Joint Appraisal report 2017

The italic text in this document serves as guidance, it can be deleted when preparing the Joint Appraisal report.

Country	The United Republic of Tanzania
Full Joint Appraisal or Joint Appraisal update	Full Joint Appraisal
Date and location of Joint Appraisal meeting	10th -12th October 2017, Dar es Salaam, Tanzania
Participants / affiliation[1]	Ministry of Health, MoF, PORALG, Gavi, KfW, UNICEF, CHAI, WHO, USAID, PATH, AMREF, CDC, MCSP/JSI, Gates Foundation, TFDA, MSD RIVO, DIVO
Reporting period	1st July 2016 to 30th June 2017
Fiscal period[2]	1st July 2016 to 30th June 2017
Comprehensive Multi Year Plan (cMYP) duration	2016-2020

1. SUMMARY OF RENEWAL AND EXTENSION REQUESTS

1.1. New and Underused Vaccines Support (NVS) renewal request(s)

Type of support (routine or campaign)	Vaccine	End year of support	Target (population to be vaccinated)	Indicative amount to be paid by country	Indicative amount to be paid by Gavi
NVS - Routine	IPV in existing presentation	2018	1,967,722	US$ 0	US$ 3,964,500
NVS - Routine	Rotavirus in existing presentation	2020	2,116,880	US$ 712,000	US$ 6,683,000
NVS - Routine	PCV in existing presentation	2020	2,116,880	US$ 1,386,500	US$ 20,194,500
NVS - Routine	Pentavalent in existing presentation	2020	2,116,880	US$ 1,130,500	US$ 3,508,000
NVS - Routine	Measles in existing presentation	2019	1,856,797	US$ 859,421	US$ 797,500

1.2. New and Underused Vaccines Support (NVS) extension request(s)

Type of Support	Vaccine	Starting year	Ending year
N/A			

[1] If taking too much space, the list of participants may also be provided as an annex.
[2] If the country reporting period deviates from the fiscal period, please provide a short explanation.

1.3. Health System Strengthening (HSS) renewal request

Total amount of HSS grant	US$ 13,512,765
Duration of HSS grant (from…to…)	2014 – December 2018
Year / period for which the HSS renewal (next tranche) is requested	2018
Amount of HSS renewal request (next tranche)	US$ 2,639,761

1.4. Cold Chain Equipment Optimization Platform (CCEOP) renewal request

.**Total amount of CCEOP grant**	N/A	
Duration of CCEOP grant (from…to…)		
Year / period for which the CCEOP renewal (next tranche) is requested		
Amount of Gavi CCEOP renewal request	US$	
Country joint investment	**Country resources**	US$
	Partner resources	US$
	Gavi HSS resources[3]	US$

1.5. Indicative interest to introduce new vaccines or request Health System Strengthening support from Gavi in the future[4]

Indicative interest to introduce new vaccines or request HSS support from Gavi	**Programme**	**Expected application year**	**Expected introduction year**
	HPV	2017	2018
	IPV	2014	2018
	CCEOP	2017	2018
	HSS-II	2018	2019
	MR Campaign	2018	2019
	Men A	Pending Risk Assessment	Pending Risk Assessment
	Yellow Fever	Pending Risk Assessment	Pending Risk Assessment

[3] This amount must be included either in an earlier HSS approval or else in the current HSS renewal request in section 1.4 above.
[4] Providing this information does not constitute any obligation for either the country or Gavi, it merely serves for information purposes.

2. CHANGES IN COUNTRY CONTEXT SINCE LAST JOINT APPRAISAL

Tanzania has remained stable and peacefully without significant changes in country context since the 2016 Joint Appraisal. There has been no any natural disaster, political instability, displaced populations, inaccessible regions, macroeconomic trends or disease outbreaks that could directly affect the performance of the immunization system countrywide.

The country has been hosting refugees from neighboring countries (DRC and Burundi) whom we have been sharing immunization resources. The number of refugees has been increasing each year due to ongoing instability in the neighboring countries and this has brought a challenging situation in Tanzania in terms of vaccines for this special group of population

Structurally, the Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) works closely with the President Office, Regional Administration and Local Government (PORALG). PORALG is has strengthened its capacity in health and has established the Immunization section in 2016 whose main role is to oversee the implementation at sub-national level of health policy and guidelines developed by the MoHCDGEC. Capacity of PORALG however remains limited and the majority of oversight responsibilities lie with the RMO/DMO and RIVO/DIVO. MoH and PORALG have developed their respective roles and responsibilities.

The government of Tanzania is currently in the process of shifting from Dar es Salaam to Dodoma. This shift is in phases and is expected to be completed in 2020. The Ministry of Health, Community Development, Gender, Elderly and Children management and some departments have already shifted to Dodoma. The Epi Program is also expected to shift as well and this will have an implication in terms of vaccine arrival at the airport (Located in Dar es Salaam) and distribution to sub-national level.

Due to the higher cost and several weaknesses observed during the EPI review and EVM assessment conducted, it was proposed to shift the CVS from MSD to IVD. Following the recommendations, the Management of the Ministry of Health Community Development, Gender, Elderly and Children on 28/09/2015 instructed MSD to hand over the CVS to IVD. A road map was developed and committee was established to oversee this process of shift.

3. PERFORMANCE OF THE IMMUNISATION SYSTEM IN THE REPORTING PERIOD

3.1. Coverage and equity of immunization

Background information

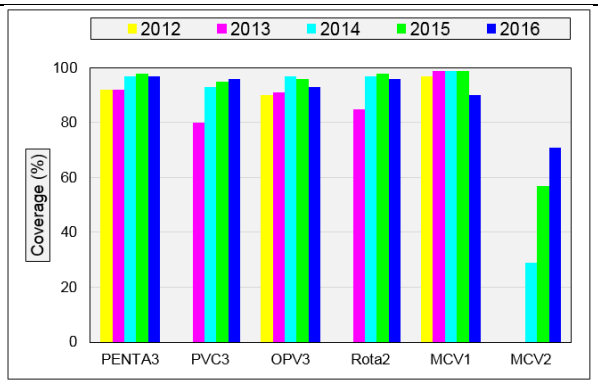
All activities implemented in reporting year were in line with 2016 and 2017 Annual Plans which are derived from the Country comprehensive Multi-year plan (cMYP) 2016-2020. The focus was mainly to achieve the global and regional goals of disease eradication and elimination, maintain high immunization coverage of all antigens, expand immunization service to life course approach, reducing vaccine preventable diseases through new vaccine introductions, adopting and updating new technology in cold chain, and data management.

The number of Councils has increased from 179 in 2015 to 194 in 2017 necessitating increase of new council/district vaccine stores that require additional resources (human resources, finances, infrastructures, vehicles, cold chain equipment, etc). The number of health facilities providing immunization services has also increased from 5,650 in 2015 to 6,029 in 2017 aiming at reaching to every child equitably.

One of the major challenges in health services is unrealistic distribution of projected target population across regions and districts from NBS. One of the efforts of the Government and immunization partners to address this challenge is scaling up of electronic registry and immunization systems that will help accurately project and distribute the population in regions and districts.

Coverage and equity of immunization

The country has managed to maintain high immunization coverage of over 90% of all antigens in the three consecutive years at national level except newly introduced MCV 2. This is due to low community awareness of vaccination services beyond one year of life. Ongoing advocacy and communication is essential in attaining the desired MCV2 coverage The chart below shows the trend of national vaccination coverage from 2012 to 2016 of selected antigens.

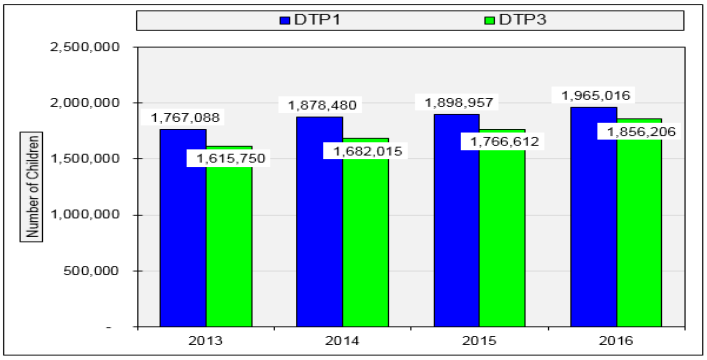


In 2016, the national target was to reach 1,921,328 surviving infants of which;

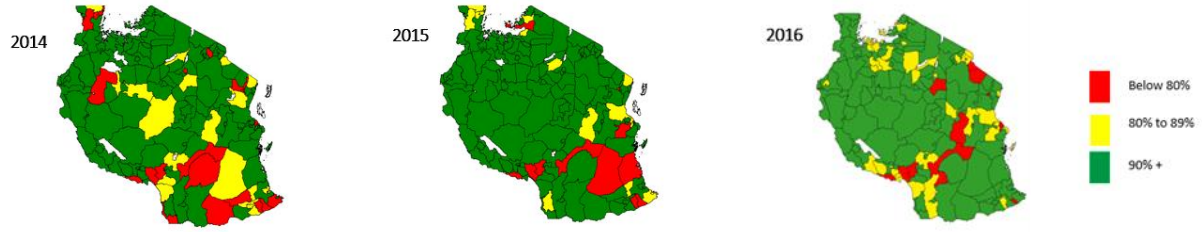
- DPT3 coverage was 97% with drop out of 6%
- PCV13 3 coverage was 96% with drop out of 6%
- Rotavirus 2 coverage was 96% with drop out of 7%
- Measles Containing Vaccines 1st dose coverage was 90%
- Measles Containing Vaccines 2nd dose coverage was 71%

In Kilimanjaro region, HPV Vaccine coverage for girls aged 9 years old (22,054) was 76% for HPV 1st dose and 65% HPV 2nd dose with drop out of 11%.

The detailed analysis has shown that the absolute figures of the children vaccinated have been increasing in the past four years using DPT1 and DPT 3 as it shown in the chart below.



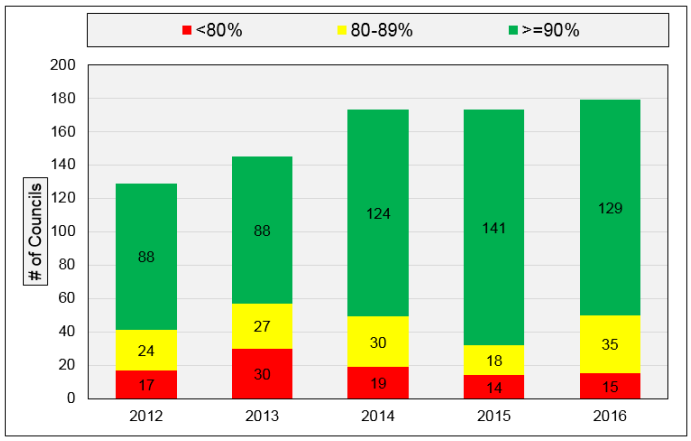
The maps below show the trend of DPT3 coverage by councils for the period between 2014 and 2016 respectively, which shows significant progress of Tanzania's efforts to enhance equity in immunization coverage.



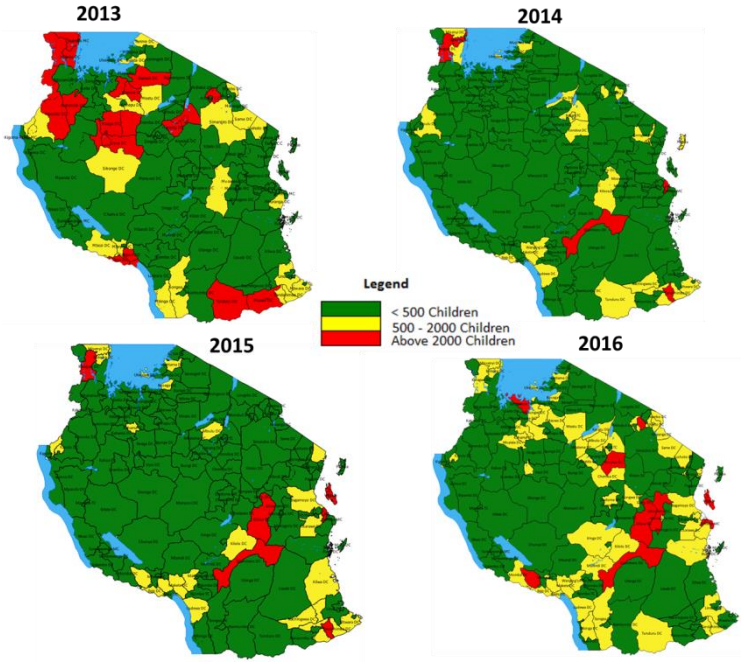
The number of councils with administrative coverage above 90% has increased by 4% from 2012 to 2016, while the number of councils with DTP3 coverage below 80% decreased by 5% from 2012 to 2016.
In 2009 55 districts showcased DTP3 coverage below 80 percent. In 2016, only 15 districts reported coverage below 80% coverage, indicating almost 3/4 reduction in underperforming districts since 2009. The low performing districts are being prioritized to increase their coverage, eg through CCEOP support.

The chart below shows the trend of number of councils in the coverage categories of above 90%, 80 to 89% and those below 80%.

The number of districts with coverage between 80-89% did increase from 18 in 2015 to 35 in 2016. This might be related to the creation of new districts and their need for additional resources. Yet further assessment is needed to understand this trend.



The map below shows the trend of unvaccinated children using the DPT1 by districts from 2013-2016



Vaccine Preventable diseases' cases:

- **Polio**

The last polio case was seen in 1996. The Country has been implementing polio eradication initiative activities by maintaining high national coverage of routine OPV 3 above 90% for the past ten years.

The number of AFP cases reported in 2016 by region is as shown in the table below;

Region Name	Expected AFP Cases	Reported AFP cases	AFP Detection Rate	Non-Polio Detection Rate	Stool Adequacy	N-PENT Rate
ARUSHA	17	32	3.8	3.2	100	6.3
DAR ES SALAAM	44	44	2.0	1.5	100	6.8
DODOMA	20	43	4.2	3.0	100	4.7
GEITA	17	24	2.8	1.7	96	12.5
IRINGA	9	25	5.6	4.0	100	0.0
KAGERA	25	57	4.6	3.8	100	5.3
KATAVI	6	14	4.9	2.8	93	0.0
KIGOMA	21	39	3.7	2.8	100	7.7
KILIMANJARO	13	25	3.8	2.1	100	0.0
LINDI	8	60	14.7	12.7	100	0.0
MANYARA	14	15	2.1	0.7	100	6.7
MARA	19	37	4.0	2.5	100	8.1
MBEYA	27	51	3.8	3.4	100	19.6
MOROGORO	21	21	2.0	1.5	100	9.5
MTWARA	12	38	6.3	4.0	100	7.9
MWANZA	29	106	7.4	6.3	100	10.4
NJOMBE	7	9	2.7	1.8	100	0.0
PEMBA	4	4	2.1	1.1	100	0.0
PWANI	11	21	3.9	2.6	100	9.5
RUKWA	10	31	6.1	4.3	97	9.7
RUVUMA	13	31	4.6	3.4	100	0.0
SHINYANGA	15	41	5.4	3.4	100	7.3
SIMIYU	16	38	4.8	3.9	100	5.3
SINGIDA	13	24	3.6	2.2	97	4.2
TABORA	23	35	3.1	1.8	100	2.9
TANGA	20	62	6.2	4.7	100	12.9
UNGUJA	9	12	2.7	2.2	100	8.3
TOTAL	444	939	4.2	3.1	100	7.1

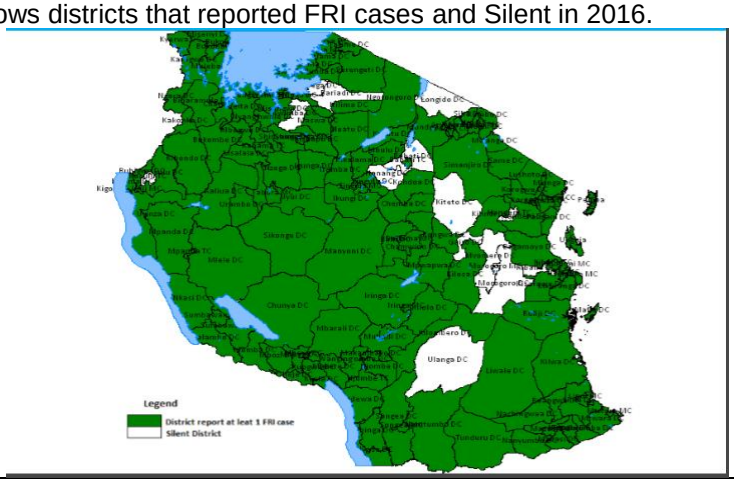
- **Measles**

  In 2016 about 91% (152) of districts reported at least one case of Non Measles Febrile Rash Illness (NM FRI) while 15 districts were silent. A total of 1279 suspected cases were reported, of which 28 were confirmed positive for measles. Negative measles cases when tested for Rubella, 22 were positive.

  The table below summaries the number of suspected non measles febrile illness cases by regions in 2016.

Region	Number of Districts	% of Districts with at least 1 Case with blood specimen (target: >=80%)		Suspected Measles Cases Reported	Confirmed Measles cases		*Non Measles FRI Rate (2:100,000)	Number of IgM Rubella Positive cases
		Number of Districts that have reported Supected Measles Case	Districts with Cases		Number of IgM Measles Positive cases	Incidence of Measles Case (<1:1000000)		
ARUSHA	7	6	85.7%	62	0	0.0	2.9	3
DAR ES SALAAM	3	3	100.0%	55	4	0.8	0.8	2
DODOMA	7	7	100.0%	63	8	3.5	1.7	1
GEITA	5	5	100.0%	55	0	0.0	1.8	0
IRINGA	5	4	80.0%	32	1	1.0	2.6	0
KAGERA	8	8	100.0%	60	1	0.4	1.4	0
KATAVI	4	4	100.0%	54	0	0.0	6.7	2
KIGOMA	8	7	87.5%	53	0	0.0	1.6	0
KILIMANJARO	7	7	100.0%	57	2	1.1	2.6	1
LINDI	6	6	100.0%	60	0	0.0	4.4	1
MANYARA	6	3	50.0%	14	1	0.6	0.6	0
MARA	8	8	100.0%	41	2	1.0	1.9	0
MBEYA	11	11	100.0%	108	0	0.0	3.0	5
MOROGORO	7	2	28.6%	13	1	0.4	0.4	0
MTWARA	8	8	100.0%	102	2	1.5	4.8	2
MWANZA	7	7	100.0%	47	0	0.0	1.3	0
NJOMBE	6	6	100.0%	89	0	0.0	4.8	0
PEMBA	1	1	100.0%	2	0	0.0	0.2	0
PWANI	7	6	85.7%	26	0	0.0	1.7	0
RUKWA	4	4	100.0%	26	0	0.0	1.1	0
RUVUMA	6	6	100.0%	36	2	1.3	1.5	0
SHINYANGA	7	6	85.7%	25	0	0.0	0.6	1
SIMIYU	5	3	60.0%	10	0	0.0	0.5	0
SINGIDA	6	6	100.0%	45	1	0.7	2.3	0
TABORA	7	7	100.0%	50	3	1.2	1.0	0
TANGA	10	10	100.0%	91	0	0.0	3.2	4
UNGUJA	1	1	100.0%	3	0	0.0	0.3	0
TOTAL	167	152	91%	1,279	28	0.6	1.8	22

The map below shows districts that reported FRI cases and Silent in 2016.



- **Rotavirus**

Rotavirus vaccine was introduced in 2013. Diarrhea gastroenteritis surveillance is done in 13 hospitals from all geographical areas in the country to assess the disease burden and impact of vaccine.
The following have been found

- A notable reduction of 40% infants' hospitalization related to diarrhea gastroenteritis has been observed.
- Vaccine effectiveness is 57% and with the high coverage of more than 95% for the two doses;
- There is reported reduction on the use of Antibiotics among clinicians
- G1P [8] and G2P [4] still predominates among the circulating genotypes as it was before vax introduction.
- 2016 data show 18% of hospitalizations due to Rotavirus but there is no information what the causes for the other 82% are.

Generally, the surveillance has been complementing GHSA through strengthening of Laboratory services and Human resources capacity both at the National and sub-national levels

3.2. Key drivers of low coverage/ equity

Key driver of low coverage

Only 15 Councils in 2016 had DPT 3 coverage less than 80%. Table shows the region and the districts

TANZANIA MAINLAND	
Dar es salaam	Kinondoni MC
Dodoma	Kondoa DC
Kilimanjaro	Mwanga DC
	Same DC
Mbeya	Ileje DC
Morogoro	Kilombero DC
	Kilosa DC
Mtwara	Nanyamba DC
Njombe	Wanging'ombe DC
	Makete DC
Pwani	Mafia DC
Tanga	Korogwe TC
ZANZIBAR	
Urban West	West
North Unguja	North B
South Unguja	South

However, it has been noted that four councils (Kilombero DC, Korogwe TC, Wangin'gombe and Makete DC) have had persistently low coverage for three years consecutively while five councils (North B, West, Kinondoni, Tandahimba, Newala DC and Ileje DC) had low coverage in two consecutive years

Key Drivers for low Coverage/Equity:

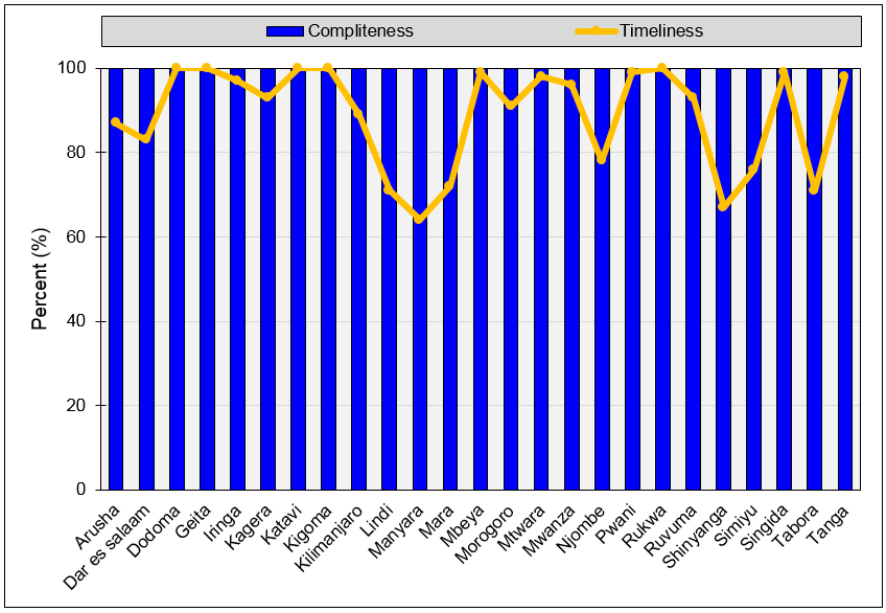
- Target population
  - Most of the councils have reported inaccurate target population given to be either higher or low compared to consumption rates.
- Shortage in human resource:
  - Human resource has been a challenge in the health sectors especially in the rural health facilities. This has affected some of the outreach services to be not implemented.
  - Of recent the situation became more critical because of the qualification verification exercise the lower carder providing immunization services was mostly affected in some of the councils.
- Vaccine stock outs
  - Stock out of vaccines and other vaccine related commodities in some of the health facilities due to delayed distribution
- Cold chain problem
  - Shortage of LP Gas in some facilities leading to sessions to be postponed
  - Non-functional of the fridges because of technical problem in some of the health facilities
- Limited Funds for outreach services
  - Cancellation of planned outreach and mobile services in some of the councils because of budget constraints.
- Equity
  - Immunisation services for all vaccines are equally provided for boys and girls; however, there are some regional differences between rural and urban. The differences have 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. Further improvements in data systems such as EIS is expected to contribute to reaching un/under immunized children.
  - Tanzania host refugee community from neighboring countries (Burundi and DRC) who are not included in the national target population used for projecting vaccine requirement. Support from UNICEF who currently supports refugees is limited. UNICEF has requested GAVI to support the vaccine needs of refugees especially underutilized and new vaccines, in line with Gavi's revised fragility policy. The request for refugee will be included in Tanzania's NVS request for 2018. UNICEF will cover the co-financing costs for the vaccine doses provided to refugees, yet further discussions with the GoT are required to include the refugee population into their target population for immunisation.

3.3. Data

- **Data availability**

Administrative data for routine immunization are collected from health facilities using standardized paper based tools; mainly Tally sheets, child registers and home-based record cards like RCH-1. All these tools are summarized into EPI monthly summary form at the end of the month and submitted to district level where it entered and summarized into excel based DVDMT tool. The country has adopted the MOH/WHO reporting schedule whereby reports from facilities to districts is by 7th, from district to regions by 15th, from region to National MOH-IVD is by 30th of a month, from National MOH-IVD to WHO/IST is by 7th of the next month.

Timeliness and completeness is monitored at all level to ensure availability of data. The chart below shows timeliness and completeness in 2016 by region.



The challenges of availability of data are

- Delay submission of health facility data at district level due to geographical location of facilities and communication
- Existence of multiple data collection tool at health facilities from other program
- High turnover of human resource

- **Data Quality**

The country conducted biannual immunization data desk review and harmonization in November 2016 and March 2017 involving regional and district immunization and vaccination officers, for purpose of to review completeness and data harmonization. The exercise revealed the following;

- Untimely submission of health facility and district reports
- Incompleteness of reports
- Duplication of data
- Outlier
- Denominator issues
- Inconsistence of data

- **Use of data**

Some of health facilities and districts don't use data for action. The main challenges are;

- Low capacity of health workers to analyze data
- Lack of training of data management to new comers
- High turnover of trained staff

- **Main effort, innovation and good practice**
    - Some districts such as Iramba DC and Singida rural have been providing transport allowance for timely submission of report.
    - Data review meetings are now conducted to some districts quarterly in Arusha, Dodoma, Geita, Lindi, Ruvuma, Tabora, Simiyu and Kagera.
    - Training of Reaching Every Child strategy accelerate data use at facility level and address equity related issues
    - National data review and harmonization meetings address outliers, duplicate, incompleteness and inconsistence issues.

The IVD program has embarked on using technology and innovations in existing data quality challenges, primarily

- Timelines and completeness and accuracy of reports
- Limited stock visibility of at district and health facility level,
- Identifying and tracing defaulters across the various facilities,
- Uncertain denominators,
- Multiple duplicate reporting and data collection tools (DVDMT, SMT, CCIT monthly report and HMS report and DHIS 2) and limited data use capacity,

The data innovations are driven by strong political commitment and leadership by the GoT to improve data for health which has been etched in Tanzania's Data Utilization Partnership to digitize Tanzania's health information systems and improve health data in the country

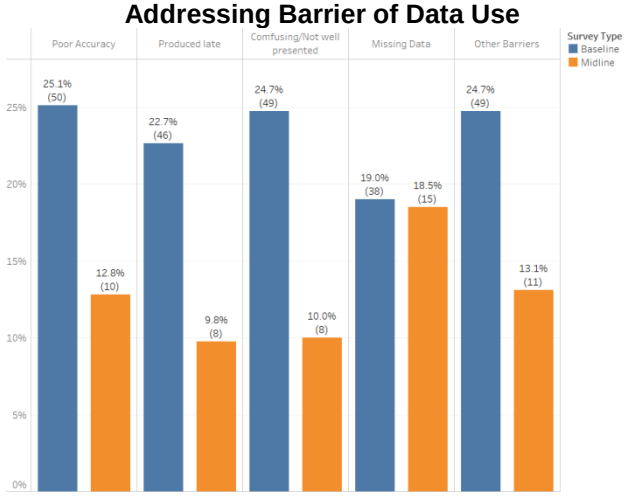
IVD, through partner support, developed an Electronic Immunization systems (EIS) which is an integration of Vaccine Management Information System (VIMS) that manage consumption, cold chain and stock at district to national level and the Electronic Immunization Registry (EIR) System (also known as BID), which collects individual child immunization records and schedule, and stock data at health facility level. To note: VIMS has integrated multiple reporting tools (CCIT, SMT, DVDMT and the monthly EPI reporting form).

The development and testing phase is complete and now is at stage of scaling up. EIS has been integrated with DHIS2 and is working towards integration with CRVS birth registry system in 2018.

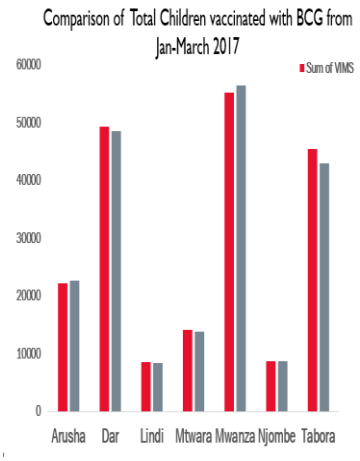
- Currently EIS in use to improve defaulter tracing, timely submission of data and on analysis at all level in Arusha and Tanga regions with subsequent rollout in Dodoma and Kilimanjaro by end of the year.
- Due to financial deficit to scale EIS nationally, IVD had prioritized scale of Vaccine Information Management System (VIMS) in 15 regions.
- The IVD program has planned to scale EIS into six more regions covering 38 district councils and 1,250 health facilities by 2018 (20% of all HFs) while prioritize scale up of VIMS into 11 remaining regions by end of 2018.
- The program plans to cover the remaining regions with EIS under HSS 2 grant support by year 2019.

- Initial Impact of EIS implementation.

Addressing Barrier of Data Use



Improved Timeliness and Completeness



	Jan-17	Feb-17	Mar-17
Reporting	99%	99%	98%
Timeliness	86%	90%	89%

Region	BCG Vaccinated (VIMS)	BCG Vaccinated (DVDMT)
Arusha	22245	22598
Dar	49305	48568
Lindi	8598	8371
Mtwara	14081	13823
Mwanza	55320	56569
Njombe	8663	8753
Tabora	45528	43024
Grand Total	203740	201706

3.4. Role and engagement of different stakeholders in the immunisation system

National coordination forum

- **ICC**
  ICC is immunization advisory, monitoring and resource mobilization body and has direct link to National Health Sector Technical Committee that is chaired by permanent secretary and members are representative from immunization partners, CSO and other line Ministries and President's Office Regional Administrative and local Government (PORALG). ICC meets quarterly and can conduct ad hoc meeting when need arise

- **NITAG (also known as TITAC in Tanzania)**
  Is independent body of experts providing technical advice to the Government on new vaccines and innovation and other programmatic issues related to immunization.

- **National Polio Committee (NCC, NPEC, NTF)**
  Independent body responsible for monitoring the implementation of polio eradication activities in the country

- **National AEFI committee**
  This body is responsible for monitoring vaccine safety

- **IVD Technical Working Group (TWG)**
  Secretariat to all immunization related body and its members are the technical representatives from all immunization partners and IVD.

CSO

Some of CSOs who run health services also provide free immunization services in the health facilities. Those with national office are members of ICC and those with office at subnational level are member of regional and district PHC.

Other donors support:

The table below summarizes the specific area of support for each of the key immunization partner

Partners	Area of support in the program	Comparative Advantage	Remarks
WHO	Overall program support	Overall program management support (policy, strategic planning and evaluation) - Routine Immunization - Data management - Surveillance - Logistic - New vaccine introduction - Capacity building	- Funding for polio activities have been reduced significantly and the number of staff will be reduced and zonal office will be closed.
UNICEF	• Vaccine Supply Chain & distribution • Advocacy and communication	- Overall program support, vaccine and equipment procurement and supplies. - Immunization equity interventions - Demand generation - Cold Chain Management and Maintenance	
CHAI	• Immunization Strategic Planning and Execution • Vaccine Logistics, supply chain and distribution	- Cold chain management and maintenance - Supply chain tools and vaccine distribution - Data management system - Strategic Program change management - Planning immunization activities at all levels (national and Subnational level) cMYP, Annual Planning and CCHPs and monitoring its implementations - Accountability on Immunization - Capability building including eLearning and Videos	
USAID (JSI – MCSP)	Program service delivery Communication Vaccine supply chain and distribution Data management Capacity building	- Program service delivery support, RED/REC strategy implementation - Advocacy and communication - Human resource capacity development - Routine data management tools, systems and quality	
PATH	Data management systems and tools	- Routine data management tools and systems - Data use interventions - Systemic demand generation interventions	
AMREF &	Service delivery	- Community based engagement interventions	
RED CROSS	Service delivery	- Community based engagement interventions	
kfW	Vaccine availability	- Procurement of newly introduced vaccine	Funding through EAC/GAVI

Private sectors

Private health facilities providing immunization services (private, FBO, NGO) receive from Government vaccine, cold chain equipment and related supplies to provide free immunization services. Also, they are supported on the trainings of their health care workers on immunization guideline.
Private sectors also participate during campaigns and support services in areas where government facilities are not available.

- **Cross-sectoral collaboration**:
  Inter-sectoral collaboration and is very high between ministry of health and PORALG in the implementation of immunization policy and guideline at subnational level. Please add detail on roles and responsibilities
  There is high collaboration with other ministries education, information during the PIRI and campaign

4. PERFORMANCE OF GAVI GRANTS IN THE REPORTING PERIOD

4.1. Programmatic performance

Gavi support has reduced the number of low performing councils (DPT3 below 80%) from 17 out of 129 (13%) in 2012 to 15 out of 179 (8%) in 2016. The introduction of Rotavirus vaccine, Pentavalent and PCV 13 have contributed significantly in the reduction of infant mortality making Tanzania among the few countries that achieved MDG4 goal.

The Country has achieved in most of the agreed grant performance framework indicators as indicated on the table below:

1. Achievements against agreed targets

SN	Indicator	Agreed Target	Achievement	Bottlenecks	Actions
1	National vaccination Coverage • DTP 3 • PCV 13-3 • Rota 2 • MCV 1 • MCV 2	91% 91% 91% 100% 81%	97% 96% 96% 90% 71%	Stock out of MCV due to delay in procurement of MCV. This has since been resolved	Redistribution of vaccines in areas that was experiencing stock out
2	Dropout rate • DTP 1 – DTP 3 • PCV 1 – PCV 3 • Rota 1 – Rota 2 • MCV 1 – MCV 2	1% 1% 1% 18%	6% 6% 7% 21%	Low awareness among caretakers, community and health care workers on when the last MCV dose should be given. Inadequate defaulters tracing mechanism in some health facilities in second year of life.	Enhance healthcare workers and community sensitization on the second dose of MCV
3	% District with Penta 3> 95% % District with Penta 3> 80% % District with Penta3 50%-80%	- 87% -	54% 92% 8%		

4	Occurrence of Stock out at National or district level	No	Yes	Delay in procurement of MCV resulted in stock out to some health facilities that was linked to national level	Redistribution of vaccines in areas that experienced stock out
5	Timely fulfilment of co-Financing commitment for all Gavi supported vaccine	Yes	Yes	Delay disbursement of fund resulted to later payment, yet still by the end of 2016.	
6	% of District receive at least one supervision by IVD TWG	90%	90%		
7	% of planned outreach conducted	80%	82%	Inadequate fund for outreach allowance and transport	Advocacy done to increase fund allocation for outreach services
8	Timeliness of district reporting	80%	89%		
9	Completeness of district reporting	85%	100%		
10	% of district with DTP1 to DTP3 dropout rate >10%	10%	19%	In adequate defaulter tracing mechanism, Missed opportunity in some district due seasonal inaccessibility, Staff turnover, Cold chain break down	Institutionalize defaulter tracing mechanism
11	% of District reporting wastage rate < 10%	100%	93%	Cold chain failure, Knowledge gap on vaccine management	Capacity building was done on vaccine management
13	% of health facility equipped with functional refrigerators	85%	83%	Formation of new health facility. Some of health facilities have outdated refrigerators contributing to frequent breakdown.	Consideration was made to these facility during application of CCEOP

Overall implementation progress of Gavi grants (**NVS**, **HSS, PBF** and **CCEOP**)

- **Gavi HSS grant:**

The country was awarded a total of USD 13,512,765 Gavi HSS fund. Since 2014, Gavi disbursed a total of a HSS funds USD 5,604,801.00 (tranche 1 USD 3,786,840 and half of tranche 2 USD 1,817,961). Total expenditure as of July 2017 is USD 4,478,534.00 (80% of disbursed fund). The remaining funds from HSS grant (USD 9,034,231) include the in-country balance of US$1,1M and US$7,9 yet to be disbursed. UNICEF will manage the remaining HSS funds of $6,965,406 on behalf of the government, until the challenges in financial management are addressed as highlighted in the Gavi audit and Programme Capacity assessment. The in-country balance will be used for procurement items. As agreed by Gavi. In addition, Gavi will directly handle the remaining funds for the CCEOP co-payment ($754,220 HSS + $1,6M PBF 2016)) and CCEOP procurement fee ($ 188,338). The HSS budget has been reallocated to prioritize fast expenditure activities before the grant closure in December 2018. UNICEF and MOH will need to coordinate closely to ensure utilization of the remaining HSS funds. Any funds left unused by the end of 2018 can no longer be used by Tanzania.

Tanzania has requested approval of the last tranche of the HSS grant (US$ 2,639,761) to be reviewed for approval by Gavi. Considering the support from UNICEF (capacity will be increased) and following the budget reallocation higher utilization is expected with activities of large item such as procurement (vehicles, cold chain equipment, tablets for BID, etc.), BID/VIMS roll-out, the co-payment of CCEOP and programme management activities (Trainings, supervision, etc.).

Gavi HSS grant has been used to implement number of activities that have impacted the health system and specifically immunization through:

- Reaching every child strategy that were implemented in 610 low performing health facilities around the country to ensure unvaccinated children are reached
- Refresher training was conducted to 58 immunization health workers from regions and Councils.
- 82% of the planned outreach were conducted in identified 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
- Procurement and installation of cold chain equipment and vehicle maintenance.
- Procurement of equipment to support immunization services (laptops, printers, scanners)
- Supportive supervision, mentorship and community mobilization and sensitization to low performing regions and districts.
- Support functions of coordinating committee (ICC, IVD-TWG, NPEC).
- Conduct bi annual progress review meeting (bi annual progress report writing, development of immunization bulletin)
- Support immunization week,
- Support Zonal VPD Surveillance review meetings.
- Support internal and external audits

- **PBF and CCEOP:**

In 2015, the country was awarded Performance Based Funding (PBF) amounting to USD 800,000.00 which is expected to support transition of vaccine handling, storage and distribution from central vaccine store (MSD) to IVD-Mabibo. The transition will help to reduce the cost of vaccine handling that was initially incurred by the Ministry. Following the audit outcome, CHAI will manage the 2015 PBF on behalf of the government and the grant agreement is in process. The 2016 PBF award amounting to USD 1,600,000.00 will be used to co-finance the approved CCEOP. These funds will be handled directly by Gavi for the requested payment to UNICEF supply division. However, these funds have not been disbursed.

- **NVS:**

HPV demonstration project was successfully implemented in Kilimanjaro region in which the program was able to attain high coverage of 81% for the first dose and 53% for the second dose (January to June 2017). The lessons learnt from demonstration will be used during national rollout which its application has been approved by Gavi. The country applied and approved by Gavi to introduce HPV vaccine countrywide in routine immunization. The introduction will include Multi age Cohort of 9 to 14 year girls in the first year of introduction and 9 year girls in subsequent years in routine immunization.

The country received VIG for IPV introduction in 2014; however funds have not been utilized due to global IPV shortage. Following the audit outcome, the in country IPV funds will be managed by UNICEF. A solution is sought to transfer the funds from the Government to UNICEF CO. The current plan is to introduce IPV in to routine in 2018 and conduct a catch-up campaign for the two missed cohorts in 2019. Tanzania decided against the use of fractional dose due to programmatic challenges.
Considering the recent outbreak of VDPV2 in Democratic Republic of Congo, TITAC have recently advised the government to consider introduction of IPV, to reduce the risk of importation of cVDPV. However, extensive surveillance has been conducted in six regions of Mbeya, Kigoma, Katavi, Songwe, Kagera, Rukwa and Kigoma.

Measles rubella progress

The country is in the elimination phase implementing the Global Measles Rubella elimination strategic plan 2012 - 2020. The Measles Rubella 5-year plan is integrated in the country multiyear plan 2016 – 2020.

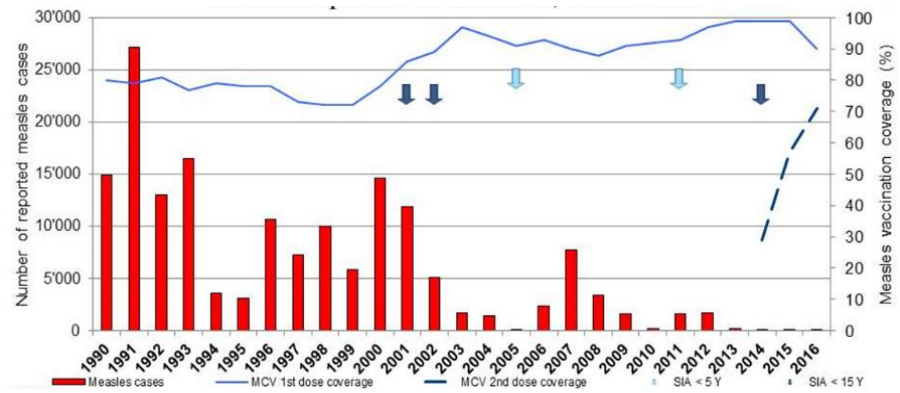
Second dose of Measles was introduced in May 2014, and Rubella vaccine introduced in October 2014 starting with follow up campaign of 9moths to 15 years, followed by introducing into routine immunization schedule in April 2015, combined with measles. The MCV1 coverage has been persistently high for the past five consecutive years for more than 90%. MCV2 coverage is increasing gradually since introduction. However, the MCV1 coverage in 2016 decline to 90% from 103% in 2015 due to delayed procurement and distribution, leading to stock outs to some health facilities. Tanzania is committed to ensure timely disbursement of funds for procurement and distribution of vaccines to health facilities.
Health workers and community sensitization will be conducted to increase uptake of MCV2.

Tanzania is planning to hold the MR campaign in Q4 2019, resulting in one year delay. A Campaign in 2018 is not feasible due to multiple priorities (eg IPV & HPV introduction, CCEOP deployment and CEF process). Tanzania plans to apply for Gavi support of the MR campaign in Q2 2018.

To mitigate risks of outbreaks following a delayed campaign, the EPI programme will strengthen its surveillance and routine coverage.

The chart below shows MCV1 and MCV2 coverage, which support the risk assessment to hold the campaign in 2019. Number of cases has decreased significantly compared to five years ago. The chart below shows the trend of measles cases.

Trend of measles cases and MCV coverage 1990 - 2016



The measles case based surveillance has been intensified as shown on the table below from 2012 to July 2017.

Measles case based surveillance performance

Indicators	2012	2013	2014	2015	2016	Jul-17
Annualized non measles febrile rash illness rate (target >2.0 per 100,000)	3	2.3	2.9	2.2	1.8	3
Proportion of districts investigated suspected case of measles (target >80%)	89%	90%	83%	83%	92%	83%
Measles cases - Lab confirmed	1668	185	88	30	33	2

4.2. Financial management performance (for all cash grants, such as HSS, vaccine introduction grants, campaign operational cost grants, transition grants, etc.)

During the year 2016/2017, Tanzania did not receive any cash grant from Gavi, however the country proceeds on utilization of funds received from previous period.

- HSS fund has now reached 80% of utilization from total funds received from Gavi. Total received is USD 5,604,801, total expenditure is 4,478,534. The funds remaining from HSS grant has been incorporated in the budget with HSS funds not sent to country which will then be managed by UNICEF.
- MR Fund has 98%of utilization from total funds received for MR operation, total received was 12,791,693 and expenditure was 12,516,349
- HPV Fund is 96% of utilization from total funds received from GAVI, total received 225,500 and expenditure was 215,745
- MSD Fund is 82% of utilization from total fund received from GAVI total received is USD 1,626,000 and expenditure was 1,328,024
- MR-VIG fund is 23% of utilization from total funds received from GAVI; received was USD 1,546,500, expenditure was 362,783
- However, USD 1,599,000 funds received for VIG-IPV have not been utilized.

The overall performance of cash grants is now 81% from total received, which is cash grants received of USD **23,393,494** and total expenditure from cash grants USD **18,901,435,** remaining balance of USD **4,492,059.**

The program wrote letter to GAVI requesting for reprogramming of un utilized funds remaining from, MR operations for the IPV introduction. Gavi has requested in return IVD to provide a budget proposal for the utilization of the balance and the SCM will seek approval to allow utilization of the MR balance for IPV.

During the year 2016/2017 the program has undergone Internal audit and the Auditor have not yet issued the report, since they are going for regional visits to health centres and facilities. Then they will compile and issue the report. External Audit follows soon after the internal Audit.

Moreover, GAVI conducted audit for cash grants received in the country from 2014 to 2016, consequently the Country has since re-funded the questioned funds of $1.3 million USD, due to some misappropriation, irregularities and unsupported document expenditures observed during the Auditing exercise.

In July 2017 this fiscal year 2016/2017 we received a team of consultants from GAVI for a program capacity assessment. The assessment will recommend Grant Management Requirements (GMRs) to be annexed to the partnership framework agreement (PFA). The successful implementation of the GMRs will determine the decision to re-direct future funding back to national systems. The GMRs are in process of finalisation.

- **Lack of Accounting software system**

The challenges from the use of excel to record accounting data is now on the final phase since the Ministry of finance has introduced special EPICOR 9 programs, this Accounting system link all donor funded program in the Government, and all projects will be required to adhere to that accounting system.

- **Deficiency of staff in finance department**

The program has increased number of staff to work in the Accounting section, previously we had only one Accountant, now the program has total of three Accountants.

- **Key issues raised in Gavi cash audit**

Irregular, unsupported and ineligible expenditures at regional level and irregular and unsupported procurement at central level were issues raised by Gavi's Audit and Investigation Unit. The Government has taken measures aimed at mitigating future risks of misuse of Gavi grants:

- The Ministry has closed all The TB accounts at regional level and now disbursement of funds to region is done through sub-treasury account which will be administered by the Regional Administrative Officer.
- The management of ministry of Health will issue/ provide guidelines on management of GAVI funds disbursed to region using the government accounting system. The ministry will develop guideline to be used by region and districts for the management of Gavi funds.
- Government accounting guidelines will be developed in line with International standards, Government circulars, proposed agreements, financial regulation and other internal memo and directives.

- Account Books for Gavi funded programmes have been rearranged and completed. Cash books are now maintained and balanced. Ledgers have been updated and maintained with clear relevant reference supporting documents.
- Gavi funds will be reflected accurately in an annual budget of the Government of Tanzania through Ministry of Finance. In order to ensure disbursements are according to the annual plan and schedules, Ministry will frequently ensure that once funds are disbursed from Gavi, follow up to Bank of Tanzania and Ministry of Finance will be done immediately by official writing communication and a copy it will be sent to Gavi.
- The Ministry of Health is expecting to introduce format which will be used for sharing information with Gavi. This Format will include all relevant information's including: Budgets; Funds received; and Expenditures. Period of reporting is proposed to be quarterly.
- In order to ensure accuracy, and as a step towards achieving and improving good governance, transparency and accountability, in the management of Gavi grants, Ministry will ensure that the annual audit plans of the Office of Internal Audit, include periodic and timely reviews of the Gavi grants, this will be in line with the duty of pre-examination activity of the Examination section to test and check reliability of documents. In doing so Ministry is planning to request Gavi to provide budget for the internal audit and pre examinations of Gavi documents.

4.3. Sustainability and (if applicable) transition planning

Tanzania has not defaulted from Gavi co-financing obligation for new and underutilized vaccines, as well as financing traditional vaccines. There is a budget line for vaccines in the Ministry budget, and funds are ring-fenced. In 2016 the Government paid full amount for co-financing amounting to (Tsh. 7,571,300,000 billion (USD 3,441,500) and Tsh.16.8 billion (USD 7,636,363) for Traditional vaccines.

Tanzania is not yet going for Gavi transition. However, the Polio transition plan will impact the availability of resources for immunisation, in particular for surveillance. More detailed documentation of the gaps is being processed by a Consultant.

4.4. Technical Assistance (TA)

Immunization equity

Orientation of the National technical working group on immunization equity assessment was conducted in December 2016 and the concept was introduced in 22 UNICEF supported Districts in Mbeya, Iringa, Njombe and Songwe regions. That initial assessment revealed that there are hidden gender and economic barriers which prevent women from taking their children for vaccination. These include engagement of women in petty trade, working in the paddy fields and mines. The equity assessment tools have been revised and adapted to Tanzanian context and a consultant has been hired to provide technical support in finalizing micro-plans developed to address the barriers/bottlenecks. The micro-plans will inform development of future joint work plans with UNICEF support.

Based on the work that had already been started in southern highlands Districts, a workshop was conducted to review the existing Interpersonal Communication (IPC) training package. Both UNICEF and IVD staff used the revised guideline to conduct more training with the aim of improving communication skills among immunization service providers but at the same time testing the guideline. Nine training sessions have been conducted in six districts covering 362 health workers. Currently the training package is undergoing final revision and will be submitted to MOHCDGEC for endorsement. The package will be used to conduct more training. It is hoped that these training will help in reducing high dropout rate in some of the districts and communities.

Cold chain

In addressing cod chain storage problems, 33 districts technicians were trained and equipped with knowledge and skills of conducting repair of cold chain equipment in their respective districts. This has resulted into reduction of non-functional cold chain equipment by 60% in the respective districts.

Activity: Facilitate the Cold Chain biannual inventory and update the replacement plan using the CCIT. Build capacity of vaccine management at all levels. Facilitate the application process for CCOEP.

Document evidence based need for transition and build the capacity in handling, storage and distribution of vaccines and related materials

- Progress: Cold chain inventory done and replacement plan developed as part Gavi requirement. The CCEOP application development and submitted to Gavi on time.

Data quality

Activity: Building the capacity of Data Quality Self-Assessment of RHMT, CHMT and Health Facilities Health Workers. Support the preparation of the Data Quality Review next financial year. Build the capacity in the use data for action at all levels.

- Progress: Data quality review and harmonization was done in both Tanzania Mainland and Zanzibar involving the National, all Regions and Councils. Data Quality Audit is in progress integrated with SARA supported by Global Fund. The DQA and SARA will inform the development of the DQIP, to be expected in Q1 2018

Activity: Building the capacity of CHMT and Health Facilities Health Workers to review the REC strategy to include the districts with high coverages which are above 100% with unvaccinated and under vaccinated children

- Progress: 71 councils with DPT 3 coverage above 100% have been identified. Consultation is ongoing on the methodology to be executed to reach unvaccinated and under vaccinated children in these councils.

Activity: Assistance to VPD case based surveillance improvement and outbreak investigation and response. 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 between labs and regional reference labs (networking)

- Progress: Standard VPD surveillance indicators have been achieved in the eradication and elimination diseases. Response was done to the Polio Outbreak in DRC by implementing intensified surveillance in the six regions. New vaccines surveillance sentinel sites performance quarterly review meetings conducted. Lab reagents supplied to the national and sentinel sites labs. Collaboration of national lab and regional reference labs enhanced by enabling national lab officer to attend Lab networks meetings.

Immunization

Activity: Facilitate the application process for HPV country wide introduction. 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

HPV country wide introduction application was submitted on time. NITAG established and functioning. Zanzibar National ICC revitalized, oriented and met twice.

5. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

Prioritized actions from previous Joint Appraisal	Current status
1. 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	• REC was implemented in 610 low performing health facilities in which large number of unvaccinated children were identified and vaccinated • Communities were sensitized that lead to MCV 2 coverage to increase from 57 % in 2015 to 71% in 2016 • Interpersonal communication training was conducted in two more districts (an addition to four districts in the past reporting period); a total of 160 health workers trained (in addition to 218

	trained in the past reporting period); the interpersonal communication training package is under revision and finalization; the package will be utilized for conducting TOT training to 4 regions and 22 respective district team • Intensification of routine immunization through African vaccination week and catch up vaccination were conducted
2. 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	• Data quality self-assessment was conducted in 33 Councils • Data review meeting, supportive supervision and data harmonization were conducted in order to build capacity of immunization officers and health care workers • VIMS has been scaled up in 15 regions and EIR in two regions
3. 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	• The country successfully applied for CCEOP to address current and future shortage of cold storage space. ODP finalised as well • The government continue to be committed for procurement and distribution of vaccines • The country has applied for temperature monitoring devices through Gavi HSS and sought support through Nexleaf. • Vaccine management and cold chain trainings for selected immunization officers at regional and district levels, and technicians have been conducted. How many trained?
4. Strengthen vaccines preventable diseases surveillance and preparedness for prompt outbreaks response	• Achieved and maintained surveillance standard indicators of AFP and Measles Rubella • Rotavirus disease burden and impact assessment of Rotavirus vaccine continued to be implemented in 8 sentinel sites • The national laboratory continued to be facilitated with reagents to enable them tests VPD specimens timely. • Preparedness and response plan for polio outbreak updated
Additional significant IRC / HLRP recommendations (if applicable)	**Current status**

If findings have not been addressed and/or related actions have not taken place, provide a brief explanation and clarify whether this is being priorities in the new action plan (section 6 below).

N/A

6. ACTION PLAN: SUMMARY OF FINDINGS, ACTIONS AND TECHNICAL ASSISTANCE NEEDS IDENTIFIED AND AGREED DURING THE JOINT APPRAISAL

Summary of findings during JA

The JA discussions identified several areas for further strengthening. As such the JA proved a helpful platform to prepare for the HSS2 grant proposal to-be-developed in 2018 through Gavi's CEF process. The below list is thus aimed to be addressed over multiple years and concrete steps to address will need to be further defined during the CEF process.
The following sections were discussed in break-out groups to allow for in-depth discussions

1. Coverage and Equity in immunization services

- ✓ Capacity of health care workers on planning and budgeting is minimal and there is a need to build capacity on them particularly on the new policy of direct financing.
- ✓ It is anticipated that there will be recruitment of large number of health care workers to address the current shortage of human resource. Building EPI and EVMA capacity of these health care workers is of particular importance in form of refresher/newcomers trainings
- ✓ There is low community engagement in immunization services and hence there is a need of using different interventions to engage community. An assessment and documentation of community engagement best practice is required.
- ✓ Despite of high number of health facilities in urban settings and slums still there is a significant number of unvaccinated children, it is important to assess immunization equity issues in urban settings. Further assessment is needed to understand the equity challenges in urban settings and slums.
- ✓ It was observed that there is a need of addressing unvaccinated children and equity issues through strengthening PIRI in specific months have shown to be successful and this can be applied both urban and rural
- ✓ There is inadequate supportive supervision and challenges in distribution of vaccines that necessitate the need for vehicles/motorcycles depending on the need of particular area.
- ✓ The Public-Private Partnership (PPP) strategy does not address immunization. There is a need to strengthen PPP to include immunization services.
- ✓ Integrated supportive supervision lack sufficient time to focus on immunization. RHMTs/CHMTs need to do immunization specific and targeted supportive supervision to address immunization issues Moreover; there is a need to reinforce cascade supervision from health centres to lower levels.
- ✓ Despite of conducting REC trainings, still some councils and/or health facilities are not implementing REC strategy. RHMT/CHMT should ensure REC strategy is being implemented countrywide and should be reflected in CCHPs and HFs micro plans. It is also important to have Reaching Every Child (REC) micro plan strongly engaging community for demand creation
- ✓ Since not all the regions are conducting Immunization Performance Review Meetings, it is important to scale up the review meetings in order to target performance issues and resolve them timely.
- ✓ There is no standardized mechanism for defaulter tracing, hence, a standardized mechanism for defaulter tracking is important to be developed and implemented.
- ✓ There is insufficient evidence on economic impact of immunization services hence there is a need to undertake Return for investment study on immunization services. WHO RO offered support in doing so
- ✓ Despite the high success the Tanzania immunization programme has achieved there is lack of documentation on the impact it has on health and economy in the country hence systematic review should be done so that to be used as an advocacy strategy.

2. Surveillance and Health Systems

- ✓ With Polio Eradication just to be achieved there is a move by WHO to reduce the number of polio assets hence there is a need to conduct gap analysis on WHO Polio Transition assets and broad surveillance needs to identify gaps and develop sustainability plan following polio transition

- ✓ IVD surveillance system is getting funds solely from WHO and currently USAID have joined with one-year funding support, so it was agreed that its highly time to bring on board all immunization partners to support surveillance system
- ✓ There is a need to prepare surveillance advocacy package so as to be able to mobilize resources.
- ✓ Due to inadequate knowledge and skills to undertake surveillance related activities, it is therefore important to build capacity of the Health Care workers at all levels including the PORALG health unity on surveillance related activities.
- ✓ There is a shortage of lab reagents and other supplies to conduct day to day testing activities and hence it is crucial to provide financial and technical support to the national laboratory

3. Data Quality

- ✓ VIMS is currently implemented in only 15 regions and EIS in 2 regions and therefore of Electronic Immunization system national wide (Vaccine Information Management Systems integrated with Electronic Immunization Registry system).
- ✓ Data quality improvement plan is not yet in place and therefore it should be finalized by the end of 2017/ Q1 2018 informed by SARA and DQS reports
- ✓ Due to unreliable target population, as a short term measure there is a need for data triangulation from existing source (previous performance data, health facility micro-plan, surveys and other sources) at all levels and in long run community child register should be instituted, integration of EIS with CVRS/RITA Birth registry information system.
- ✓ Revision of facility based (VIMS) data collection tool to reduce redundant data elements and translate to Swahili to reduce associated.
- ✓ Develop and strengthen data sharing and feedback flow mechanism across all level including community (religious leaders, community) level through innovation and technology. National level to provide guidance on how the HFs can share the immunization information to their village leaders to prevent wrong interpretations that may arise
- ✓ Development of Electronic Data Collection System and Use Guideline,
- ✓ Inclusion of number of defaulter traced as indicator in integrated supervision checklist to health facility level.

4. Stakeholders Engagement

- ✓ Tanzania is unique in the fact that all partners are coordinated in the support provided through IVD leadership under different areas TWGs.
  - ✓ There are also subcommittees on Data management, VPD Surveillance, Capacity building (Training), Logistics, Demand creation and Service delivery
- ✓ Individual partner provide complementary technical and financial support across different areas hence no lead organization. Partners are complementing each other and all have a comparative advantage

The following are stakeholders identified

Immunization System Component (ISC)	Description	Partner
Surveillance	VPD Surveillance	WHO, CDC, JSI-MCSP,
Service Delivery	• Microplanning • REC • SS • Defaulter tracking • Mentorship	JSI- MCSP, CHAI, WHO, UNICEF, AMREF, PATH
Demand Creation	• demand generation activities • Advocacy • Communication and social mobilization	UNICEF, JSI-MCSP,LIONS ROTARY INTERNATIONAL, CHAI,AMREF, RED CROSS, COMMUNITIES

Logistics, SS and Distribution		JSI- MCSP, CHAI, WHO, UNICEF
Data Management		PATH, JSI, CHAI, WHO, UNICEF, AMREF
Program Management	• SS	PATH, JSI - MCSP, CHAI, WHO, UNICEF,AMREF
Capacity building	• Trainings	PATH, JSI - MCSP, CHAI, WHO, UNICEF,
Research		MUHAS, IFAKARA HEALTH INSTITUTE, PEDIATRIC ASSOCIATION OF TANZANIA
Other Government entities	• Line ministries and entities	TRA, TFDA, MSD, PORALG, MoE, MoF

Potential partners:

- MEWATA (Cervical cancer screening, etc.)
- JHPIEGO (Cervical cancer screening, etc.)
- MDH (cervical cancer for HIV positive girls)
- AGOTA
- CDC (TA in immunization related issues. Program evaluation, data management, Lab, advocacy)
- TPHA
- PATH

Private sectors:

- Currently under immunization there are private service providers (private HFs)
- Potential PPPs
  - Area that need to be explored (learn from other countries and/or other programmes)
  - E.g. Telecom companies, DHL

✓ Partners should extend/stretch their services to also support Zanzibar as they have limited partner support

✓ To encourage involvement of private sector through Public Private Partnership

5. Performance of Gavi Grants

✓ There is a need to improve financial management system by leveraging the existing government financial reporting system, e.g. EPICOR used for Global Fund

✓ Delayed disbursement of funds lead to some activities not to be implemented on time which ultimate result in low utilization of funds

✓ There is a need to conduct capacity building (mentoring and training) to the national, regional, district and HF immunization staff to better plan and manage financial resources according to guidelines to mitigate risks, yet also to better target priority activities such as equity and EVM.

✓ It is important to have a Return for Investment study, to document on immunization investment that has led to positive results in Tanzania to build further political support.

✓ To address refugee needs, quantification of Vaccine/related supplies for refugees can be included in national forecasting however government to take a note on co-financing issue.

✓ Given priority and human resource capacity at IVD national level, Gavi can support human resource under the next HSS2 grant.

6. Supply Chain

✓ Inadequate storage capacity at sub national and health facility level to be addressed by the CCEOP

✓ Country should use upcoming HSS 2 grant to bridge the equipment gap that was not covered by CCEOP

✓ Shortage of spare parts to be addressed by CCEOP and upcoming HSS 2 funds and the districts to continue budgeting for procurement of spare parts in their CCHPs

✓ Due to delayed disbursement of funds and lack of warehouse information management software to effect the shifting from MSD to IVD, it is important to have revised timelines based on funding

availability and scope available cost effective options for warehouse information management software
- ✓ There is a need for training of healthcare workers on Supply Chain Management and Effective Vaccine Management
- ✓ The inadequate dry storage space at sub national level, PORALG should make sure districts construct/upgrade DVS as per sketch shared by MOH and decommission of obsolete equipment to be undertaken to free space.
- ✓ There is a need to carry out vaccine supply chain assessment

Overview of key activities proposed for next year:
For the year 2018, the key activities to be implemented will include but not limited to the following:

1) Data quality improvement activities at all levels to ensure the data provided are of high quality, available on time so as to be used in making decisions
2) Activities related to equity so as to reach unreached children at last mile (Equity assessment and REC activities)
3) The country will also implement activities related to new vaccine introduction. All activities related to HPV introduction, Introduction of IPV
4) Improvement of Cold chain and logistic related activities such as shift the handling, storage and distribution of vaccine and related commodities from central store (MSD) to IVD at Mabibo
5) Capacity building at all levels which include newcomers and refresher trainings
6) Activities related to Surveillance to ensure there is close follow up of vaccine preventable diseases
7) Activities related to advocacy, communication and social mobilization – supported by impact and RI evidence.
8) National scale up of electronic immunization of systems (EIS)
9) Preparation for the next HSS grant through the CEF (2019-2023)
10) Procurement of vehicles and cold chain equipment's to support low performing districts and increase outreach
11) Support immunization committee's meetings such as NITAG, TWG, ICC and AEFI.
12) Conduct targeted supportive supervision at region, council and Health facilities.

During the joint appraisal process, the IVD program has express for needs of technical supports in most of activities mentioned under JA findings sections through partner support. Understandably, under GAVI TCA and EPF may not be able to support all of the technical supports needed by IVD program and it was agreed that partners should seek additional resources from other donors to support the program on some of these critical challenges.

The prioritized technical support under GAVI support are:

Key finding 1	Maintain and sustain high coverage and attain equity in provision of immunizations services with safe vaccines.
Agreed country actions	• Strengthening Microplanning • Review and Implementation/ of REC Strategy approach in all districts • Strengthening the community link and use of CHW for defaulter tracing • Strengthening PIRI to reduce number of un/under vaccinated children • Implementation of immunization communication strategy • Further equity analysis and research eg in urban settings & slums
Associated timeline	Continuous
Technical assistance needs	• Review and implementation of REC strategy • Strengthening the Community link, understanding for immunization and the use of CHW for defaulter tracing • Assess immunization bottlenecks and conduct operational research in equity challenges among unvaccinated children in poor-performing areas, such as rural, urban slums • Document best practices on strengthening community health workers lessons to identify linkages between CHW and immunization

Key finding 2	Introduction of new and under used vaccines (HPV vaccine and IPV) and development of HSS2 grant proposal (CEF) & MR application
Agreed country actions	• Develop introduction plan and guidelines • Microplans • Implementation • Launching • Monitoring and evaluation
Associated timeline	2018
Technical assistance needs	• Planning • Implementation • PIE • Monitoring and evaluation • Advocacy and Social Mobilization • Impact assessment of newly introduced vaccines
Key finding 3	Maintain and sustain standard indicators of VDP surveillance and AEFI Surveillance
Agreed country actions	• Intensification of VPD surveillance system • Monitoring and evaluation of surveillance system • Strengthening existing sentinel sites • Provision of support to laboratories
Associated timeline	continuous
Technical assistance needs	• Strengthening surveillance system of VPD and AEFI • Monitoring and evaluation of surveillance system • Support laboratory services Implementing community surveillance
Key finding 4	Data quality and Management Issues
Agreed country actions	- Scale up of Electronic Immunization System (VIMS integrated with EIR) to all regions and districts of Tanzania mainland. - Intensifying data quality reviews and harmonization - Triangulation of data to address target population challenge - Conduct data quality self-assessment and audit - Finalise DQIP - Build capacity on data use for action at all levels - Provision of data management tools and devices - Improve feedback on immunization performance - Conduct midterm EPI Review
Associated timeline	Continuous
Technical assistance needs	- Build capacity on data quality and management, incl triangulation - Implementation and scale up of data review to district and health facility level /data summits - Implementation of Electronic Immunization Systems to improve data quality collection, analysis and planning - EPI midterm review & HSS1 evaluation - DQSA and DQA & DQIP - Assessment on issues of data quality & denominator
Key finding 5	Improve vaccine management and cold chain
Agreed country actions	• Implement EVMA and improvement plan • Improve vaccine management • Implement cold chain improvement plan • Support national vaccine management (support MSD to IVD Warehouse shift)
Associated timeline	continuous
Technical assistance needs	• Implementation of EVMA • Develop EVMA and cold chain improvement plans • Implementation to improve national vaccine management • Support CCEOP implementation

7. JOINT APPRAISAL PROCESS, ENDORSEMENT BY THE NATIONAL COORDINATION FORUM (ICC, HSCC OR EQUIVALENT) AND ADDITIONAL COMMENTS

The IVD-TWG met from 28th August to 8thSeptember 2017, whereby after reading JA Analysis guidance, divided into groups for filling up the JA 2017. Discussions were made on each component of JA, and then were submitted to ICC for discussion and endorsement.

The IVD-TWG included members from WHO, UNICEF, PATH, CHAI, JSI-MCSP and MOH-IVD.

The ICC meeting was conducted on 26th September, 2017 under the chairmanship of the Permanent Secretary of the Ministry of Health, Community Development, Gender, Elderly and Children. Members were World Health Representative for Tanzania (WHO-WR), Country Representatives from CHAI and JSI, representative from UNICEF, USAID, Germany KfW, PATH, PORALG, MSD, AMREF, RED CROSS and MOH.

The ICC Secretariat presented the JA by highlighting on each component in the JA. Key discussion points focused on data quality and reaching unvaccinated children in all districts. Members suggested the need of adapting the achievement from other regions that are implementing REC strategy and defaulter tracing as well the use of electronic immunization systems in improving data quality. Recommendations were made and accommodated by the secretariat. ICC endorsed the Joint Appraisal 2017 and directed the secretariat to submit the report before the suggested deadline.

8. ANNEX

Compliance with Gavi reporting requirements

Please confirm the status of reporting to Gavi, indicating whether the following reports have been uploaded onto the Country Portal.

It is important to note that delayed reporting may impact the decision by Gavi to renew its support.

	Yes	No	Not applicable
Grant Performance Framework (GPF) reporting against all due indicators	√		
Financial Reports			
Periodic financial reports	√		
Annual financial statement	√		
Annual financial audit report	√	√	
End of year stock level report	√		
Campaign reports	√		
Immunisation financing and expenditure information	√		
Data quality and survey reporting			
Annual desk review	√		
Data quality improvement plan (DQIP)		√	
If yes to DQIP, reporting on progress against it			√
In-depth data assessment (conducted in the last five years)	√		
Nationally representative coverage survey (conducted in the last five years)	√		
Annual progress update on the Effective Vaccine Management (EVM) improvement plan	√		
Post Introduction Evaluation (PIE)	√		
Measles-rubella 5 year plan	√		
Operational plan for the immunisation program		√	
HSS end of grant evaluation report		√	
HPV specific reports	√		
Transition Plan			√

In case any of the required reporting documents is not available at the time of the Joint Appraisal, provide information when the missing document/information will be provided.

DQIP delayed due to DQA and SARA, will be completed in Q1 2018

2015-2016 & 2016-2017 external audit reports due by March 2018

HSS evaluation due in 2018

Annex II: RECOMMENDATIONS FOLLOWING THE TANZANIA JOINT APPRAISAL MEETING 2017

CATEGORIES	No	RECOMMENDATIONS	TA	Who?	Priority	Timeline
Category#1: Performance of immunization system	1	Assess immunization bottlenecks and conduct operational research in equity challenges among unvaccinated and under vaccinated children in low -performing areas, such as: Rural, Urban areas (slums) and others.	Y	WHO, PATH, USAID, JSI, CHAI, UNICEF, (select based on regional presence)	High	Q1
	2	Roll out immunization performance review meetings to all regions and council in the country	Y	WHO, CHAI, JSI	High	Q1-4
	3	Synergize the introduction of IPV and HPV vaccines in the country	Y	WHO, UNICEF, JSI, JHPIEGO, AMREF	High	Q1
	4	Build the capacity of the RHMTs and CHMTs to be able to empower Health Facilities in planning and budgeting immunization services.	Y	CHAI, WHO, JSI, USAID	High	Q2
	5	Continue procurement of vehicles and motorcycles to ensure a timely distribution of vaccine/related supplies and supportive supervision at sub-national level	N	UNICEF		
	6	Conduct newcomers and refresher trainings to HCW on immunization services.	N	IVD-HSS	Medium	Q3-4
	7	Strengthen the REC approach to ensure all children are reached with vaccination services by conducting quarterly analysis and developing mitigation plans in low performing and hard to reach areas.	Y	JSI, WHO, USAID AMREF	High	Q1-4
	8	Document best practices on the use of Community Health Workers to improve immunization services as part of community linkages	Y	USAID, CHAI, JSI AMREF	High	Q1
	9	Develop standardized mechanisms for defaulters tracing	Y	WHO, CHAI, USAID JSI, AMREF, Red Cross	High	Q2
	10	Build the capacity of PORALG Immunization Unit to coordinate, monitor and supervise immunization activity at sub national level.	Y	WHO	High	Q1

	11	Conduct EPI Mid-term review of cMYP, Surveillance Review and EVM.	Y	WHO	High	Q2
	12	Conduct vaccine coverage surveys	Y	WHO	Low	Q4
	13	Develop advocacy plan for sustainability supported by impact assessment of immunization services	Y	WHO,JSI	Medium	Q3
	14	Measles Rubella campaign application for 2019	Y	WHO	High	Q1
	15	Preparation of next HSS grant application	Y	UNICEF	High	Q1
	16	Create advocacy to Parliamentarians on the importance of economic Return on Investment for Immunization				
Category#2: Data management and use	1	Harmonize immunization data tools with HMIS to minimize workload	Y	WHO, PATH, JSI, AMREF		
	2	Develop capacity for data triangulation from existing source (previous performance data, health facility micro-plan, surveys and other sources) at district level		WHO,	Medium	Q1
	3	Develop and finalize data quality improvement plan by the end of 2017	Y	WHO, JSI	High	Q1
	4	Integrate of mVaccination with VIMS and Scale up of VIMS and EIS to the remaining regions by Q4 of 2018	Y	AMREF, PATH, JSI	High	Q1-4
	5	Conduct DQSA	Y	WHO		Q1-2
	6	Continue discussion with the NBS on varied immunization target population projections	Y	IVD		
	7	Integration of EIS with CRVS/RITA birth registry information system	Y	WHO, IVD	Medium	ongoing
	8	Revising VIMS forms to reduce duplication of variables	Y	IVD, WHO, JSI		
Category*#3:* Surveillance	1	Conduct gap analysis on Polio Transition assets and broad surveillance need to identify gaps and develop sustainability plan following polio transition	Y	WHO, USAID	High	Q1
	2	Continue build capacity of the Health Care workers at all levels on surveillance related activities	Y	WHO, USAID, AMREF		Ongoing

	3	Develop a plan through HSS funds to address gaps related to health system	Y	IVD-HSS		
	4	Advocate for allocation of resources for surveillance activities using the Gap analysis reports.	Y	IVD, WHO,USAID		
	5.	Support for laboratory with required equipment and reagents	Y	WHO, USAID		
Category#4: Engagement of immunization partners	1	Partners should extend/stretch their services to also support Zanzibar as they have limited partner support	Y	WHO, Zanzibar		
Category#5: Performance of Gavi Grants	1	Improve financial management system by leveraging the existing government financial reporting system, e.g. EPICOR is used for Global Fund	Y	Gavi to suggest partner	High	Q1-4
	2	Improve coordination between PORALG and MOH (IVD) to plan together immunization activities (e.g., NVI, Annual plans, CCEOP etc) in 2018	Y	MoH, PORALG		
	3	Conduct supply chain assessment at all levels to find other causes of vaccine stock out	Y	WHO, JSI, CHAI		Q3
	4	Decommission of obsolete equipment's to free space – need to define protocol and pilot in one district	Y	UNICEF, CHAI		Ongoing