

## Tanzania Internal Appraisal 2014

### 1. Brief Description of Process

This Internal Appraisal for the United Republic of Tanzania was conducted for Gavi by independent technical expert **Deborah McSmith**, in cooperation with Gavi Senior Country Managers (SCM), **Alison Riddle** and **Stefano Lazzari**, and is based on reports, documentation and clarifications provided to Gavi by the national authorities and institutions in the country for the year 2013.

Tanzania received support from Gavi in 2013 for the following vaccines: penta, pneumo, rota, and HPV.

### 2. Achievements and Constraints

Total births and total surviving infants figures for 2013 in the JRF are based on National Bureau of Statistics 2012 Census, using a growth rate of 2.7, and differ from estimates in the cMYP tool. There are no changes in wastage by vaccine.

The rotavirus coverage target of 95% was not reached (achievement of 85%) due to a delayed start – March instead of January – in several districts including the whole of Zanzibar. However, PCV13 vaccine was introduced at the same time and the target appears to have been exceeded. MCV 1 coverage was higher than the projected target because immunised children over 1 year of age were included in some district databases. Although the number of children vaccinated by Penta has increased by 7,263 compared with number of children vaccinated in 2012, vaccination coverage decreased from 92% to 91% due to the higher target population.

With the exception of BCG, the 2013 APR reports no coverage discrepancies between the administrative data system, TDHS and the WHO/UNICEF Estimate of National Immunization Coverage. BCG coverage is reported at 107% with no explanation provided. Annual DTP dropout rate could not be calculated as Tanzania is reporting on Penta rather than DPT coverage.

Tanzania perceives no gender related barriers for immunization services and asserts that the REC strategy ensures that both girls and boys receive services. Per TDHS 2010, DTP3 coverage for males was 88.2% and for females 87.8%. The country notes that men are increasingly accompanying wives to immunizations centres and in some instances taking children themselves to immunization centres. To address socio economic barriers, immunisation services are provided free of charge in both public and private health facilities. National HMIS data collection tools were revised in 2013 to include sex disaggregated data. GAVI may wish to follow up through 2014 to ensure that tools are being used and this data is being collected.

### 3. Governance

Per the APR, the ICC met 5 times in 2013. Membership is comprised of MOHSW and MOH Zanzibar, Ministry of Finance, WHO, UNICEF, USAID/MCHIP, Tanzania Red Cross, CHAI, Paediatric Association, KfW, Lions Club, and 2 CSOs – Tanzania Red Cross and Christian Social Service Commission (CSSC). The ICC discusses and endorses the EPI Annual Plans and reviews the implementation reports. Minutes indicate that the committee also thoroughly reviewed the APR 2013 submission to GAVI.

Key committee recommendations in 2013 were to use both 1<sup>st</sup> and 2<sup>nd</sup> dose MR vaccine, integrate a planned 2014 Measles follow up campaign with IPV, and increase capacity of district vaccine stores to be able to accommodate vaccines for 3 months to reduce shipments. APR makes no reference to a NITAG.

In the APR, the ICC commended the successful introduction of 2 new vaccines (RV and PCV13), anticipated the smooth introduction of forthcoming new vaccines (Measles Rubella and IPV), and commended MOHSW for strengthening HR capacity at the IVD unit by adding 9 staff.

#### 4. Programme Management

The Expanded Programme on Immunization (EPI) in Tanzania was established in 1975 with the primary aim of protecting children from Vaccine Preventable Diseases, and the overall goal to contribute to the reduction of infant and childhood mortality rates. In 2011 the programme changed its name from Expanded Immunization Programme (EPI) to Immunization and Vaccine Development (IVD) to be in line with GIVS.

The Programme is comprised of seven main sections: program management, human resource management, costing and financing, vaccines, cold chain and logistics, immunization services, and surveillance and reporting.

Tanzania has an infection safety plan, dedicated pharmacovigilance capacity, a newly established AEFI expert review committee, but no risk communication strategy to address vaccine crises. Sentinel surveillance is conducted for RV diarrhoea and paediatric bacterial meningitis. Of note, injection safety is not under the IVD program but under the MOHSW Department of Quality Assurance.

An EVM assessment was carried out in June 2012 and the next is planned for June 2015. There have been changes in the EVM improvement plan, including training of regional and district cold chain resource persons; health facility comprehensive cold chain inventory assessments; and expansion of district and facility cold storage capacity.

#### 5. Programme Delivery

Both PCV13 and Rotavirus vaccines were introduced countrywide in January 2013, in single dose presentation. A delay in receiving Rotavirus vaccine resulted in consumption of the buffer stock, and the introduction of Rotavirus and PCV13 vaccines was delayed for two months in Zanzibar because of training delays. The target for RV was not achieved; however the target for PCV13 was exceeded.

Tanzania reports some challenges related to the implementation of Measles Second Dose and HPV demonstration activities at the same time - largely due to the significant workload. No information is provided as to whether this affected coverage.

Tanzania experienced no stock outs in 2013; however there were postponed deliveries and slight differences between total doses agreed in the 2013 decision letter and total doses received.

Key programme delivery activities reported for 2013 were those supported with carried over ISS funds as well as the introduction of RV and PCV 13 into the RI schedule, the PIE for PCV 13 and RV, various trainings, and a baby tracking intervention conducted in 4 districts.

The PIE found that overall introduction of PCV13 and RV vaccines was smooth and both vaccines were well accepted. Numerous strengths were identified: implementing majority of recommendations from previous assessments prior to introduction; involvement of local partners in introduction; conducting extensive training nationwide; updating key recording and reporting tools; using introduction to promote additional interventions for diarrhoea and pneumonia prevention; well-established system for integrated supervision; ensuring adequate CC capacity including appropriate use of fridge and freeze tags; conducting launching ceremonies at national and subnational levels and distributing appropriate IEC materials; establishment of a national AEFI expert committee; availability of waste management policy guidelines; and establishment of PBM and RV sentinel surveillance at 5 sites.

Key issues of concern included: DVDMT and DHIS/HMIS had calculation errors; 2012 census figures provided lower target populations; coverage of vaccines administered at the same visit not matching in some areas; limited skills at regional and district level for preventive maintenance and repairs of equipment, especially for new cold rooms; stock out of vaccines and supplies at different

levels; some staff lacking data interpretation skills for corrective actions; follow up and implementation of corrective actions resulting from earlier supervisory visits inconsistent and not documented; some disposal sites not properly secured and thereby constituting public health hazard; and insufficient focus on other EPI vaccines and integrated approaches in printed IEC materials on new vaccines.

The National EPI team has developed a work plan based on PIE recommendations, and will share implementation progress with the ICC and partners on a quarterly basis.

Key program challenges described for 2013 include: shortage of human resources; poor working conditions of most vehicles on which EPI programme depends at district level; creation of new districts and regions which require establishment of more vaccine stores; high turnover of trained health workers; and hard to reach areas requiring mobile outreach services.

Plans and actions to address these challenges include: implementation by MOHSW of a Human Resources for Health Strategic Plan to support increased student enrolment in health institutions; mobilization of resources including Gavi support to procure additional vehicles; advocacy by MOHSW for government budgetary allocations for newly formed regions and districts prior to their establishment; and implementation of HRH retention schemes for hard to reach rural areas. To reduce the number of dose shipments, the country will continue to increase cold storage capacity at the national level and plans to use Pentavalent 10 dose vials to maintain low vaccine wastage.

The APR outlines key priority actions for 2014/15:

- Increase Pentavalent national coverage to at least 94% (from 91% in 2013);
- Maintain DTP-HepB-Hib1 to DTP-HepB-Hib3 dropout rate to less than 10%;
- Increase core Vaccine Preventable Disease surveillance indicators to reach at least 80% of the target;
- Increase CC storage capacity in all district stores to accommodate vaccines for at least 3 months;
- Prevent wild polio virus importation in Tanzania and increase population immunity;
- Reduce number of un/under vaccinated children by 50% compared with 2013 using REC;
- Improve data management at regional and district levels;
- Introduce measles-rubella vaccine (MR vaccine) and IPV in routine immunization.

The APR does not include more detailed information about strategies and plans to complete these actions successfully, particularly with regard to data management improvement.

## 6. Data Quality

Since 2011, Tanzania's actions to improve data quality have included distributing updated vaccination data management tools to all districts and providing on-the-job training for new immunization personnel. Future improvement plans include: the introduction of a web-based immunization data management system; conducting data quality self-assessments; and further revision to the HMIS tools to include Measles Rubella and IPV.

The 2013 PIE for PCV13 and RV vaccine introduction made the following recommendations with regard to data quality, which the country should add to its data improvement planning for 2015:

- Require that all updated data collection and reporting tools are distributed to all levels prior to future vaccine introduction.
- Ensure that all regions currently without updated data collection and reporting tools receive them as soon as possible.
- Distribute corrected electronic data management tools (DVDMT, DHIS) to all regions and districts.
- Proactively work with the National Bureau of Statistics on discussing recently released census figures to address the issue of potentially unrealistic target population figures.

- Include children outside catchment areas in summary reports and check whether data collection tools account for these children.
- Investigate reasons for apparent differences in coverage of vaccines that should be administered at the same visit and high dropout rates in some areas.
- Conduct annual refresher training for district and health facility staff.
- Ensure that supervisors are trained in supportive supervision techniques and data collection tools.

## 7. Global Polio Eradication Initiative, if relevant

In the APR, the ICC made special reference to the announcement of polio as a public health emergency and expressed its commitment to ensure there is strengthened OPV vaccination and improved surveillance indicators following global guidelines. Two priority actions for the 2014 EPI programme relate to polio eradication:

- prevent wild polio virus importation in Tanzania and increase population immunity
- introduce combined measles-rubella vaccine (MR vaccine) and IPV into the RI program.

## 8. Health System Strengthening

Tanzania was approved in May 2012 for a new HSS grant, though satisfactory submission of Level II clarifications was only completed in 2013. As such, funds were only released in January 2014. Gavi received a draft report on implementation of HSS activities in August 2014. Twenty activities are planned for 2014; with a total cost of US\$ 3,786,840.00. Implementation of most 2014 activities was scheduled to take place in the third and fourth quarter to allow for implementation of measles second dose and HPV demonstration project activities. One activity (Support program management, including in-house trainings by technical assistance, for better results including support to by annual progress report writing) has so far been implemented partially with US\$ 13,016 of the budgeted US\$ 75,317 spent. A plan of implementation for 2015 was also submitted.

As part of the HSS PBF approach, countries are required to have one household survey every 5 years to assess immunization coverage/equity and factors associated with non-immunization; an additional mid-grant evaluation is also recommended. A budget household survey was conducted in 2013; however results are not yet published. The next DHS will be conducted in 2015. An analytical health sector performance review was also conducted in 2013. The country plans to use post campaign immunization coverage surveys and may engage health research institutions to conduct analytical coverage reports for the PBF performance component of HSS support. Tanzania is currently eligible for PBF DTP3 performance payment for 2015 but not for the equity performance payment component.

A Pay for Performance (P4P) strategy is being piloted in 2 regions and should be reported on the 2014 APR. P4P provides financial incentives to staff of health facilities who have met targets in indicators including immunisation coverage. Initial reports indicated that P4P has raised coverage and Tanzania plans to roll out the scheme to all regions.

## 9. Use of non-HSS Cash Grants from GAVI

Tanzania is not reporting on CSO fund utilisation for 2013.

Tanzania did not receive ISS funds in 2013, but carried over funds from 2012 in the amount of US\$ 2,610,731. ISS expenditures in 2013 were US\$ 1,011,462, leaving a balance of US\$ 1,599,269 carried over to 2014. This remaining balance has been included in the 2014 IVD Annual Plan. A request for ISS reward achievement is not applicable for 2013.

ISS funds were used in 2013 for supportive supervision to low performing districts, implementation of REC in districts with high numbers of under/un vaccinated children; increasing positive storage capacity through procurement of 280 MK 404 for District Vaccine Stores; an annual IVD Evaluation Meeting for the regional and national teams; printing and distribution of data management tools;

and procurement of vehicles for new regions and districts to support distribution of vaccines and related supplies.

Both PCV13 and Rotavirus vaccines were introduced Countrywide in January 2013, in single dose presentation. Carried over Gavi funds in the amount of US\$ 2,796, from a 2012 VIG grant for the introduction of PCV13, were used for the PIE conducted in November 2013.

Although no data for the HPV demo project was included in the APR, the ICC minutes from the May 2014 meeting endorsing the APR indicate that coverage for the demo was 92% with no reported AEFI to date.

## **10. Financial Management**

An FMA was conducted in 2012. Per APR, all recommendations have been fully implemented.

Gavi ISS funds are planned and budgeted in the EPI Annual Plans, which are part of the Health Sector Strategic Plan III 2009-2014 for Tanzania Mainland and Health Sector Reform Strategic Plan for II for Zanzibar 2007- 2012, and are reflected in the Medium Term Expenditure Frame work (MTEF) every year.

WHO Tanzania Country Office maintains custody of ISS funds and releases them upon approval of the National IVD Plans by the ICC and after review of financial requests from EPI Programme Managers for Tanzania Mainland and Zanzibar, based on implementation schedules. Resources appear to be transferred effectively from national to decentralised levels.

No external audits are pending to Gavi from Tanzania. As ISS funds are under WHO management, they would not require an external audit report to Gavi.

## **11. NVS Targets**

The APR provides explanations for over and under achievement of 2013 targets. Adjustments for 2014 are minimal and should be achievable.

Within HSS funding, the country lists expectations for the level of improvement for coverage of vaccines as medium for DTP3 coverage (91% coverage already) and geographic equity (percent of Districts with  $\geq 80\%$  DTP3 coverage) and high for measles coverage (chance of children accessing vaccination services at least once is high).

For the planned campaign of Measles Rubella, integrated with IPV in October 2014, the country plans to target 20 million children less than 15 years of age. The Country is encouraged to prioritize the PIE data improvement recommendations prior to this wide scale campaign.

## **12. EPI Financing and Sustainability**

Historically Tanzania has paid for its own traditional vaccines. In 2013 the country financed 12% of the total immunization expenditures, funding 5% of new and underused vaccines, with Gavi funding the remaining 95%, and increasing its contribution to injection supplies and other routine recurrent costs. Gavi, UNICEF, WHO and CHAI all contributed to cold chain costs. The country, Gavi and USAID were the primary contributors to other routine recurrent costs with similar contribution levels. Auto disable syringes were also financed by the Government of Tanzania, except for PCV13 and Penta, which are co-financed with Gavi.

The country has never defaulted on its co-financing obligations. In 2013, it fully financed its co-financing obligations, which is an improvement from 2012, when 97% of the funding for co-financing came from donors. The country also plans to pay for the 2015 requirements from its own resources.

The Government of Tanzania's co-financing contributions in 2013 totalled \$3 million.

The 2013 PCV13 and RV PIE emphasizes the following areas for allocation of government funds: printing updated child health cards and registers prior to introduction of new vaccine; health worker refresher trainings; and a budget line for immunization programme activities in regional health budgets.

The country indicates that it does not require technical assistance.

Support from Gavi for both the HSS grant and new and under-used vaccines and injection supplies is reported in the national health sector budget. The country has included a budget line for planned 2014 HSS activities/costs within the national Mid-Term Expenditure Framework and Comprehensive Council Health Plans to help ensure financing sustainability. One activity within the HSS grant is an advocacy meeting in September 2014 to involve the private sector in raising immunisation coverage.

### 13. Renewal Recommendations

Topic	Recommendation
NVS - Penta	Renewal of support without change in presentation
NVS - PCV	Renewal of support without change in presentation
NVS - Rota	Renewal of support without change in presentation
HSS	Disbursement of the 2nd tranche of funds for program year 2015 only after review by the Secretariat of the second annual implementation report due in May 2015.

### 14. Other Recommended Actions

Topic	Action Point	Responsible	Timeline
Gender	Follow up on sex disaggregated data collection using the revised National HMIS data collection tools	SCM	December 2014
Equity	Follow up on country plans to use post campaign immunization coverage surveys and may engage health research institutions to conduct analytical coverage reports for the PBF performance component of HSS support.	SCM, HSS	December 2014