lyophilised and 10 dose liquid. For Yellow Fever, it applies to 5 dose lyophilised and 10 dose lyophilised)

Estimated prices of supply are not disclosed

Table Annex 4B: Freight cost as percentage of value

Vaccine Antigen	Vaccine Type	2018	2019	2020
HPV quadrivalent, 1 dose(s) per vial, LIQUID	HPV	2.10 %	2.10 %	1.87 %

Table Annex 4C: Initial self-financing phase - Minimum country co-payment per dose of co-financed vaccine

Vaccine	2018	2019	2020
HPV quadrivalent, 1 dose(s) per vial, LIQUID	0.2	0.2	0.2

12. Banking Form

In accordance with the decision on financial support made by the Gavi, the Government of United Republic of Tanzania hereby requests that a payment be made via electronic bank transfer as detailed below:

Name of Institution (Account Holder):	Ministry of Health		
Address:	6 Samora Machel Avenue, 11478 P.O.Box 9083		
City Country:	Dar es Salaam, Tanzania		
Telephone no.:	+255 22 2120261/7	Fax no.:	
	Currency of the bank account: US DOLLAR		
For credit to:			
Bank account's title:	Gavi Health Strengthening System		
Bank account no.:	9931209581		
Bank's name:	Bank of Tanzania (BoT)		

Is the bank account exclusively to be used by this program? True

By who is the account audited? Controller And Auditor General (CAG)

Signature of Government's authorizing official

Name: Dr Neema Rusibamayila	Seal
Title: Director of Preventive Services	
Signature:	
Date: 30/01/2017	

FINANCIAL INSTITUTION		CORRESPONDENT BANK (In the United States)	
Bank Name:	Bank M Tanzania LTD		
Branch Name:	Kisutu		
Address:	P.O.Box 96		
City Country:	Dar es Salaam, Tanzania		
Swift Code:	BNKMTZTZXXX		
Sort Code:			
ABA No.:	N/A		
Telephone No.:	+255 22 2135518		
FAX No.:	+255 22 2135517		

I certify that the account No 0250024132 is held by Gavi Health Strengthening System at this banking

institution

The account is to be signed jointly by at least 2 (number of signatories) of the following authorized signatories:

1		
	Name:	Dr Neema Rusibamayila
	Title:	Director of Preventive Services
2		
	Name:	Dr Dafossa Lyimo
	Title:	Program Manager
3		
	Name:	Hellen Saria Mwakipunda
	Title:	Chief Accountant

Name of bank's authorizing official	
Elias Mfere	
Signature:	
Date:	1/30/2017 12:00:00 AM
Seal:	