Joint appraisal report

When submitting this report, the country confirms that the grant performance framework has been reviewed as part of this joint appraisal. Performance against agreed metrics has been analysed, and explained where relevant.

Country	TANZANIA, United Republic
Reporting period	*1st July, 2015 to 30th June, 2016*
Fiscal period	*1st July, 2015 to 30th June, 2016*
If the country reporting period deviates from the fiscal period, please provide a short explanation	*N/A*
Comprehensive Multi Year Plan (cMYP) duration	*2016-2020*
National Health Strategic Plan (NHSP) duration	*July 2015 to June 2020 (HSSP IV)*

1. SUMMARY OF RENEWAL REQUESTS

[These tables will be pre-populated by the Gavi Secretariat. If there are any changes to be made, this should be discussed as a group during the joint appraisal and flagged in the report – see the guidance document for more details]

Programme	Recommendation	Period	Target	Indicative amount to be paid by Country	Indicative amount to be paid by Gavi
NVS -Penta in existing presentation (Penta 10ds)	Extension	2017	1,954,523	US$ 1,244,000	US$ 6,660,500
NVS- PCV in new presentation (PCV13 4ds)	Extension	2017	1,954,523	US$ 1,342,500	US$ 24,070,000
NVS - Rota in existing presentation (Rota 2ds sch)	Extension	2017	1,954,523	US$ 855,000	US$ 8,754,500
NVS - IPV in existing presentation (IPV 5ds)	Extension	2017	1,880,874	US$ 0	US$ 2,226,500

NVS Measles 2nd dose in existing presentation (MR10ds lyo)	Extension	2017	1,895,888	US$ 0	US$ 735,000
HSS performance payment 2015	Approval	2016	NA	NA	US$1,600,000

NB: 3 HSS core tranches have already been approved. Hence no need for renewal request.

Indicate interest to introduce new vaccines or HSS with Gavi support*	**Programme**	**Expected application year**	**Expected introduction year**
	HPV	*January 2017*	*January 2018*
	IPV	*Already done*	*Depend on vaccine availability*
	CEEOP	*May 2017*	

**Not applicable for countries in final year of Gavi support*

2. COUNTRY CONTEXT*(maximum 1 page)*

This section does not need to be completed for joint appraisal update in interim years

[If relevant, comment only on any changes since the previous joint appraisal to key contextual factors that directly affect the performance of Gavi grants – see guidance document for more details]

There is no much changes after previous joint appraisal despite the country undergoing general election in 2015. All activities implemented complied with national rules and regulations.

The country comprehensive multi-year plan (cMYP) 2016-2020 was developed and aligned with GVAP 2011-2020 and emphasizes reaching global and regional goals of disease eradication and elimination, sustaining high coverage while reaching every last child equitably, expanding immunization service to life course approach, reducing vaccine preventable diseases through new vaccine introductions, adopting and updating new technology in cold chain, supply chain and data management.

The establishment of NITAG was endorsed by the ICC and orientation of the members has been conducted in October 2016 by WHO and SIVAC.

The number of Councils (districts) in the country have increased from 173 in 2014 to 185 in 2016 hence there is a need of increasing resources including human and cold chain equipment in the new districts. The number of health facilities providing immunization services have also increased from 5,650 in 2015 to 5,685 in 2016 so as to comply with country policy of having at least one health facility in each village (MMAM 2007-2017)

Men A risk assessment was conducted in 2016, due to limitation of data findings were inconclusive to support the introduction of MenA vaccine. It was recommended that the country should develop a national plan for epidemiological and laboratory meningitis surveillance; and should also consider to join the Network of Enhanced Surveillance of Meningitis in Africa.

The yellow fever risk assessment is planned to be implemented during the coming rainy season as guided by WHO and it will be led by epidemiology section.

Recommendations from 2015 comprehensive EPI review were incorporated in the 2016 – 2020 cMYP for implementation including EVMA recommendations. These are reviewed on annual basis.

Immunization services in the Refugee communities is ongoing using the Tanzania Immunization schedule and guidelines. Health services for refugees including immunization are provided by Tanzania Red Cross Society (TRCS), International Rescue Committee (IRC) and Medicins Sans Frontiers (MSF).. Currently all vaccines including new and underused are procured by UNICEF. UNICEF would like GAVI to support procurement of new and underused vaccines. Proposal to include refugee children in the National target for vaccines forecasting was not accepted by the Government due to the unstable nature of the refugee population.

Technical support and close monitoring and supportive supervision of services in the refugee camps are provided by UNICEF and WHO. Data generated are integrated in the respective districts and some of the Refugee Health Facilities provide services to the local communities.

3. GRANT PERFORMANCE AND CHALLENGES*(maximum 3-4 pages)*

Describe only what has changed since the previous year's joint appraisal. For those countries conducting the joint appraisal 'update', only include information relevant to upcoming needs and strategic actions described in section 5

3.1. New and underused vaccine (NVS) support

3.1.1. Grant performance, lessons and challenges

[Comment on the relevant bolded areas listed in the table in this section of the guidance document,e.g.: programmatic performance of each vaccine programme against approved targets and planned activities, including progress and bottlenecks in implementation; actual versus planned financial expenditure, associated challenges, proposals for using unspent funds, and complementarities between all cash grants]

The coverages of vaccines provided in Tanzania through Gavi support in 2015 were above targets as reported by MoH/WHO/UNICEF Joint Reporting Form (JRF).

Achievements of targets and of intermediate results

Based on 2015 performance targets, all vaccine coverages were above the target except MCV2

- Pentavalent (2015 coverage 98 %) drop out 7%)
- PCV-13 (2015 coverage 95%), drop out 9%)
- Rotavirus (2015 coverage 98%), drop out 6%)
- The coverage for first dose of Measles Rubella was 103% and Measles Rubella Second Dose (2015 coverage 57%). With continued social mobilization, the coverage for Measles Rubella second dose is expected to increase.
- HPV demo second year (2015) coverage 89.1% first dose and 78.1% second dose by September 2016.

Equity

According to JRF 2015 percentage of Councils with Penta-3 coverage above 95% was 62% (108 out of 173),Councils with coverage between 80% to 94% was 29% (51 out of 173). This shows that 92% of districts had coverage above 80% in 2015 compared to 89% in 2014. Immunisation services for all vaccines are equally provided for boys and girls, however there are some regional differences between rural and urban. The differences has also been noted based on the mother's education level and wealth (Tanzania Demographic Health Survey 2015-16. The Reach Every Child strategy is used to address equity issues.

Status of implementing any outstanding recommendations from the IRC, HLRP or Senior Country Manager

Some of the key recommendations given by reviews and stakeholders were;

i. Technical review and consideration of new vaccine introductions.

- *The newly established NITAG will be key in providing technical assistance and guidance for future introduction*

ii. Consider long term sustainability of immunization financing.

- *Discussion has started on sustainability of immunization financing.*
- *Sustainability plan is yet to be developed*.

iii. Fast track ICC recommendation to reposition vaccine handling, storage and distribution.

- *Ministry of Health in collaboration with partners are working on repositioning of Vaccine Handling, Storage and Distribution from Central Medical Store Department (MSD) to IVD.*
- *Costing analysis and Standard Operating Procedures documented.*

iv. Establishment of NITAG.

- *See section 2 above under country context.*

v. Explore IT solutions through VIMS to capture real time stock availability.

- *VIMS which include stock management tool is on the final stages of development, Will be roll out countrywide in 2017/2018*

vi. Implement system for preventive maintenance and repair.

- *EVMA recommendations implementation plan has been developed and in process to be executed.*
- *Training of RIVO and DIVO on cold chain maintenance has been conducted*
- *Capacity building was done for regional and council technicians on regular maintanance*
- *National Team of technicians were deployed to the regions for major repairs*

vii. Establish accredited courses for vaccines and logistics management

- The courses are intergrated in the East Africa Centre of excellence courses

viii. Establish surveillance TWG.

- *Surveillance TWG exist under the umbrella of the bigger IVD TWG*

ix. Sustain and maintain quality vaccine surveillance.

- *The surveillance syste has been maintained with surveillance officers from the district and regional levels who are working closely and with support and guidance from Zonal WHO officers posted around the country*

x. Despite the high coverage, the country needs to indentify underperforming districts to ensure coverage with equity.

- *Under performing districts are indentified and appropriate action is done. Annual data is analyzed those underperforming (high number of unvaccinated and under vaccinated) are included in the REC approach*

Participation of key stakeholders in Implementation (including Civil society organization):

All immunisation partners (WHO, UNICEF, Cliniton Health Access Initiative, MCSP, PATH, Red Cross and Lions Club and AMREF) are participating in implementation of all Gavi financed activities. All these organization have membership in immunisation Technical Working Group. In some districts have CSO which support them locally on immunization services depending with local agreement; example: Flying Doctors Services supporting mobile services in nomadic community in Arusha and Manyara .

Status of strengthening surveillance systems

Diseases surveillance system in the country has improved in recent years which resulted in achieving the global surveillance indicatorsfor AFP and Measles Case-Based Surveillance. The country polio free documentation were accepted in November 2015 by ARCC. To ensure that there is timely detection and response of Polio, Mealses and Rubella there is a need to intensify and maintain the ongoing VPD Case based surveillance in the country. To ensure emerging diseases Yellow Fever, Ebola and Zika are also early detected the surveillance need to be intensified. New vaccine surveillance is ongoing also in selected in 8 sentinel surveillance sites for Rotavirus, Congenital Rubella Syndrome (CRS) and Paediatric Bacterial Meningitis (PBM) which also need to be intensified including the laboratory support.

Compliance with data quality and survey requirements:

All immunization data are collected from service delivery points with standardized data collection tools available at the collection point. IVD data collection a health facility level,the tools are paper based. From district level the data tools are electronic (either web-based or in computerized excel format). In order to ensure quality, data is discussed and harmonized at respective level before submission. National coverage survey of 2014 has shown no significant difference from routine performance data .

Key lessons learned to inform future routine vaccine introductions or Campaigns:

- Detailed macroplan at national, regional and district level to identified all health facilities, communities and resources is required and important
- Detailed microplan at health facility level is very crucial and important to ensure all the communities are reached with intended services
- Intensification of social mobilization using the community media, CSOs, religious groups and influencial community members
- Political commitment at all levels

Key implementation bottlenecks and corrective actions, along system Components

1. Inadequate Human Resource and high staff turnover
   - On going advocacy for higher level for employing and retention of staff
   - Training for new comers for newly recruited staff
2. Lack of a reliable target population
   - Use of electronic immunization register which are piloted in Arusha, Shinyanga and Geita Regions
   - Discussion for establishment of child register that is done by Registration Insolvency and Trusteeship Agency (RITA) and partners
3. Data quality
   - Establishment of electronic data management tools (VIMS, BID, Web-SMT)
   - Builiding capacity of data quality self assessment.

Overall programmatic capacity to manage NVS grants

The country has successful implemented GAVI NVS grant since 2013 in collaboration with existing immunisation partners in the country. The program has shown the ability to manage the grant and is using the challenges identified to position itself to better manage the grant going forward

Financial performance from 2014 to June 2016

Cash grant	Amount received in 2014-2016(USD)	Expenditure in 2014-2016(USD)	% spent
HSS first tranche	**5,604,801**	4,351,173.46	77%
HPV cash support	225,500	212,000	94%
MCV2 VIG	1,626,000	1,328,024	82%
MR routine VIG	1,546,500	331,955	22%
MR campaign operational costs	12,791,693	12,271,412	96%
IPV VIG	1,599,000	0	0%
TOTAL	**23,393,494**	**18,494,564.46**	**79%**

key challenges regarding financial management:

- Competing global priorities for implementation of activities

- Delayed introduction of IPV in routine Immunization have created a situation of under utilization of funds as it was recommended to synergize VIG activities. Such funds are MR introduction grants, Measles Second Dose grants and IPV funds.

Actual versus planned financial expenditure

Complementarity between VIGs, operational costs and HSS funds

Overall financial capacity to manage NVS grants

3.1.2. NVS future plans and priorities

[Comment on the relevant bolded areas listed in the table in this section of the guidance document, e.g.: for existing vaccines - reasonableness of targets for next implementation year, plans for any changes in presentation or type, risks to future implementation and mitigating actions; for new applications – any expected future applications (include in table 1 above), emerging new priorities for the national immunisation programme]

Currently approved vaccines:

Reasonableness of targets for next implementation year

- The projected surviving infants in Tanzania for 2017 is 1,844,684 which is 2.6% increased compared to 1,796,187 in 2016 which is reasonable population projected.
- The projected wastage for the DTP-HepB-Hib, PCV13, Rota and MSD are 10%, 5%, 5% and 18% respectively.
- With recent years high coverage of more than 95% the expected coverage for 2016 is expected to be sustained for all vaccines due to implementation of REACH EVERY CHILD strategy and outreach services in many councils..

Expected future applications to Gavi for new vaccine introductions

- HPV vaccine application for National Roll out

Plans for change in any vaccine presentation(s) or type(s):

- One dose vial of PCV13 vaccine is expected to be changed to 4-dose vial in 2017 to reduce the cold chain storage space required for the vaccines storage and hence offer additional space to other new vaccines introductions in future. The changes has been endorsed by ICC.

Risk to future implementation:

- Many future expected introductions such as HPV ,Men A and Yellow Fever targeting age group above 2 years risk poses a risk for acceptance by general population. Advocacy and social mobilization specific to these vaccines will be enhanced.
- The increased costs of the new vaccines will affect programme management due to additional budget from the government in co-financing and vaccines handling. Advocacy to high level decision makers on the cost-benefit for the new vaccine introductions will be enhanced.

New applications or new immunisation programme priorities:

Any expected future applications to Gavi for new vaccine introductions or campaigns

- See session 3.1.2. on NVS future plans and priorities

Emerging new priorities for the national immunization programme based on the latest cMYP and annual work plan:

- To reach previously unreached children with quality/potent vaccines (unvaccinated and under vaccinated children);
- Conduct REC/RED strategy and Data Quality Self- Assessment to all low performing districts;
- Intensify the routine immunization services and increased demand for community awareness for immunization services;
- Ensured regular availability of potent IVD vaccines in all health facilities providing vaccination services;
- Strengthen vaccines preventable diseases surveillance and preparedness for prompt for outbreaks and;
- Increasing cold chain storage capacities at all levels
- Strengthen IVD to support transition of clearance, storage and distribution from MSD"

3.2. Health systems strengthening (HSS) support

3.2.1. Strategic focus of HSS grant

[Comment on the extent to which the HSS grant contributes to improve coverage and equity in access to immunisation, and how it helps to address the technical, health systems and financial bottlenecks that might jeopardize the sustainability of these gains. See guidance document for more details]

- Improved knowledge and skills through training of health care workers in reaching every child (REC) strategy which addressed health facilities with relatively low accessibility and utilization of immunisation services.
- Improve knowledge and Skills of health care workers throung new comers and refresher trainings
- Support implementation of outreach/mobile services to underserved communities.
- Procurement of refrigerators, cold boxes, Walk-In Cold Rooms (WICR), vehicles, motorcycles and bicycles that led to improved access and utilization of immunization services, especially in hard-to-reach and underserved communities through improved distribution of vaccines and supportive supervision.
- Through supportive supervision, mentorship and community mobilization and sensitization, MR2 coverage increased from 29% in 2014 to 57% in 2015

3.2.2. Grant performance and challenges

[Comment on the relevant bolded areas listed in the table in this section of the guidance document, e.g.: achievements of targets and intermediate results; actual versus planned activity implementation and financial expenditure; use of PBF reward and budgets/plans; degree of participation of key stakeholders in implementation of HSS proposal; implementation bottlenecks and key challenges regarding financial management of HSS grant; compliance with data quality and survey requirements]

Achievements of targets and of intermediate results

The immunization coverage for DTP3 has increased from 97% in 2014 to 98% in 2015. This gain was observed in all other antigens except for MCV2 which was 57% in 2015 and was at 29% in 2014. Improved equity has also been seen in 2015 as outline in section 3.1.1

Performance Based Funding (PBF) reward

The country is due to receive USD 800,000 as a performance based funding reward which is expected to support transition of vaccine handling,storage and distribution at central level.

Actual versus planned activity implementation, based on approved work plan:

- Reach Every district (RED)/Reach every child (REC): RHMTs/CHMTs and health facility workers microplanning training were conducted as planned in which 93 percent of the total budget allocated was utilized.
- Refresher training for regional and districts EPI Managers was conducted whereby 12 percent of the allocated budget was used. Refresher training for health care workers was done with 1.25 percent fund utilized. The process for conducting other training sessions is ongoing.
- Technical Assistance on financial management was provided with 83.13 percent of the allocated fund utilized.
- Funding for programme management to support operational costs was utilized by 60 percent, other operational costs are ongoing.
- ICC and NPEC meetings were conducted as planned with 28 and 98 percent of allocated fund utilized respectively.
- Bi annual progress report writing and documentation was conducted where by 11.67 percent of allocated budget was utilized. Other scheduled meeting was postponed due to GAVI Audit visit in September 2016.
- Only 2% of the funds allocated for support of outreach services in hard to reach districts was utilised.
- Supportive supervision from National to regions/districts was conducted with 92 percent of the allocated budget utilised.
- Supportive supervision from Regions to districts/facilities was conducted by 14.5 percent of the fund used.
- EPI Annual performance review meeting was conducted with 89 percent of the fund used.
- VPD Zonal Surveillance review meetings were conducted whereby 47percent of the allocated budget consumed.
- Two percent of the allocated funds for vehicle maintenance was used. Other funds was postponed until 2017 after shifting cold rooms from MSD to IVD Mabibo.
- Immunization week was conducted as planned and it was used as a platform to reach the last mile children. The allocated fund used was overspent by 35% of the initial estimation.
- Sensitization meetings to 25 SHEHIA Custodium Committees were conducted with 74 percent of the allocated funds utilized.
- Procurement and installation of cold chain storage equipment was conducted in which less than 1% of the fund allocated was used. The remaining will be used for procurement and installation of the cold chain equipment for the health facilities

Participation of key stakeholders

Implementation of activities under the GAVI HSS funds were conducted in collaboration with IVD key stakeholders within the technical working group which includes but not limited to WHO, UNICEF, CHAI,PATH, MCSP/USAID, Lions Club (Rotary) and Tanzania Red Cross.

Implementation bottlenecks, corrective actions, and lessons learned

- There was election campaign between September and October 2015 which interfered with implementation of planned social services activities including immunization activities
- Global competing priorities (Polio Endgame activities) and national events such as emergencies (Cholera outbreak)
- Changes of high level management in the Ministry
- New financial management procedure in the government system

3.2.3. Describe any changes to HSS funding and plans for future HSS applications

[Present the rationale for a new tranche of HSS funds (and the associated amount as per table in section 1) or no-cost extension, or any planned changes in terms of re-allocation or reprogramming]

HSS activities have been revised for improvement of immunisation outcome, coverage and equity, budget reallocation has not reached 25%. The needs has changed since 2012 when the HSS application was done. During the several implementation reviews and JA the Technical Working Group has gone line-by-line through the original budget to identify which activities are still relevant and others that could be re-allocated. Some activities were omitted and new ones were added or modified.
The new activities were;

- Procurement of tools in handling vaccines and related supplies at national vaccines store
- Procurement of temperature monitoring devices
- Support sentinel Surveillance activities (review meetings and strengthen laboratory capacity)
- Support building capacity, operations and meetings of immunization commitees.
- Conduct operational research on Immunization preventable diseases and vaccine management
- Conduct Data Quality Audits and build capacity on DQSA.
- Dissemination of IVD implementation and operational research reports
- Strengthen the distribution of vaccine and supportive supervision.
- Support implementation of REC
- Printing and distribution of data management tools.
- Procurement and installation of cold chain storage equipment for IVD/MSD transition
- Support in VINS roll out

3.3. Transition planning *(if relevant)*

[Comment on all bolded areas listed in the table in this section of the guidance document, e.g. progress of implementation of planned activities; implementation bottlenecks; changes required to the transition plan for coming years, including rationale and costing/proposed financing]

The Country is not yet in transition so this session is **NOT APPLICABLE**

3.4. Financial management of all cash grants*(e.g. HSS, VIG, campaign operational cost grant, transition grant)*

[Comment on the bolded areas listed in the table in this section of the guidance document, e.g.: cash utilization performance and financial capacity constraints; modifications to financial management arrangements; major issues arising from cash programme audits or monitoring review; degree of compliance with Financial Management Requirements]

Cash utilization performance and financial capacity constraints

From 2000-2016 Tanzania received a total of $5,604,801 for implementation of GAVI HSS activities. The country has also received $13,500 for HPV year two demo and $1,599,000 as IPV VIG which have not been utilized due to global shortage of IPV which led to delay in its introduction. The implementation of GAVI HSS activities have been described in Section 3.2.1 and 3.2.2 above respectively

GAVI monitoring team visited Tanzania in March 2016, reviewed financial statements, procedures and provided the necessary comments to work on as a country.

Major issues arising from Cash Programme Audits and Monitoring Review

Some of the challenges in utilization of the HSS and other funds were noted during financial monitoring review and audits and have been continually addressed;

- Delays in transfer of funds from Ministry of Finance to Ministry of Health
- Use of manual accounting and reporting system
- Lack of Memorandum of Understanding (MoU) between MoHSW and sub-implementers
- Lack of monthly/quarterly management accounts
- Delay in commencing external audits of Gavi cash grants

4. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

[Status of top 5 prioritised strategic actions from previous joint appraisal and any additional IRC or HLRP recommendations (if relevant)]

Prioritized strategic actions from previous joint appraisal/HLRP process	Current status
1. Consider change in presentation of vaccines e.g., PCV 4 dose vial	• Country accepted the change • In process for application for Gavi switch support
2. Technical review and consideration of future plans for introductions	• Comprehensive EPI Review 2015 • EVMA 2015 • HPV coverage survey and costing study 2015 • Meningitis risk assessment in 2016 • Yellow fever risk assessment planned in 2017. • HPV countrywide application in January 2017
3. Consideration for long term sustainability of immunization financing	Discussion ongoing within the govenment
4. Plan for rollout and maintenance of Vaccine Information Management System (VIMS)	• VIMS piloted in 7 regions since July 2016.
5. Agree on use of PBF reward payment (USD800,000) to improve programme performance	• PBF funds to be used to support the transition of vaccine handling, storage and distribution at National centrre store.

5. PRIORITISED COUNTRY NEEDS[1]

[Summarise the highest priority country needs and strategic actions that could significantly improve coverage, equity and financial sustainability; the timeline for completing the actions and the type of technical assistance needed if applicable – see guidance document for more details]

Prioritised needs and strategic actions	Associated timeline for completing the actions	Does this require technical assistance?**(yes/no)* If yes, indicate type of assistance needed

[1] Subsequent planning and discussions on Targeted Country Assistance will take place - detailed guidance on the process will be shared in May 2016.

To reach unvaccinated and under vaccinated; • **Identify unreached children** • **Increase demand by creating community awareness for immunization services** • **Intensification of the routine immunization services by ensuring access and utilization of services**	**Ongoing**	**YES** • Building the capacity of CHMT and Health Facilities Health Workers on the REC Components. • Support the monitoring of the implementation of REC strategy • Evaluation of the REC Startegy and update the implementation approach and quality improvement issues • Review the REC strategy to include the districts with high coverages which are above 100% with unvaccinated and under vaccinated children
Improve data quality, management and use at all levels • **To build capacity on Data Quality Self- Assessment** • **Build capacity on use of data for action** • **Data Quality Audits**	**Ongoing**	**YES** • Building the capacity of Data Quality Self-Assessment of RHMT, CHMT and Health Facilities Health Workers. • Support the preparation of the Data Quality Audit next financial year. • Build the capacity in the use data for action at all levels.
Ensured regular availability of potent IVD vaccines in all health facilities providing vaccination services • **Increasing cold chain storage capacities to all levels** • **Procurement and distribution of vaccines** • **The procurement and use of temperature monitoring devices at all levels** • **Build capacity in the cold chain and vaccine management**	**Ongoing**	**YES** • Facilitate the Cold Chain biannual inventory and update the replacement plan • Build capacity of vaccine management at all levels • Build capacity in the cold chain management.
Strengthen vaccines preventable diseases surveillance and preparedness for prompt outbreaks response	**Ongoing**	**YES** • Support the NVS Sentinels Sites and National Lab with reagents and supplies to facilitate timely testing of the specimen • Building the capacity and monitor the performance of Labs • Facilitate quality assurance (internal and external) and supportive supervision to the labs. • Support the quarterly performance reviews of the Sentinel Sites • Enhance collaboration bwtween labs and regional reference labs (networking) • Assistance to VPD case based surveillance improvement and

		outbreak investigation and response.
support transition of handling, storage and distribution of vaccines at national vaccine store	**Ongoing**	**YES** • Building capacity in the vaccine management • Technical support in the operationalization of the transition process
Application for Country wide introduction of HPV	**Ongoing**	**YES** Facilitate the application process for country wide introduction of HPV
Implementation of the HSS grant, costing and financial sustainability, management support to Immunization Committees and NITAG, specific grant programmes management	**Ongoing**	**YES** • Build the capacity and facilitate the operations of NITAG, National AEFI Committees • Provide technical support on the management and operationalization of ICC for both Tanzania Mainland and Zanzibar • Technical support in the immunization related costing and financial sustainability • Provide technical support on the management and implementation of HSS grant and other specific grants
Application for CCOEP support	**Ongoing**	**YES** Facilitate the application process for CCOEP

**Technical assistance not applicable for countries in final year of Gavi support*

6. ENDORSEMENT BY ICC, HSCC OR EQUIVALENTAND ADDITIONAL COMMENTS

This section does not need to be completed for joint appraisal update in interim years, instead the EPI manager is expected to endorse the joint appraisal report.

Brief description of how the joint appraisal was endorsed by the relevant national coordination mechanism	Not applicable
Issues raised during debrief of joint appraisal findings to national coordination mechanism	
Any additional comments from: • **Ministry of Health** • **Gavi Alliance partners** • **Gavi Senior Country Manager**	

7. ANNEXES

This section does not need to be completed for joint appraisal update in interim years. Please include the following Annexes when submitting the report, and any others as necessary

Annex A. Description of joint appraisal process (e.g. team composition, how information was gathered, how discussions were held)

Annex B: Changes to transition plan *(if relevant)*

Changes proposed	Rationale for changes	Related cost (US$)	Source of funding for amended activities	Implementation agency	Expected result