TANZANIA

Gavi 2020 multi-stakeholder dialogue: immunisation planning in light of COVID-19

Introduction

2020 has been marked by the unprecedented crisis caused by COVID-19. Though the longer-term trajectory of the pandemic remains uncertain, evidence shows that immunisation services in Gavi-supported countries have been disrupted. Millions of people are expected to miss out on immunisation, likely leading to a resurgence of VPDs, further exacerbating existing inequities and putting the most marginalised and poorest communities at greater risk. Gavi-supported countries have already had the opportunity to re-allocate or re-programme[1] existing HSS and TCA support to respond to immediate needs presented by the COVID-19 pandemic. The Gavi Alliance is fully committed to assisting countries to restore immunisation services that have been scaled-back, brought off-track or otherwise affected during the pandemic response.

As an alliance, multi-stakeholder engagement remains key to Gavi's portfolio management approach. It is particularly critical in 2020 as a forum for engagement on how the Gavi Alliance partners and other stakeholders can support countries as they deal with the different phases of the COVID-19 pandemic and seek to maintain and restore primary health care, including immunisation services that have been disrupted. Civil society organisations (CSOs), in particular, will have a vital role to play in engaging communities to rebuild trust and demand, deliver services where there are gaps in government provision and in overcoming gender-related barriers.

Recognising the difficult operating environment and the rapidly evolving landscape currently faced by countries, and to ensure that Gavi's continuing support to the EPI programme is aligned with realities, countries are not requested to conduct a traditional Joint Appraisal in 2020. However, countries are encouraged to sustain the multi-stakeholder dialogue. This dialogue should review the immunisation programme performance in 2019, the impact of the COVID-19 pandemic on immunisation, discuss the needs for maintaining and restoring immunisation services in the context of primary health care, plan for short-term catch-up activities and, where needed, create a roadmap for further re-allocation/planning within the country's recovery plan.

The 2020 multi-stakeholder dialogue exercise

This 2020 multi-stakeholder dialogue exercise will be tailored to the country context, taking into account current constraints in terms of travel, meetings, and workload. The process will involve preparatory work on data for the review, potentially multiple exchanges with at least one event for live discussion (likely a virtual meeting), concluding with the finalisation of a report and relevant additional documents (e.g., workplan and budget for short-term response/recovery activities, roadmap for further planning). The process should be inclusive and transparent, with meaningful engagement of partners and civil society.

The 2020 multi-stakeholder dialogue report is structured as follows

- Section 1: Country situation: overview of performance of vaccine support, HSS grant implementation, PEF-TCA and other Gavi support, up to end of 2019/early 2020; pre-COVID-19.
- Section 2: Update on impact of COVID-19 immunisation service delivery and immunisation coverage (in 2020) and status of the implementation of the COVID-19 recovery plan (if relevant).
- Section 3: Discussion on priorities, immediate catch-up needs, related action plan, estimated budget and technical assistance needs. Roadmap for further analysis and re-allocation/planning in the context of the country health sector recovery plan.

[1] This document refers generally to the reallocation of Gavi support. Changes might also be categorized as reprogramming which is used for more significant modifications and may require to be reviewed by the Independent Review Committee.

Much of the information contained in sections 1 and 2 on the country immunisation programme and Gavi support is pre-filled by Gavi from existing documents and completed by the country. These form the basis for the multi-stakeholder dialogue. Section 3 focuses on a concise overview of Gavi's potential contribution to maintaining and restoring essential services, with focus on immunisation, and short-term catch-up needs and further planning. It is to be tailored to the country context.

TANZANIA

Tanzania 2020 multi-stakeholder dialogue: immunisation planning in light of COVID-19

1. Country situation pre-COVID-19, based on information received by Gavi

[This section is pre-filled by the Gavi Secretariat. The main source is the country dashboard, as well as the analysis slide set prepared by Gavi's Country performance Monitoring and Measurement (CMM) Team. Both documents -which are more comprehensive than below summary- may be annexed to this report if considered useful.]

1.1. Overview of performance of vaccine support (end of 2019/early 2020; pre-COVID-19)

Vaccines introduced and forecasted to be introduced

2.1.1 - Routine Introductions

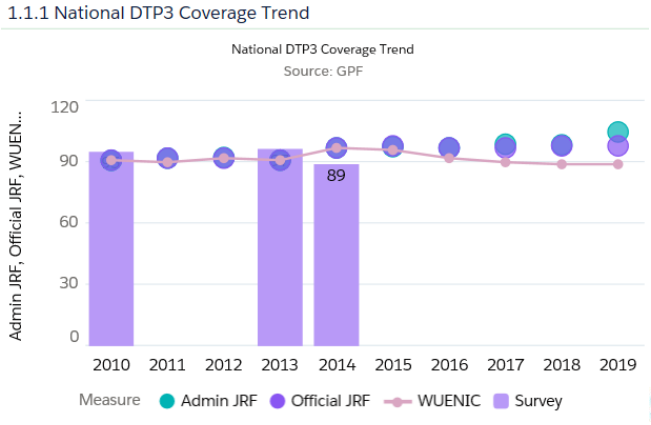
Vaccine	Introduction Date	2018 Coverage (%)	2019 Coverage (%)	2019 Target	2020 Target
PENTA	04-2009	89	89	99	99
PNEU...	12-2012	84	83	98	99
ROTA	12-2012	85	85	99	99
MEASL...	04-2014	88	88	99	99
HPV	04-2018	-	-	80	82
IPV	04-2018	56	89	90	95

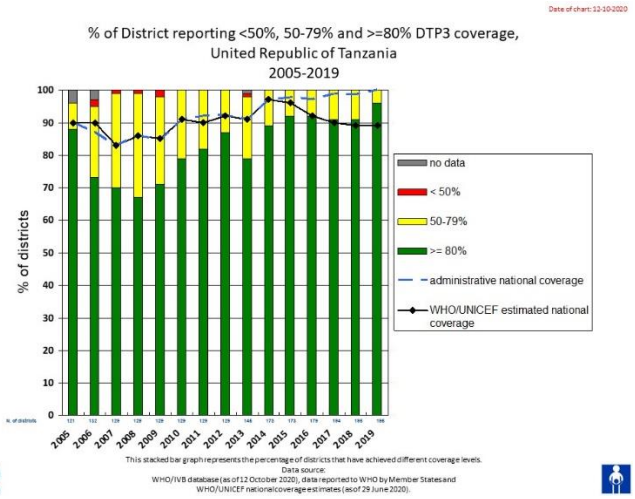
Performance against Alliance KPIs

1.1.2 Performance against KPIs (source: GPF)

Indicator	Source Name	Year	Value	Trend
Measles containing vaccine (second dose) coverage at the national level (MCV2)	WUENIC	2019	72	▲
Pentavalent 3 coverage at the national level (Penta 3)	WUENIC	2019	89	→
Drop-out rate between Penta1 and Penta3	WUENIC	2019	2.2	→
Difference in Penta3 coverage between children of urban and rural residences	Survey	2019	0	▲
Difference in Penta3 coverage between the highest and lowest wealth quintiles	Survey	2019	0	▲
Penta3 coverage difference between the children of educated and uneducated mothers/care-takers	Survey	2015	11	▲
# of Underimmunised Children	Calculated	2019	238523.01	▼

Trends and district equity





Progress against indicators and targets achievement

Table provided by gavi

Vaccine Programme	Source (2019)	Intermediate results Indicator	Reported actuals	Rel. % change
PNEUMO	Admin (JRF)	Number of surviving infants who received the first recommended dose of PCV vaccine (PCV1)	2,240,035	6%
	Admin (JRF)	Number of surviving infants who received the third recommended dose of PCV vaccine (PCV3)	1,995,135	1%
PENTA	Admin (JRF)	Number of surviving infants who received the first recommended dose of pentavalent vaccine (Penta1)	2,240,633	6%
	Admin (JRF)	Number of surviving infants who received the third recommended dose of pentavalent vaccine (Penta3)	2,161,097	9%
MCV	Admin (JRF)	Number of children in the target population who received the second recommended dose of measles containing vaccine (routine) (MCV 2)	1,780,440	10%
	Admin (JRF)	Number of surviving infants who received the first recommended dose of measles containing vaccine (MCV1)	2,104,972	4%
IPV	Admin (JRF)	Number of surviving infants who received the first recommended dose of IPV	2,075,110	83%
All others	EVMA Reports	Effective Vaccine Management Score (composite score)	NA	NA
	JRF	Occurrence of stock-out at national or district level for any Gavi-supported vaccine	Yes	NA
	Admin (JRF) & Survey	Percentage point difference between Penta 3 national administrative coverage and survey point estimate	NA	NA

Relative % change refers to the percentage increase/decrease of the reported value from the year prior.
The cell is green when the relative change increased, yellow when it remained the same and red when the relative change decreased.

1.2. **Overview of HSS grant implementation** (end of 2019/early 2020; pre-COVID-19)

HSS2 implementation summary as of June 2020

Recipient	Grant	Funds Disbursed	Expenditure	Country cash balance	Comment
MoH	HSS2 (Y1 2nd tranch2)	3,359,319	n/a	n/a	Funds were disbursed in Dec '20 – financial report due in sept '21
UNICEF	HSS2 (Y1 (1st tranche)	3,558,516	2,241,668.93	1,137,513.56	Balances used for EIS Tablet procurement
Total					

HSS key milestones achieved in 2019

Structured based on grant objectives or GPF indicators (graph prepopulated by Gavi)

	Process Indicators			Intermediate Results		
	Indicator name	Value	Rel. % change	Indicator name	Value	Rel. % change
OBJ-NA	percentage of councils having met all targets tracked under the VIMS score card related to reporting rates, service delivery, vaccine sessions and vacine management	18	NA	CCEOP Maintenance	94	NA
	percentage of district to HF level distribution of all vaccines done vs planned	71	NA	Percent of defaulter children traced and vaccinated for MR2 at national level	NA	NA
	Percentage of health facilities with CCE having more than 6 temperature alarms during last month	4	NA	Percent of districts that conducted community awareness meetings/ mobilisation sessions	100	NA
	percentage of HF reports submitted on time (by 15th)	84	NA	Percent of MR zero-dose children who have received their overdue vaccines within one month of being identified	NA	NA
	Percentage of outreach sessions conducted	71	NA	percentage of health managers and technicians trained for supply chain oversight function	52	NA
				percentage of HF with no stock out of penta	89	NA
				percentage of regions with functioning EIS system	38	NA
				percentage of time at facility level recording of optimum temperature for vaccine storage		NA

Relative % change refers to the percentage increase/decrease of the reported value from the year prior.
Value cell color is green if target has been >= 90% met, yellow if 70-90% met, and red < 70% met.

Indicator type	CCEOP indicator	Value	Rel. % change
Core	CCE expansion in existing equipped sites	0	NA
	CCE extension in unequipped existing and/or new sites	49	NA
	CCE replacement/rehabilitation in existing equipped sites	23	NA
Tailored	CCEOP Maintenance	94	NA
	Percentage of health facilities with CCE having more than 6 temperature alarms during last month	4	NA

Color coding:
Value cell is green if target has been met and red if not.

1.3. Overview of other Gavi support, such as VIGs, OPS, PBF, switch grants, transition grants etc. (as applicable)

2.2.2 Other Recent Cash Programme Details

High Level Category	Programme	Start Year	End Year	Committed	Approved	Disbursed
CCEOP	CCEOP	2018	2019	8,878,132	8,878,132	8,508,094
OPS	HPV MAC - Op costs	2018	2019	2,224,858	0	0
	MR-Follow-up campaign op.costs	2019	2019	4,599,470	4,599,470	4,599,470
VIG	HPV	2018	2018	1,719,890	1,719,890	1,719,890

2.2.1 HSS Commitments, Approvals, Disbursements by programme year

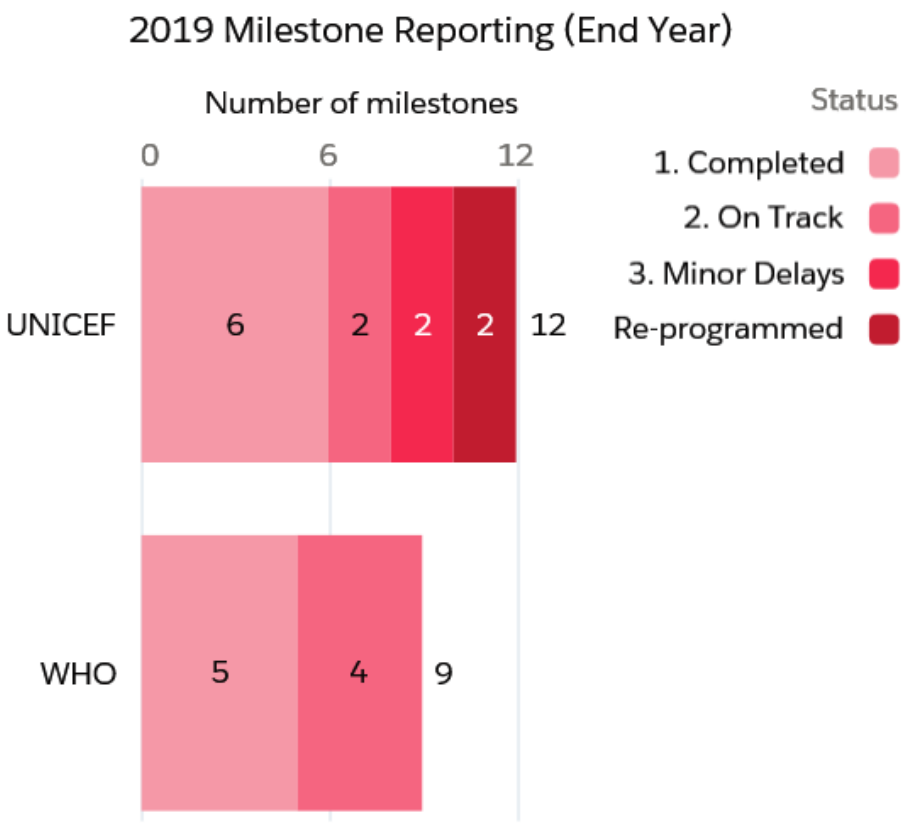
Programme	Start Year	End Year	First Disbursement	Last Disbursement	Committed	Approved	Disbursed	% Disbursed
HSS 2	2019	2023	2019-07-23 00:00:00	2020-11-27 00:00:00	41,857,716	29,486,824	8,564,370	29
HSS 1 - PBF	2015	2019	2017-12-08 00:00:00	2020-03-16 00:00:00	7,200,000	7,200,000	2,945,979	41
HSS	2012	2017	2014-01-09 00:00:00	2018-12-18 00:00:00	13,497,223	13,497,223	13,497,223	100

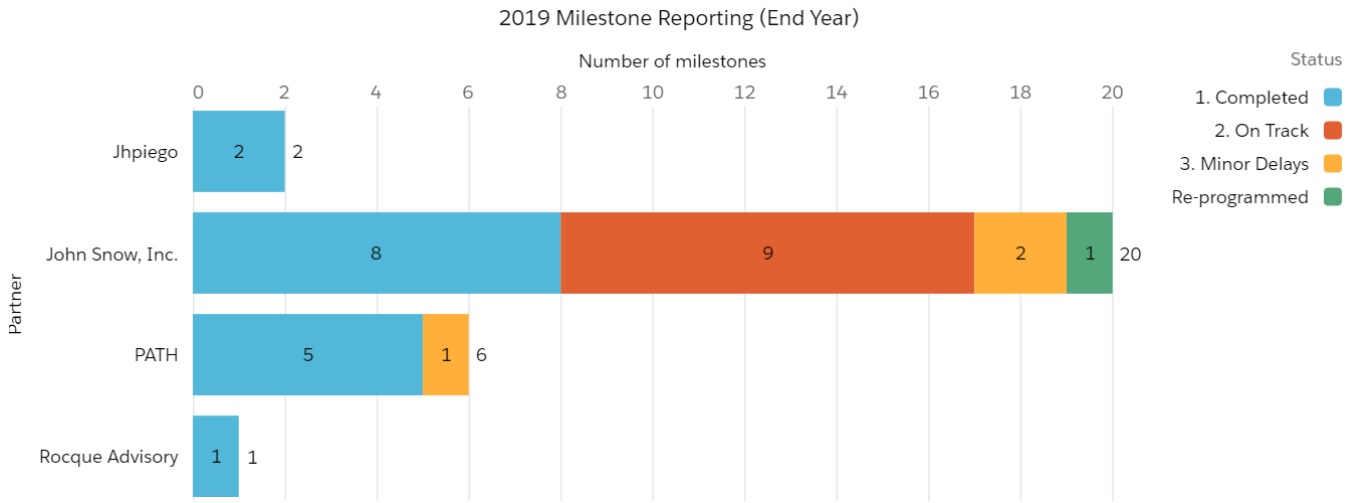
1.4. Compliance, absorption and other fiduciary risk matters

i. Comments on financial absorption: No key risks residual risks noted by Gavi
ii. Compliance with financial reporting requirements (periodic/annual financial reports, audits): All financial and audit reporting is compliant as of January 2021.

iii.
iv. Compliance with programmatic reporting requirements (GPF): met
v. Other financial management and fiduciary risk comments: N/a

1.5. **Overview of PEF TCA progress** (end of 2019/ early 2020**)**





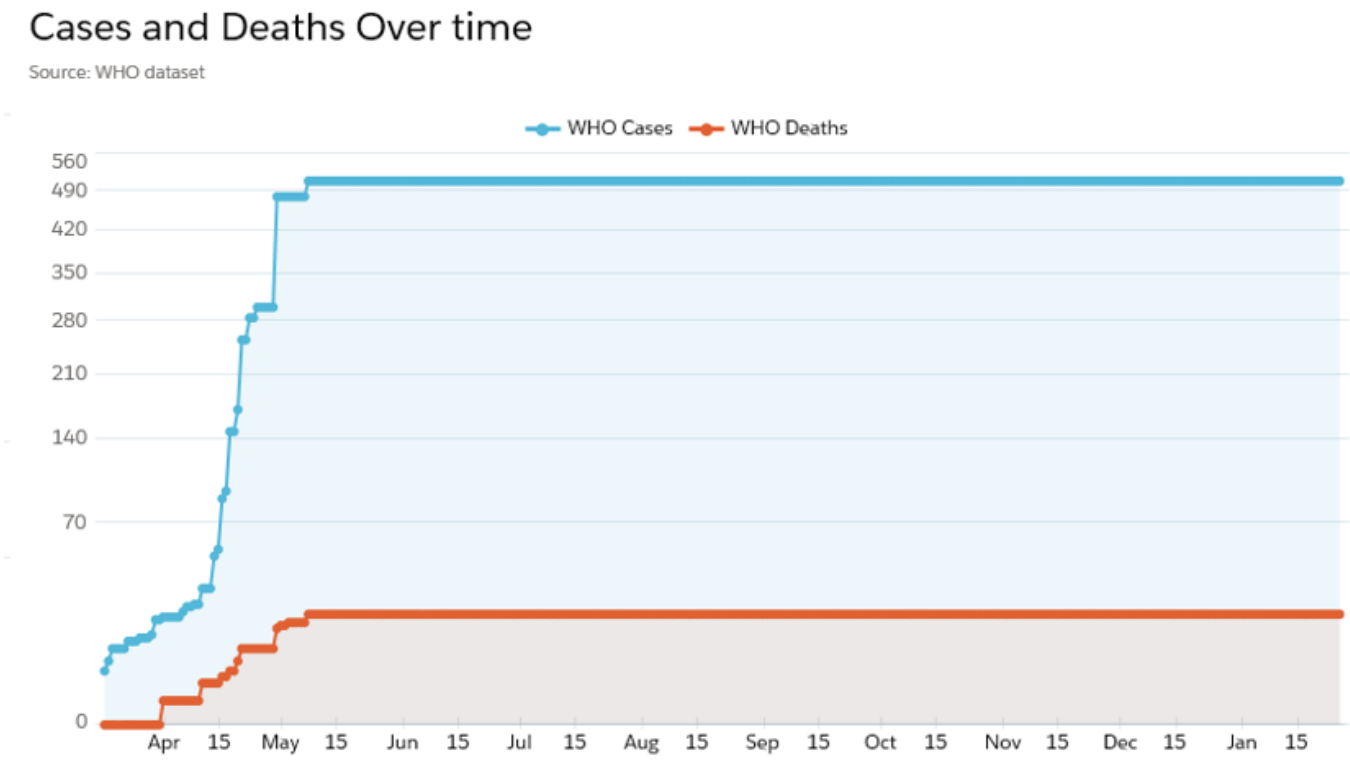
Please provide any additional comments -as relevant- on the implementation of the TCA plan (e.g. progress in key areas, challenges, constraints, reallocations, no-cost extensions)
n/a

2. COVID-19 impact on immunisation (in 2020): current situation

[This section is partially prefilled by the Gavi Secretariat.]

2.1 COVID-19 cases and deaths. To note, no new data released since 1 May 2020

Download Gavi covid-19 cases and deaths dataset



2.2 Disease Surveillance and Incidence

[Information from CCM team and/or
https://www.who.int/immunisation/monitoring_surveillance/data/en/]

Impact of COVID-19 on disease surveillance

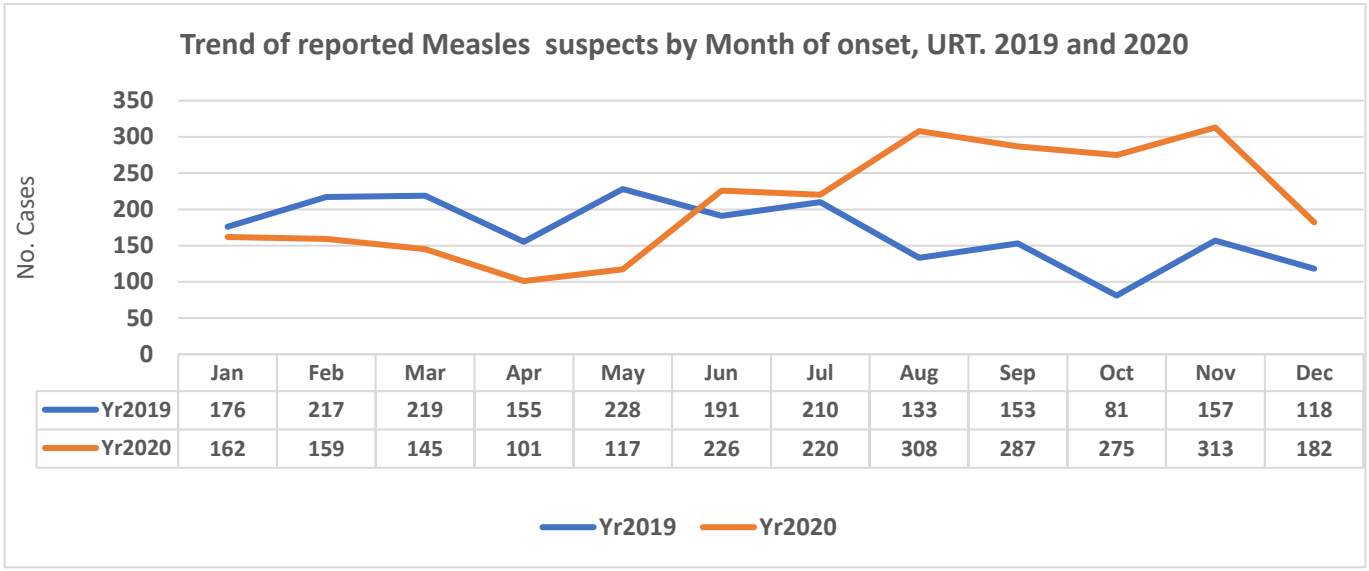
Briefly describe the impact of COVID-19 on the sensitivity and specificity of vaccine preventable disease surveillance. Measles surveillance data are one option to illustrate that impact, including:

Changes in the number of reported suspected measles and AFP cases

Although there was no lock down measure implemented in the country, health care workers practised preventive measures including physical distancing mask wearing and hand hygiene. Health workers observed infection and prevention control measures while continuing with other healthcare services including immunization services.

Vaccine preventable diseases surveillance continued with the detection of suspected cases and shipping of samples. There was notable decrease in number of reported cases and sample shipment from Field to National level since beginning of the year 2020 compared to previous year 2019, the trend remained low during March through May 2020 compared to the same period in 2019. The trend of reported cases peaked back during the month of June.

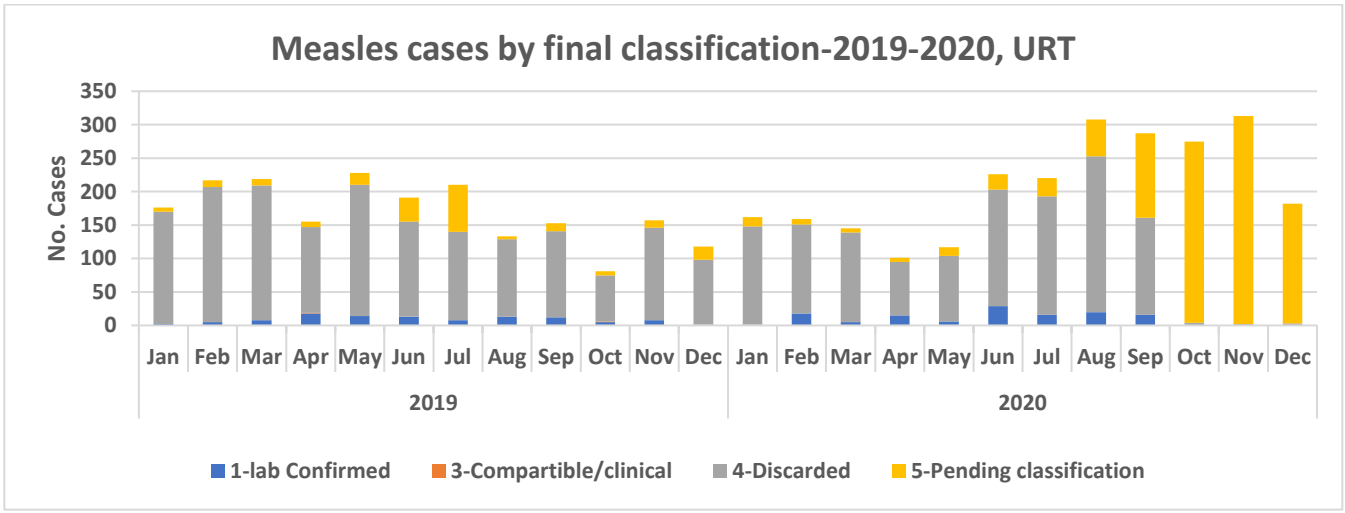
TREND OF SUSPECTED MEASLES RUBELLA CASES REPORTED IN URT DURING 2019 AND 2020.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Yr2019	176	217	219	155	228	191	210	133	153	81	157	118
Yr2020	162	159	145	101	117	226	220	308	287	275	313	182

vi. Changes in the number or rate of discarded suspected measles cases

There is no significant difference between cases discarded in 2019 as compared to 2020



vii. Changes in the proportion of suspected measles cases that undergo laboratory testing
Surveillance data from other diseases can be used as well to highlight key areas of impact.

During the period of January 2019 to December 2020, 4533 samples collected from suspected measles/rubella cases from subnational level to National laboratory were tested. During the year, 2020 there was longer turnaround time for measles rubella results compared to 2019.

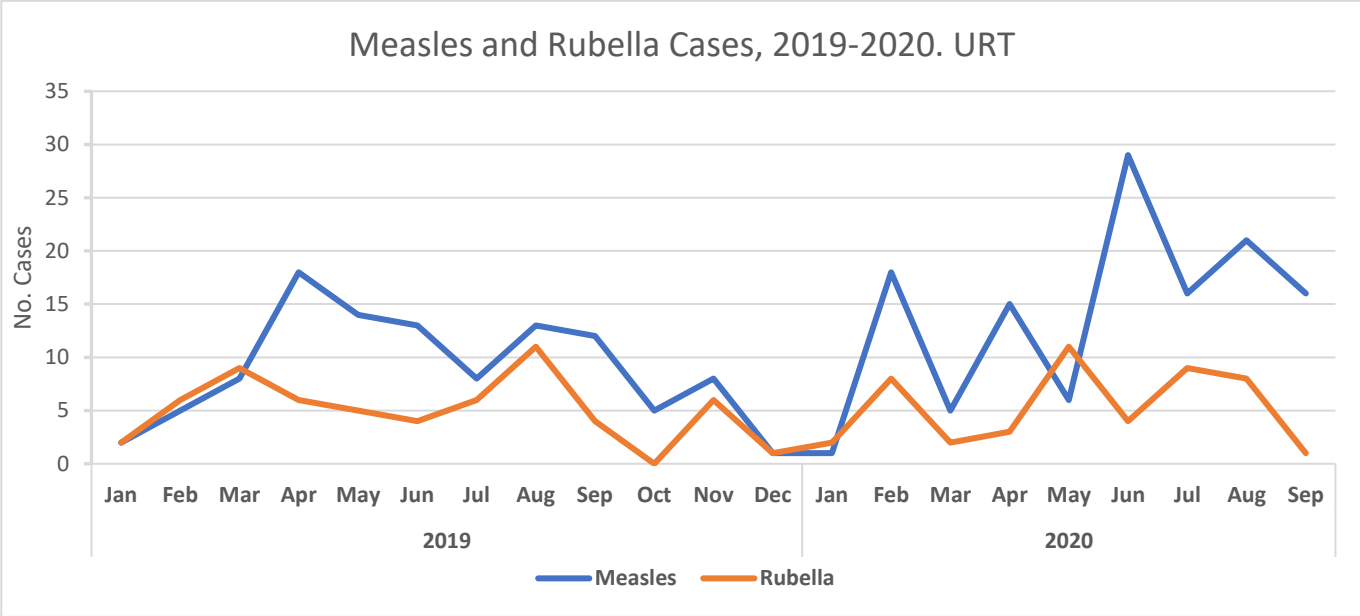
Impact of COVID-19 on disease cases

Briefly describe the impact of COVID-19 on vaccine preventable disease incidence. Since measles is the vaccine preventable disease most likely to have a rapid increase in incidence

due to declines in immunisation coverage associated with COVID-19, measles data can be used to illustrate this impact, including:

viii. Changes in the number or rate of confirmed measles cases

During January 2019 to December 2020, the number of measles IgM+ detected varied between months. More cases of laboratory confirmed measles documented during 2020 compared to the same period in 2019.



ix. Interpretation of changes in the number or rate of confirmed measles in light of changes in surveillance performance. For example, assessment of whether decreases in measles incidence are due to actual declines or decreased sensitivity of measles surveillance. Similar data for other diseases can be used as well.

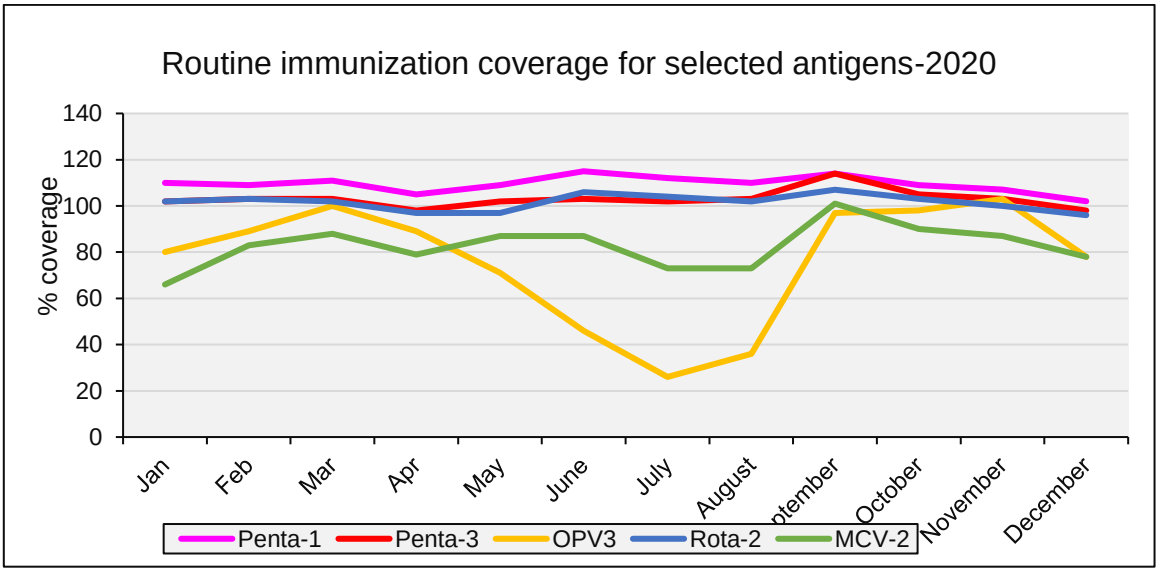
Trend of laboratory confirmed cases of measles-rubella for the period of January 2019 to September 2020. shows slight difference as shown in the above graph. Likewise, it shows a slight peak of confirmed cases in June 2020 compared to the same period in 2019. Still there pending specimens awaiting Lab results

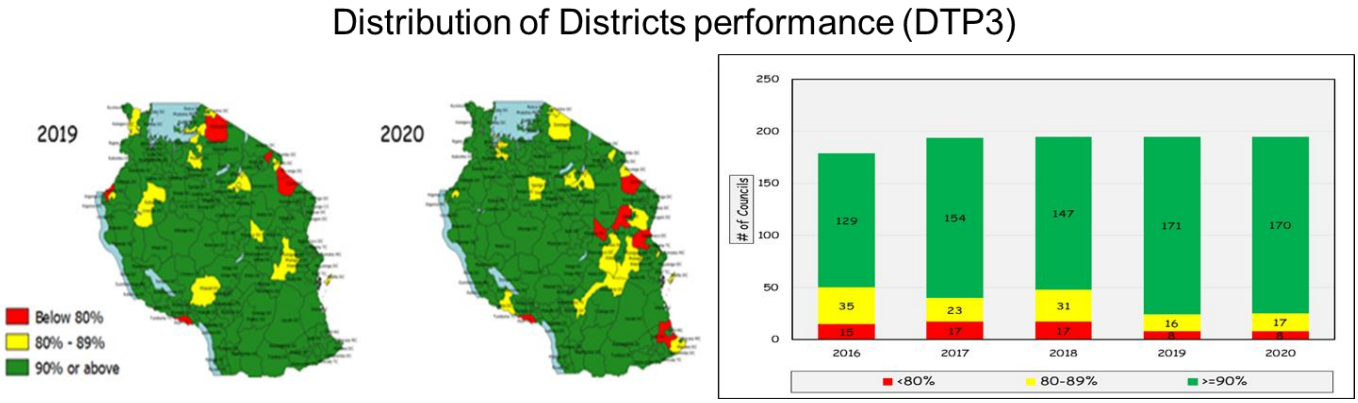
2.3 Impact of COVID-19 on immunization

Briefly describe the impact that COVID-19 has had on your ability to effectively deliver immunisation services, including:

x. Constraints on routine immunisation services (e.g., are health workers still carrying out immunisation services? What barriers do health workers face?)

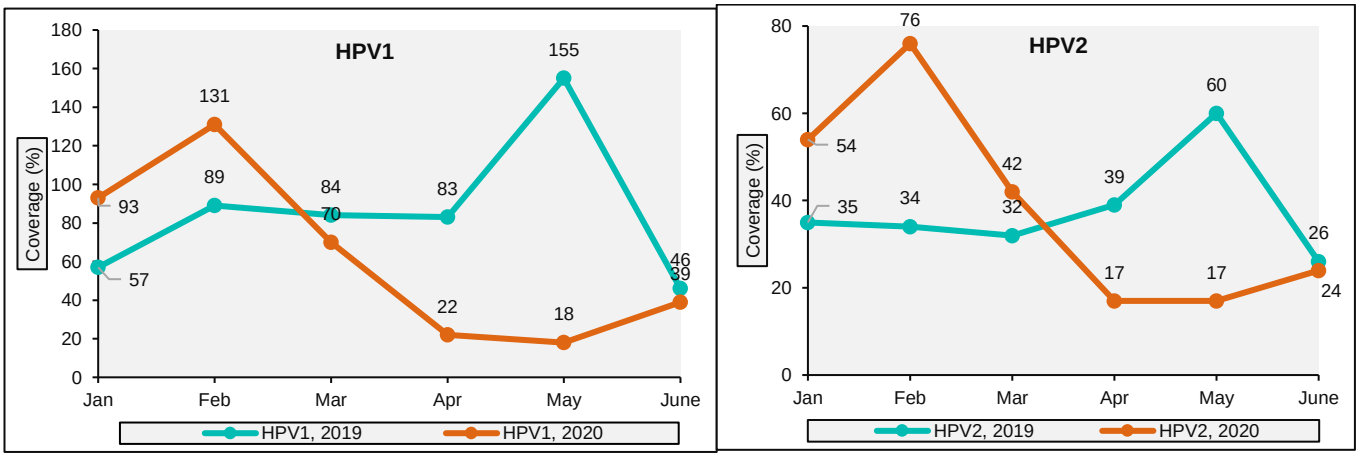
Generally, there was minimal disruption of immunization services during the outbreak of COVID-19. Continuity of immunization services attributed to the fact that, no lock-down measures undertaken in Tanzania. Fixed session was conducted normally, and anecdotal data showed pocket of cancellation of outreach services. Moreover, community engagement in the outreach services was minimal due to fear of contacting the disease resulted in minimal outreaches being conducted. *See figure 1 below*





This was more noticeable during the initial response to the disease (March to June 2020). There was noticeable disruption of HPV vaccination services due to school closure. (*See figure 2 below*). During this period, significant health workforce was diverted to the prevention of COVID-19 outbreak resulting to cancellation of some outreach services in some health facilities.

Figure: HPV 1 and 2 Performance 2019 vs 2020



Mitigation measures undertaken:

i. **Guidance on continue provision of immunization services**
A guidance note to health workers on provision of immunization services during COVID 19 pandemic was provided. The guidance emphasized on continuation of services while adhering to IPC measures to protect themselves and protecting the community against the covid-19 pandemic.

ii. **Webinar meeting**
Series of webinar sessions (zoom, skype and teams) on signs, symptoms and management on COVID 19 were conducted to district and regional immunization focal personnel to increase awareness among them.

iii. **Media seminars**
Zonal media seminars were conducted to journalists, writer's and bloggers to help in community sensitization for continuation of immunization services provision and adherence to preventive measures against the covid-19 pandemic.

iv. **E-learning**
The immunization e-learning platforms was used for training and orientation of healthcare workers to raise awareness on Covid-19. Various modules developed on diseases detection, contact tracing, sample selection and transportation to national laboratory, description of signs, symptoms and management of cases.
Also, awareness was created to district and regional immunization officers to increase uptake of HPV vaccines to girls during closure of schools.

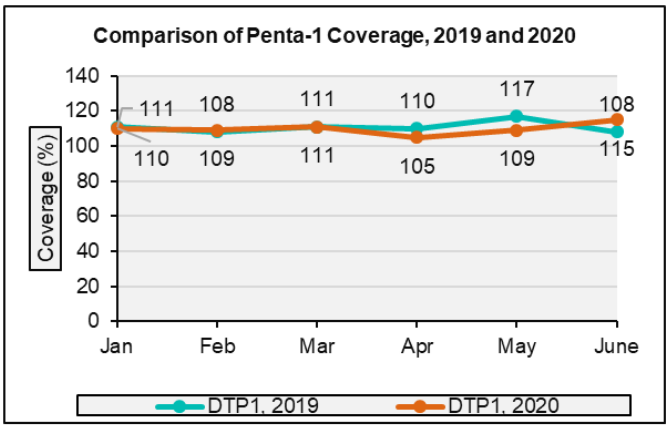
v. Impact of the pandemic that may have exacerbated gender related barriers to immunisation experienced by caregivers, adolescents and/or health workers.

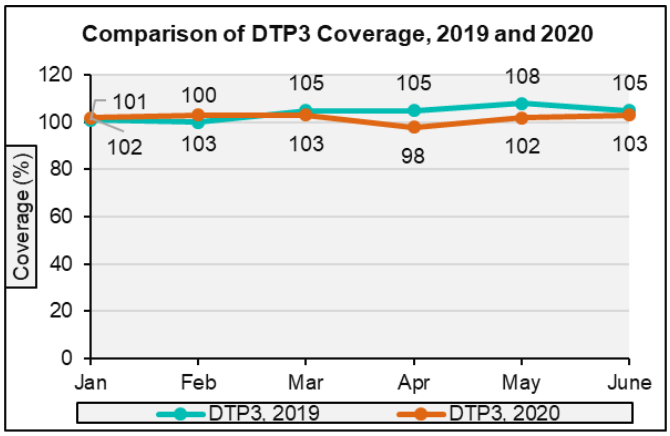
- There were no gender disparities in relation to access to immunization services during COVID 19 outbreak that were reported by service providers. Immunization continued to be provided free in both public and private facilities to both boys and girls as usual. All boys and girls accessed the services equally and the general immunization coverage reached at 98%

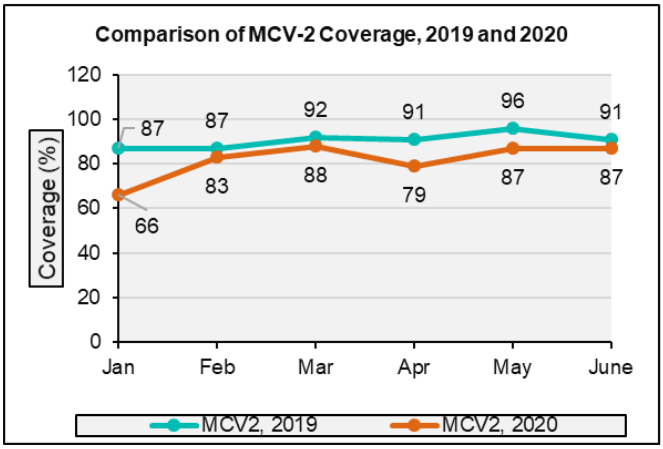
vi. Impact on uptake, demand and community engagement (including impact of rumours or misinformation)

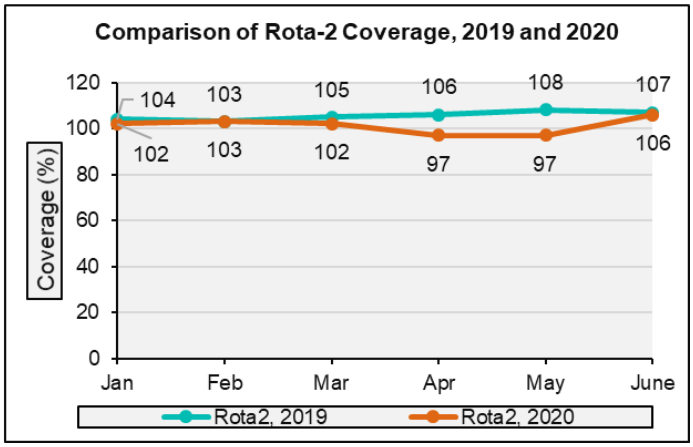
During the initial months of response to COVID 19 pandemic (March - June), there was minimal drop in uptake of the immunization services (Figure 2 below). This interruption was mainly caused by fear of contacting COVID-19 from both community members and Health workers. Advocacy and Social mobilization activities which usually is intensified during African Immunization week in month of April was not implemented due to avoidance of overcrowding and implementation of physical distancing. This impacted in drop of DPT3 coverage compare to the same month in 2019 and indicated below figure

Figure: Comparison of vaccination coverage for selected antigens January- June (2019 vs 2020)









vii. Impact on any planned new vaccine introductions or campaigns

Tanzania conducted integrated MR campaign in October 2019 before the outbreak of COVID-19.

Likewise, there were no New vaccine introduction or Campaign planned to be implemented in 2020.

viii. Impact on vaccine stocks (e.g. restocking of vaccines and related supplies, risk of expiry, updating dose requirements, reallocating stocks internally within the country/districts to ensure equity of supply)

Tanzania continued to monitor vaccine stock at the national, regional and district during reporting period levels using the Vaccine Information Management System (VIMS). There was observed one month stock out of bOPV, MR and BCG caused by delay in disbursement of fund to UNICEF SD which was exacerbate by delay vaccine delivery from manufactures following global Covid-19 pandemic in 2020 which resulted into cancellation of many commercial international flights, there were delayed shipments of vaccines causing disruption of supply chain at national and sub national levels for some antigens. To ensure continuity of services, the country undertook redistribution efforts using electronic, web-based stock monitoring system across regions and councils.

ix. Impact on health and immunisation (incl. vaccines) financing (e.g. repercussions on the health/ immunisation/ vaccine budget; delays in budget disbursements relating to

immunisation activities; intention of other donors to make additional funding available for health/ immunisation/ vaccines)

There was delay in disbursement of funds for procurement of vaccines at national level and for implementation of immunization services at sub national level, the delay was linked to funds been prioritised for procurement of PPE and facilitation of preventive measures activities for health care workers during pick of Corvid -19 outbreak. Disbursement of funds for vaccines were later paid at the end of December 2020 leading to stock out of some vaccine.

What has been the impact on the implementation of Gavi support (vaccines, HSIS, TCA, other), including financial absorption, stock management etc.?

Gavi HSS supported activities were implemented as planned because lock down measures were not implemented in Tanzania. Some of the TCA faced difficulties in implementation due to organizational policies requiring remote working travel and physical meetings restrictions. This delayed implementation of some activities, hence the need for a no cost extension.

2.4 Already agreed budget reallocations of HSS grant for COVID-19 response
[Please complete table to reflect any budget reallocations already approved – example below]

Tanzania had initially requested to utilise the outstanding in-country balances of $1,646,534 for PPE procurement in response to the C19 pandemic. Yet due to shift in needs, it was later decided to no longer use these funds for PPE, yet return n to the HSS2 grant for later allocation (eg towards NIS priorities)

2.5 Already agreed modifications in Technical Assistance (if applicable) N/A
[This refers to modifications already agreed as part of the COVID-19 emergency response]

No modification for TCA

2.6 Unspent funds and savings from Gavi support, available for re-allocation
[Brief narrative and/or table. Considering that some activities have been cancelled, delayed or modified, this is an overview of funds available to be re-allocated.]

All partners did not have unspent funds except for World Health Organisation (WHO) who had $**216,870** from 2019 MR Campaign grant which will be used to strengthen routine immunization through implementation of Periodic Intensification of Routine Immunization (PIRI) in councils with high number of un and under vaccinated children. The activity has been planned to be conducted in Q1 of 2021.

3. Discussions on priorities, action plan and technical assistance needs; Roadmap for further re-allocation/planning

WHO Priorities

i. Support Zanzibar immunization strategic plan development for the year 2021 -2025
ii. Support strengthening of Measles rubella case-based surveillance activities and documentation of progress towards elimination.
iii. Support Strengthening of routine immunization with focus on increasing uptake of MCV2 vaccine.
iv. Provide technical support, participate and facilitate in the 2020 data review and harmonization, triangulation at National, Regional and District level before completion of the WHO/UNICEF JRF
v. Support mapping of zero dose children and set strategies to vaccinate all eligible children in selected regions

UNICEF Priorities

i. Provide technical support in Implementation of strategies for Identification of Zero Dose children in routine immunization services using Community Health Workers (CHWs) in urban communities
ii. Support and Conduct high level Advocacy meetings for integration of Immunization and Nutrition/Birth registration Services to ensure integrated service delivery
iii. Support in Quantification of vaccines and CCE and quarterly review of the supply plan so as to ensure there are no stock out of vaccines
iv. Support and Coordinate and monitor implementation of the CCEOP plan
v. Conduct Equity Assessment to identify gap in reaching communities for immunization services following COVID 19 outbreak in 2020
vi. Support in high level Advocacy for Financial sustainability of the immunization program
vii. Support and Conduct high level Advocacy meetings for transitioning to paperless following implementation of Electronic Immunization System (EIS)
viii. Support and strengthen management and coordination of EPI Program in Zanzibar so as to increase and sustain immunization coverage in Zanzibar

PATH Priorities

i. Support TImR software enhancement to include immunization inequity indicators completed and deployed in selected testing districts and health facilities.

ii. Support IVD & RITA System Integration and demonstration in selected district for improved denominator (Integration of Birth Registration System 4th Generation (BRS4G) and TimR.

iii. Support and build capacity of MoHCDGEC in transitioning into completely paperless data collection, processing and reporting from facility level to national level.

CHAI Priorities

i. Redesign and strategize on implementation of high impact interventions for improving urban immunization coverage and reduction of zero dose.

ii. Development of costed decommissioning plan for obsolete cold chain equipment following CCEOP deployments.

JSI Priorities

i. Strengthen the integration, scale-up, and local hosting of electronic immunization systems (VIMS, TImR, RTM, WMS, DHIS2, Surveillances systems including case-based surveillance system)
ii. Development and monitoring of data use strategies to support the identification and micro-planning to reach zero dose children and un/under vaccinated children and girls (HPV)
iii. Strengthening immunization supply chain and cold chain performance

Girl Effect Priorities

i. Raise awareness to increase coverage of HPV vaccine, particularly dose 2
ii. Continuing the campaign into 2021 - allowing 2/3 re-runs of the MoH girl centric toolkit campaign
iii. Follow up on FEMA mini magazine with HPV content
iv. Integrate HPV content in Season 2 of *Tujibebe* drama
v. 5 Creating strong demand for MoH content creation materials
vi. Share the impact findings of the studies that have been conducted recently

Jhipiego Priorities

i. Improve and sustain coverage of HPV Vaccination with specific focus on the 2nd dose
ii. Support scaling up HPV Vaccine Integrated program in other Regions linked with lesson and best practices learnt in the existing Program

AMREF Priorities

i. Continue with strengthening the integration, scale-up of electronic immunization systems (VIMS and TImR)
ii. Work with other partners to implement strategies for identification of Zero Dose children for completion of vaccine doses and follow ups of un/under vaccinated children in routine immunization services linking with Community Health Workers (CHWs)
iii. Strengthening immunization supply chain and cold chain performance
iv. Support and sustain coverage of HPV Vaccination to un/under vaccinated girls

Based on the analysis of the current programmatic and financing status of your immunisation programme (captured in Sections 1 and 2), the questions below provide guidance for a multi-stakeholder dialogue.

This should result in an outline of your plans to reinforce/re-establish routine immunisation activities, catch-up on missed children, and potentially re-activate some of the planned new introductions and/or campaigns, in the context of the country epidemic response/recovery plans while taking into account the guidance provided by the Alliance.

The country is expected to:

- Define short/medium-term activities to maintain/restore routine immunisation and catch-up on coverage as needed. For these, a workplan and budget will be required.
- Define a roadmap for further re-allocating/planning of activities not captured here, considering the medium/long-term country recovery plan, domestic resources and those available from other development partners, lessons learned and innovative approaches used to cope with the epidemic, and synergies with all relevant stakeholders, including CSOs, with the vision of “building back better”.

The multi-stakeholder dialogue may consider the following questions, taking into account the latest programmatic guidance provided by the Alliance:

Short/medium-term activities to maintain/restore routine immunisation

iii. COVID-19 recovery plan: does the country have a recovery plan which includes restoring essential health services including immunisation?

Country as have experienced minimal disruption of immunization services did not develop recovery plan. The country through its annual immunization plan 2021 has indicated activities to strengthen immunization services.

- If not, is the recovery plan being developed? Please give a brief overview of the process and timelines for its completion.

iv. Immunisation services: What strategies have been implemented at the service delivery points to re-activate immunisation services and to address any immunisation gaps resulting from COVID-19?

Country plan to continue use of reaching every district/reaching every council (RED/REC) strategy at health facility level and Periodic intensification of Routine Immunization (PIRI) will also be implemented in low performing district and districts with large number of under /unvaccinated children.
Strengthen school health platform to enable teachers disseminate immunization messages to parents and community from service delivery.

Mapping of zero dose children and set strategies to vaccinate all eligible children in selected regions, Use of Community health worker for defaulter tracking and identification of zero dose children
Scale up use of electronic immunization registry to track defaulter children and monitor provision of immunization services.

v. Lessons learned and/or innovative approaches to immunisation service delivery that were used to cope with the epidemic are worth broader adoption and scaling-up

- Strategies to reduce fear- Early communication to regional and district focal person and provide guidance on protective measures while continue provision of services
- Continuous communication through WhatsApp, zoom meeting and other virtual platforms.
- E leaning platform for continue training and learning.

Equity approach: What are the plans to ensure that underserved and missed communities, including zero-dose children, are prioritised within the country's recovery plan?

- REC strategy,
- Use of community health worker for defaulter tracking and Zero dose
- TCA UNICEF and WHO to support the strategies to identify zero dose and missed opportunity
- Strengthening urban immunization (UNICEF, CHAI -TCA)
- Equity assessment and implement strategies methodology to reach them

Overview of the funding landscape for the immunisation program and highlight any gaps in support.

The Government of Tanzania (GoT) allocated and approved Tsh.30 billion (USD) in MTEF for the year 2020/2021 for procurement of vaccine and vaccine related materials. Gavi HSS2 funds complement operations at national level and prioritised regions and districts. Funds for immunization are ring-fenced. Funds for operational activities at regional and district levels are indicated and detailed in Comprehensive Council Health Plan (CCHP). Most source of funds

rely on Basket Funds. At Council level there are variety of sources that include but not limited to Block Grant, Health Basket Fund, Cost sharing as well Council Own Sources. The priorities at council level vary from Council to Council.

Roadmap for further medium/long-term planning

Please briefly outline your roadmap for developing a more detailed medium/long-term recovery plan to restore immunisation services and address any immunity gaps created by the COVID-19 pandemic. In your response, you can consider the following:

- Is there a need to conduct an assessment of the COVID-19 pandemic impact on immunisation services in order to best facilitate the development of a longer-term response plan?
- What is the envisioned planning process, including efforts to engage communities in the development of the plans, to join broader health sector planning exercises, and to ensure harmonisation of support with all relevant bi-lateral and multi-lateral development partners?
- Will a technical assistance plan be developed alongside the recovery plan? Will it be holistic and ensure support from all TA partners is harmonised?
- Finally, please note whether planning has already begun for a potential introduction of a COVID-19 vaccine if/when such vaccine becomes available?

Medium- and long-term priorities

Tanzania is developing a new National Immunization strategy 2021 -2025 following expiry of cMYP 2016-2020. The Strategic objectives gear to address challenges faced during Corvid -19

Short/Medium term activities which will also need TA support included;

- Strengthen Outreach and mobile services in hard to reach, urban and nomadic population
- Advocacy and social mobilization to strengthen HPV and MR2 uptake
- Switching from 10 to 5 dose vial of MR vaccines to avoid missed opportunity
- Strengthening implementation of EIS
- Operationalize the IVD central vaccine warehouse management
- Strengthen VPD surveillance
- Conduct EVMA and develop improvement implementation plan
- Strengthen vaccine cold chain and vaccine management – RTM, CCEOP, Cold chain maintenance,
- Plan for introduction of IPV2, TCV,
- Conduct data quality assessment
- Advocacy for financial support for immunization and financial sustainability

Long term activities included;

- Programme management capacity building
- Financial sustainability for immunization services
- Plan for introduction of Malaria vaccine, HIV, YF, Men A