NATIONAL EPI

COMPREHENSIVE MULTI YEAR PLAN

2012 – 2016

THE GAMBIA

May 2011

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List of abbreviation

AD	Auto-Disable
AEFI	Adverse Events Following Immunization
AFP	Acute Flaccid Paralysis
BCG	Bacillus Calmette-Guerrin
BI	Bamako Initiative
CATR	Cellelui de Appaui Technicien Régionale
cMYP	Comprehensive Multi Year Plan
CRD	Central River Region
CSF	Cerebro-Spinal Fluid
CSM	Cerebro-Spinal Meningitis
DC	Direct Current
DHMT	Regional Health Management Team
DHT	Regional Health Team
DOSH	Department of State for Health
DPHO	Regional Public Health Officer
DPT	Diphtheria Pertusis and Tetanus
EDC	Epidemiology and Disease Control
EPI	Expanded Programme on Immunization
FMA	Financial Management Assessment
FSP	Financial Sustainability Plan
GAVI	Global Alliance for Vaccines and Immunizations
GIVS	Global Immunization Vision and Strategy
GNI	Gross National Income
HBV	Hepatitis B Vaccine
HEU	Health Education Unit
HIB-PRP-T	*Haemophilus Influenza type b*
HIPC	Highly Indebted Poor Countries
HRH	Human Resources for Health
I.U	International Units
ICC	Inter-Agency Co-ordination Committee
IDSR	Integrated Disease Surveillance and Response
IMCI	Integrated Management of Childhood Illnesses
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MLM	Mid-Level Management
MNT	Maternal and neonatal tetanus
MPM	Maintenance Policy Monitoring
MRC	Medical Research Council
MVDP	Multi Dose Vial Policy
MYP	Multi Year Plan
NACP	National AIDS Control Programme
NaNA	National Nutrition Agency
NBDW	North Bank Region West
NGO	Non-governmental Organization
NIDs	National Immunization Days

NNT	Neonatal Tetanus
NRA	National Regulatory Authority
OPV	Oral Polio Vaccine
PAB	Policy Analysis & Budgeting
PIE	Post Introduction Evaluation
PHC	Primary Health Care
PRSP	Poverty Reduction and Strategy Paper
RCH	Reproductive and Child Health
RED	Reach Every District
SIAs	Supplemental Immunization Activities
TB	Tuberculosis
TFR	Total Fertility Rate
TT	Tetanus Toxiod
UNICEF	United Nations Children's Fund
URD	Upper River Region
USD	United States Dollar
VDC	Village Development Committee
VPD	Vaccine Preventable Diseases
VVM	Vaccine Vial Monitor
WDU	Waste Disposal Unit
WHO	World Health Organisation

Executive summary

The Gambia is one of the smallest countries on the West Coast of Africa. It has a total land area of 11,000 square kilometres and an estimated total population of 1.7 million (projected from the 2003 Census). Infant and under-five mortality, though still high are in the decline (from 84 in 1993 to 74/1000 live births in 2003 and 135 in 1993 to 99 in 2003 respectively). Common communicable diseases are the major cause of morbidity and mortality especially among the under-fives. These diseases are malaria, diarrhoea and respiratory infections.

The Gambia health care delivery system is based on the Primary Health Care (PHC) Strategy and was adopted in 1979. The health services are delivered through a network of many primary health posts and health facilities (6 government hospitals, 6 major health centers, 32 minor health centers, 19 Private, 24 NGOs and 232 Outreach posts). These are staffed by Medical Doctors, Nurses, Public Health Officers and Community Health Workers. They provide curative,

preventive, promotive (community sensitization and rehabilitation health services) and child health services including immunization.

In order to ensure an effective and efficient management and a functioning Public Health Sector, the Government of The Gambia in 1993 further decentralized the management of the health system; thus dividing the country into six (6) Administrative Health Regions. The Regional Health Management Team (RHMT) is responsible for the planning and day to day administration together with the monitoring and supervision of health services in the Region, including immunization services.

Compared to other countries within the sub-region, The Gambia has a good track record of high immunization coverage due mainly to good access and service utilization. Furthermore, the Gambia has added hepatitis B and Haemophilus Influenza type b to the traditional vaccines in 1990 and 1997 respectively. It is envisaged that Measles second dose , Men. A and Rota vaccines would be introduced in 2012, 2014 and 2015 respectively.

With the availability of funds, the EPI will continue to conduct bi-annual immunization coverage surveys, using the WHO cluster sampling technique tools to validate the routine immunization data. In addition, the EPI has conducted assessments and other studies and the findings of these are among the back ground documents used in the development of this comprehensive Multi-Year Plan.

The national EPI Programme is still faced with challenges and some of these include inadequate funding, high staff attrition and high vaccine wastage. All these challenges have had a direct negative impact on overall immunization coverage. It is hoped that this cMYP will address these problems.

The goal of the five year plan is, among other things, to reduce morbidity and mortality due to vaccine preventable diseases ;Tuberculosis, Polio, Diphtheria, Pertusis, Tetanus, Measles, Yellow Fever, Hepatitis B, Hib and Pneumococcal diseases. It is expected that this would be achieved through capacity building, improving access to immunization services, introducing new vaccines, reducing vaccine wastage and drop-out rates

The situational analysis is based on the results of the desk review which revealed strengths and weaknesses of the programme. The Gambia has attained and maintains high immunization rates (97% Penta 3 coverage in 2010) due to good geographic access and active community involvement and participation. Immunization services are delivered through static and outreach services and the programme is heavily dependent on four-wheel vehicles to conduct the services. However, it was revealed that there has been a drop in immunization rates (TT 2+ coverage from 79% in 2009 to 752% in 2010) due to inadequate supervision and poor recording keeping.

In a drive to eradicate and/or eliminate EPI targeted diseases, The Gambia conducted five rounds of Polio NIDs in 2010 for Polio and Measles (in 2003 and 2007) and achieved remarkable results. These SIAs were conducted with other interventions like Vitamin A

supplementation, Mebendazole and bed net count. Another follow up measles SIA is planned in 2011.

The national surveillance system was reinforced in 2000 and has made steady progress in case detection, notification and confirmation, which has greatly contributed to the reduction of incidence and prevalence of EPI targeted diseases. The Gambia is committed to pursuing global and regional initiatives such as polio eradication, NNT and Measles elimination and yellow fever control. However, inadequate mobility continues to hamper the present surveillance system; thereby making case search and sample transportation very difficult.

To ensure quality, vaccines for routine EPI services are procured through UNICEF from WHO approved sources. Vaccine requirements are forecasted annually using a bottom-top approach annually in collaboration with UNICEF. Vaccines are received twice yearly in country and a push system is used for their quarterly delivery to the regions. However, there is limited capacity to forecast vaccine needs at both Regional and health facility levels.

The Gambia has considerable experience in the introduction of new vaccines for example tetratvalent in 1997, Pentavalent and Pneumo in 2009. The opportunity of the introduction of new vaccines has always been seized to improve infrastructure for example the procurement and installation of solar refrigerators in all health facilities before PCV-7 was introduced. Currently, there is adequate storage capacity at all levels.

The development of the EPI Communication plan in 2004, the existence of a functional ICC and the availability of a communication officer at national and in all the regions have come as added advantage in strengthening EPI advocacy. However, in adequate funds for the implementation of the EPI communication plan affects the promotion of key elements of the plan which may have a negative impact on the utilization of EPI/RCH services.

The programme conducts joint monthly monitoring and supportive supervisory visits country wide using supervisory checklist. However, the review revealed the lack of concise and clear job description for EPI staff and no annual operational plans at Regional and health facility levels.

The cMYP has been costed by components detailing key intervention strategies. This plan focuses on five service components namely: vaccine supply and logistics ($9,678,617); Service delivery ($1,145,757); advocacy and communication ($269,572); monitoring and disease surveillance ($408,990) and programme management ($26,493), amounting to a total of $11,529,429. The annual plan for 2012 has also been developed.

1.0 Background/Introduction

1.1 Background

The Gambia is a narrow strip of land on both sides of the river, stretching inland for about 400 kilometers and occupies 11,000.square kilometres of land. The climate is subtropical savannah with an annual rainfall of between 800mm – 1200mm lasting for about 5 months (mid June to mid October). The Gambia is predominantly an agrarian society with ground nut being the main cash crop. However, tourism also plays an important role in the economy.

1.2 Demographic Profile

The Republic of The Gambia has an estimated total population of 1.7 million in 2011 (projected population from the 2003 census) with an annual growth rate of 2.8%. The Gambian population is characterized by its youthful nature. Forty-four percent (44%) are below the age of 15 years; females constitute 51% of the total population and women of the reproductive age (i.e. 15 – 49 years) represent 23.3%. The table below shows some basic demographic indicators:

Table 1 Selected Basic Demographic Indicators

Indicator	**1993**	**2003**
Population (millions)	1.03	1.3
Growth Rate	4.2	2.7
Density (pop/km^2	97	128
Crude Birth Rate	46	46.2
Crude Death Rate	19	19.2
Total Fertility Rate	6.0	5.4
Infant Mortality	84	75
Under Five Mortality	135	99
Maternal Mortality	1050	730
Life Expectancy (years)		
Male	52	62.4
Female	54	65

1.3 Socio-economic profile

The Gambia is predominantly an agrarian society and groundnuts (peanuts) are the main stay of the economy and tourism is the highest foreign exchange earner. The dependency ratio is 68.1% and the GDP per Capita is 6%. The GNI is per capita in US dollar is 740.

1.4 Health Profile

The Gambia adopted the Primary Health Care (PHC) strategy in 1979 and has a three-tier health system comprising of Primary, Secondary and Tertiary levels. The Health Services are delivered through a network of many Primary Health Care Posts, Health Facilities (i.e. 4 government hospitals, 6 Major Health Centres, 32 minor Health centres, and 232 Outreach sites). These facilities are staffed by Medical Doctors, Nurses, Public Health Officers and Community Health Workers. The primary level consists of the Village Health Services and community clinics; the Secondary comprises of Minor and Major Health centres whilst the Tertiary is made up of general and teaching hospitals.

In order to ensure an effective and efficient management and a functioning Public Health Sector, the Government of The Gambia has in 1993 further decentralized the management of the health system; thus dividing the country into six (6) administrative health regions as shown in the table.

Table 2 showing health facilities by type and regions

Health Regions	Public Hospitals	Private Health Facilities	NGO Clinics	Major H/C	Minor H/C	Outreach
Western	2	15	13	2	7	33
L. R.D	0	1	1	1	3	30
N. B.D.W	0	1	2	1	3	32
N.B.D.E	1	0	1	0	6	27
C.R.D	1	2	3	1	7	57
U.R.D	0	0	2	1	6	53
National	4	19	22	6	32	232

In each region, there is a Regional Health Management Team (RHMT) headed by a Regional Health Director supported by the Regional Public Health Officer, Regional Public Health Nurse, Health Administrator and other Support Staff. The RHMT is responsible for the planning, implementation, monitoring and evaluation of health services in the Region, including immunization services.

1.4.1 The EPI Programme

The Expanded Programme on Immunisation (EPI) is one of the frontline public health intervention programmes under the directorate of Health Services within the Ministry of Health (MoH&SW). EPI started in the Gambia in May 1979, following the 1978 yellow fever epidemic in the Upper River Region (URR). Since its inception, it has been integrated into the Reproductive

and Child Health (RCH) and services are delivered primarily through the static and outreach strategies. Owing to the high infant and under five mortality rates, EPI has also been linked with other public health intervention programmes/units such as the Epidemiology and Disease Control, National Malaria Control , Leprosy/Tuberculosis Control, Integrated Management of Neonatal and Childhood Illnesses (IMNCI), National Aids Control Programme (NACP) and the Health Education Unit (HEU). Furthermore, the Ministry of health's effort is complemented by a host of NGOs (local and international specifically health-oriented) and other private clinics within the Greater Banjul Area.

From May 1979 to date, the EPI has made steady progress in implementing and attaining Global Initiatives such as Polio Eradication, Maternal & Neonatal Tetanus (MNT) and Measles Elimination as well as Reaching Every District (RED) strategy.

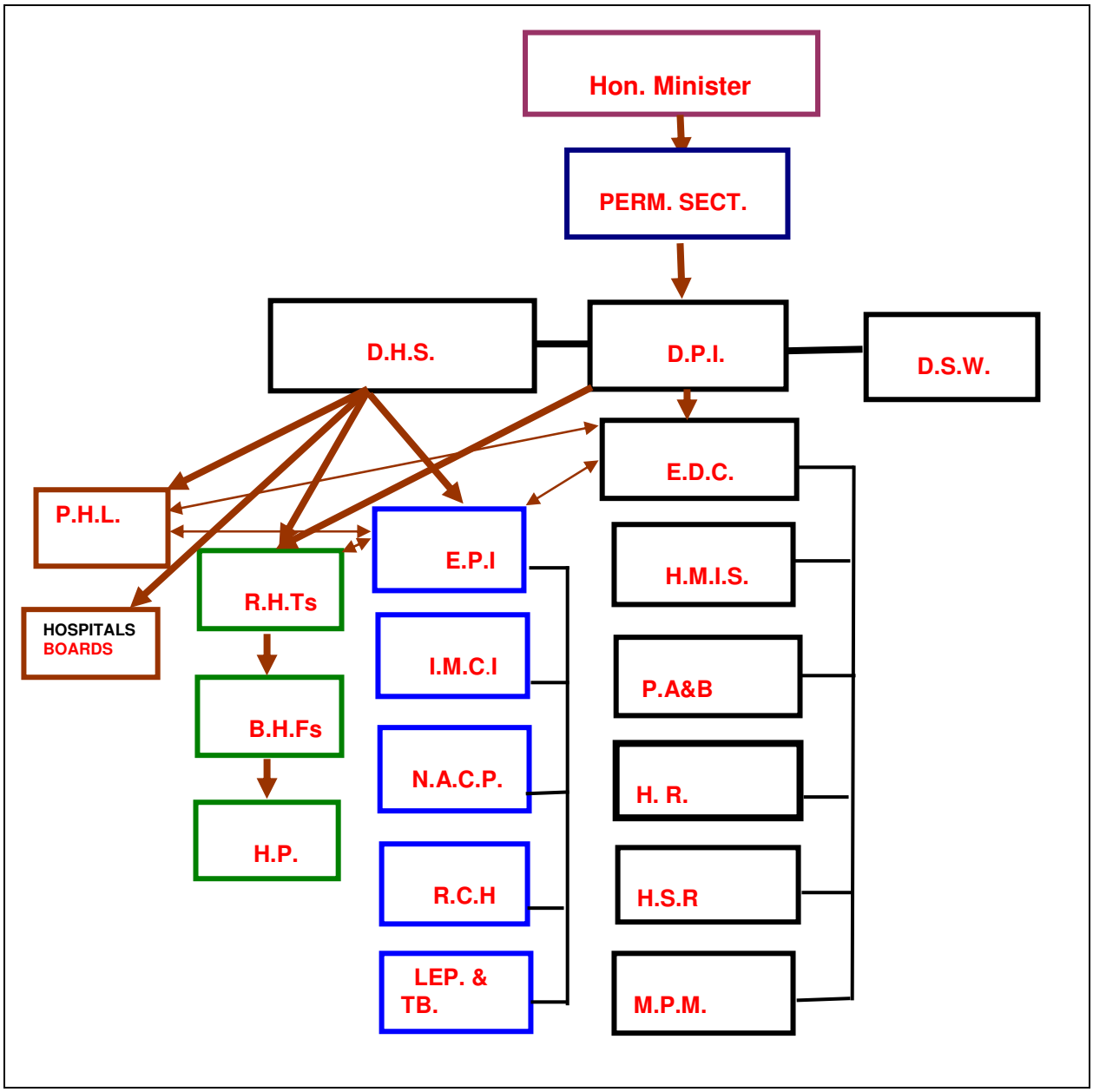
1.4.2 Programme Goal

The goal of the EPI Programme is to reduce childhood morbidity and mortality due to EPI target diseases. These include Tuberculosis, Poliomyelitis, Diphtheria, Pertusis, Tetanus, Measles, Yellow Fever, Hepatitis B, Haemophilus influenza type b and pneumococcal diseases.

1.4.3 The EPI Structure

Immunization services are provided through the Expanded Programme on Immunization. This is one of the high impact child survival and development programmes of the Ministry of Health & Social Welfare. There are five directorates within the Ministry of Health namely, Directorates of Health Services, Planning & Information, Food Safety and Quality Assurances, National Public Health Laboratories and Social Welfare. The EPI Unit is under the Directorate of Health Services and is linked to other intervention programmes eg. RCH, EDC, IMNCI etc. Immunization services are provided to the communities through the RCH clinics monitored and supervised by the Regional Health Teams. Figure 1 is an organogram showing the location and linkages of the EPI programme within the health sector.

Figure 1. Organogram of MoH



1.4.4 EPI Staffing

The EPI programme consists of the following:- Programme Manager; Deputy Programme Manager; Surveillance Officer; Data Manager; Logistician; Communication Officer, 2 Cold Chain

Technicians, 1 Storekeeper, 2 Drivers and a Secretary. In addition there is an EPI focal person (RPHO) in each Region and all the health facilities.

1.4.5 Immunization Services

Table 3: National Immunization Schedule

Antigen	Age given
BCG,OPV0 & Hep.B0	At Birth
OPV1, Penta 1/Pneumo1	2 Months
OPV2, , Penta2,Pneumo2	3 Months
OPV3,, Penta 3 &Pneumo3	4 Months
Measles,Y.F & OPV4	9 Months
OPV BOOSTER	18 Months
DPT BOOSTER	1Year After Penta 3

The Gambia EPI Programme provides ten antigens to its target population through static and outreach strategies based on the national immunization schedule (see schedule above). The static clinics are conducted in health facilities whilst outreach clinics are held at key villages/health posts. Both strategies are implemented through the Reproductive and Child Health (RCH) clinics; thus at a single visit, mothers and children can access a wide range of services. Approximately 60% of immunisation services are delivered through outreach clinics.

1.4.6 EPI Financing

Financial support for public health services including EPI comes from three (3) principal sources:

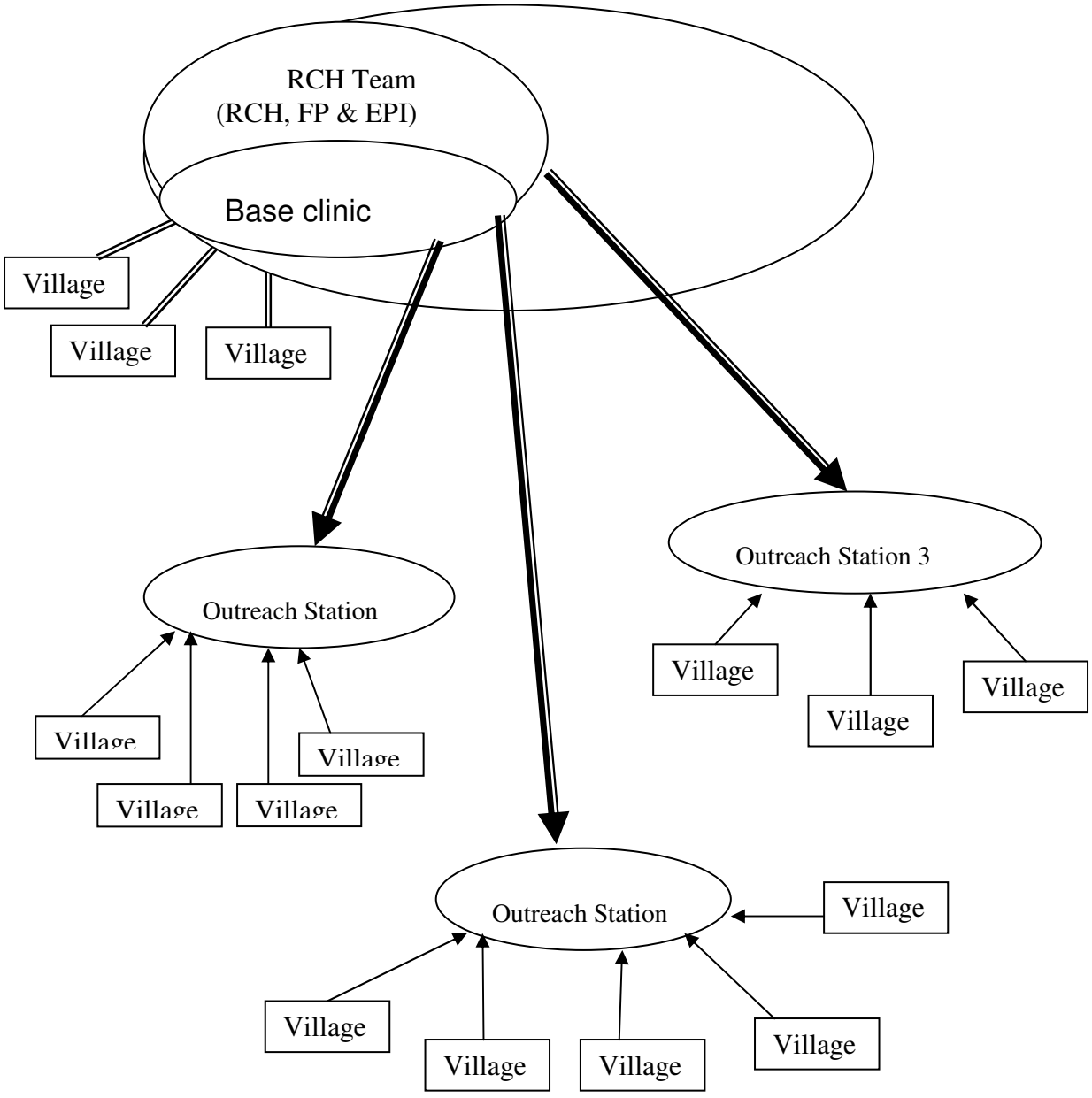
(a) Government recurrent and development budget (10 -14%).
(b) Cost-recovery on drugs(effective in some of the Bamako Initiative health facilities)
(c) External assistance

1.4.7 Reviews, Coverage Surveys and Operational Research

Several reviews, coverage surveys and operational researches have been conducted to guide effective programme implementation. Key amongst them are:

- Post Introduction Evaluation Assessment in 2010
- Regional Coverage survey in 2010 in West Coast Health Region (Supported by MRC)
- The Cold Chain Review in 2007
- The 2006 comprehensive review
- Drop- Out Study in 2005
- Injection Safety Assessment December/January 2005/2006(supported by WHO)
- The 2004/2005 Coverage Surveys
- System –Wide Barriers to Immunization in 2004

Figure 2. Diagram of EPI service delivery



2.0 Situational analysis of the National EPI Programme

2.1. Service Delivery

2.1.1 Routine Immunization

The 2011 EPI desk review revealed that The Gambia attained and maintained high immunization coverage rates (see table 4 below) due to the following strengths: high political commitment; improved access with about 95% of the population living within a radius of 5 to 8 kilometres; availability of continuous quality vaccine supplies and Auto Disable (AD) syringes; monitoring monthly immunization coverage and dropout rates, down ward trend in the incidence of vaccine preventable diseases like measles (see Graph below). Improved injection safety at all levels (Injection Safety Assessment in 2007 and Post Introduction Evaluation in 2010), regular monitoring of EPI activities at field level, solarisation of the cold chain system; active community involvement and participation and availability of vehicles for out reach services and successful introduction of new vaccines such as Penta and Pneumo.

However, the review also revealed the following weaknesses: frequent staff movement at all levels; high staff attrition rates (30-60%); difficult to access funds,,, inadequate supervision by the RHTs (PIE) and limited capacity of staff at operational level to calculate wastage and drop-out rates and uses these data for action as indicated in the 2010 PIE report. These weaknesses, if left unchecked, can negatively impact on the overall performance of the programme.

A major threat has been the high cost of vaccines and consumables, coupled with worsening economic situation. In a bid to improve services, government has contracted an international NGO (Riders for Health) to ensure the availability of reliable transport services.

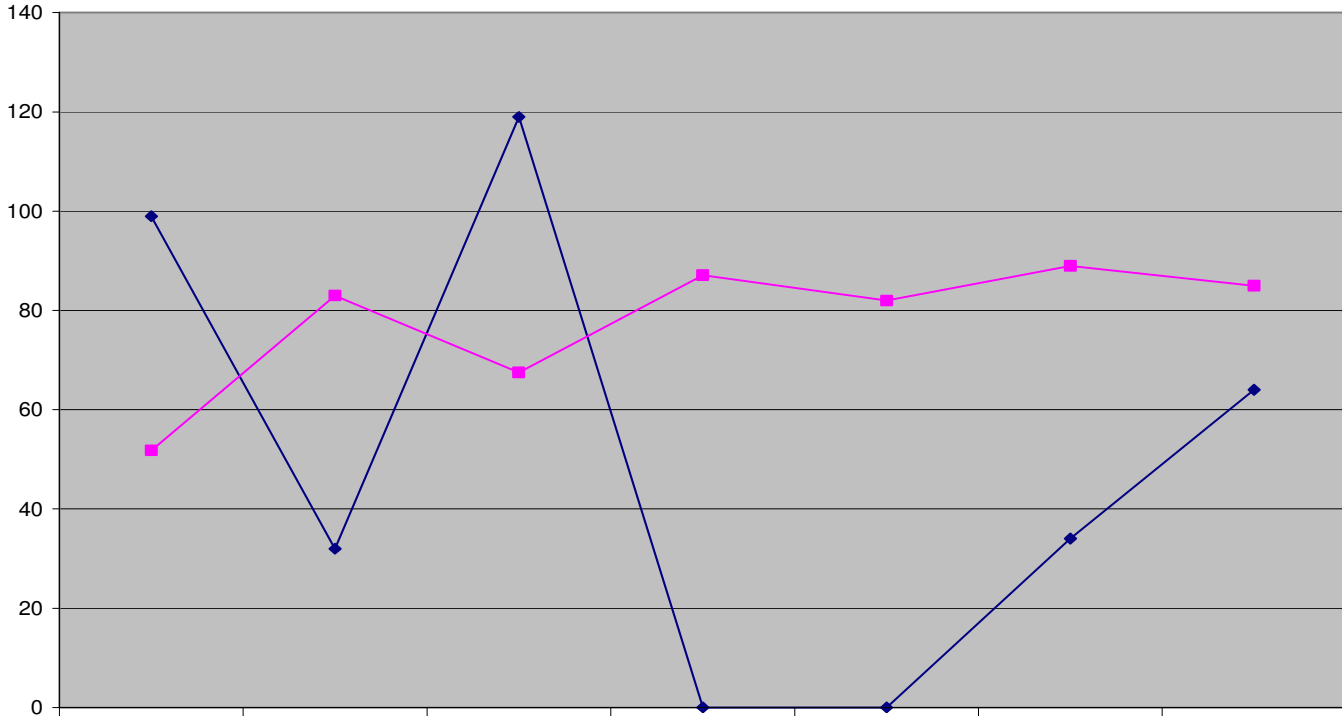
Table 4: Routine Immunization Administrative Data by year-2002-2010

	2002	2003	2004	2005	2006	2007	2008	2009	2010
BCG	88%	85%	88%	83%	90%	95%	95%	94%	92%
HepB – Birth Dose	87%	97%	89%	91%	93%	90%	96%	94%	93
DTP-Hib-HepB1	87%	92%	95%	96%	90%	94%	103%	98%	104%
DTP-Hib-HepB3	80%	90%	92%	89%	91%	94%	96%	98%	97%
Polio3	70%	108%	91%	91%	92%	94%	97%	97%	97%

Measles	83%	85%	86%	81%	90%	85%	91%	96%	92%
Yellow Fever	85%	87%	86%	87%	89%	85%	94%	96%	92%

Source: National EPI Unit, Medical Headquarters, MoH-Banjul, 2010

Graph Showing Suspected Measles Cases and Coverage(2001-2007)



	2001	2002	2003	2004	2005	2006	2007
Cases	99	32	119	0	0	34	64
Coverages	51.8	83	67.5	87.1	82	89	85

2.1.2 Supplemental Immunizations

The EPI programme has been conducting SIAs since 1998. During this period the programme achieved and maintained high coverage (Measles catch-up campaign 96% in 2007 and 98% national Polio coverage in 2010, 90% national coverage of H1N1 in 2010). Suffice it to state that

there has been high political commitment during supplemental immunization activities (SIAs). Records have shown that all the Polio SIAs in 2010 and 2011 were launched by high profile personalities and coverages were above 90% nationally.

In order to maximize the utilization of meager resources during SIAs, Vitamin A supplementation and de-worming were integrated into the Polio SIAs in 2010. The high immunization rates in the SIAs coupled with high routine coverage rates resulted to the attainment of polio free status in 2004, as well as the drastic reduction in measles cases. Adverse Events Following Immunization (AEFI) Surveillance was also conducted during the 2007 Measles SIAs.

Needless to state that there had been some challenges such as inadequate funding for the 2010 and 2011 NIDs, and insufficient logistics support e.g. transport.

2.2.3 Vitamin A Supplementation

Vitamin A deficiency is of public health importance in The Gambia. In a survey conducted in 1999, 64% of children under the age of 5 years were found to be moderately deficient while 9% had evidence of severe deficiency. However, ocular manifestation of severe Vitamin A deficiency was rare.

The integration of Vitamin A Supplementation (VAS) into the RCH/EPI services started in early 2000. As part of the health intervention integration process, Vitamin A is administered to children 6-59 months and post partum mothers within 8 weeks after delivery. Steady increase in coverage rates among the <5year old were registered from 2001 to 2003, 56.3% (NaNA) and 80% in 2006 (MICS 2006). The National Nutrition Agency in 2008 and 2009 conducted stand alone national Campaigns on VAS and deworming with coverage of 86% and 88% respectively. Furthermore Vitamin A supplementation formed part of the Polio and Measles SIAs conducted in 2003 and 2005 84% and 96% respectively as well as 109.7% and 101.6% in 2010 for first and second rounds respectively.

Table 5: Vitamin A Supplementation Schedule currently in place

AGE GROUP	DOSAGE	FREQUENCY
Infant 6-11 months	100,000 I.U.	At 6 months
Children 1-4 years	200,000 I.U.	Every 6 months
Postpartum mothers (up to 8 weeks after delivery)	200,000 I.U.	Single dose

Source: National EPI Unit, Medical Headquarters-DoSH, Banjul 2011

2.2 Surveillance and Accelerated Disease Control

Disease Surveillance has been an integral part of EPI services since its inception in May 1979.The primary purpose of EPI surveillance calls for the continuous monitoring of the occurrence of EPI target diseases through regular and systematic collection, collation and

analysis of data and using the information to prevent, control, eradicate and/or eliminate EPI target diseases.

The Ministry of Health has established a national surveillance system coordinated by EDC under the Directorate of Health services to provide such services. The Unit consists of a coordinator supported by three surveillance officers. The Regional Public Health Officers serve as the EPI/surveillance focal persons who monitor and supervise case investigators at health facility and community levels.

There has been steady progress in case detection, notification, confirmation and data management, which have greatly contributed to the reduction in the incidence and prevalence of targeted diseases. After the establishment of the IDSR surveillance system in 2002, case-based surveillance for Measles, Yellow fever, NNT as well as Meningitis have been reinforced with the development and revision of guidelines and case definition. Surveillance officers and case investigators are active at the three (3) levels of the health system. It is therefore worth mentioning that The Gambia is committed to pursue global and regional initiatives such as Polio eradication, NNT and Measles elimination and Yellow Fever control.

However, the 2011 desk review has revealed some of the strengths and weaknesses as highlighted in the table below:

Table 6: Strengths and Weaknesses of Accelerated Disease Control and Surveillance

Diseases	Strengths	Weaknesses
Polio Eradication	➢ High routine immunization coverage rates of 98% and 97% for 2010 and 2011 respectively ➢ High NIDs coverage rates (2010-2011) ➢ Strong Non Polio AFP rate of >2/100,000 persons below fifteen (15) years of age ➢ Strong collaboration between national and reference labs ➢ Attainment and maintenance of polio free status from 2004 to date	➢ Limited trained manpower to carry out polio surveillance and data management at Regional and health facility levels ➢ Limited commitment to active case search by some of the case investigators, ➢ The training plan was not implemented
Measles Elimination	➢ High routine measles vaccination coverage rates (92%) in 2010 ➢ High SIAs coverage rates for the catch- up campaigns (93%) ➢ No laboratory confirmed measles	➢ Limited trained man power for measles surveillance ➢ Limited active case search ➢ In adequate mobility for case investigators

	cases from 2004 to 2009 ➢ Improved measles data management at the national public health laboratory	
Yellow Fever Control	➢ One of the first countries to include yellow fever in her national immunization schedule ➢ No laboratory confirmed Yellow Fever cases recorded since 1980 ➢ High immunization coverage (93% in 2010)	➢ Inadequate trained man power ➢ Lack of Yellow Fever reagents in the national laboratory ➢ Inadequate community/HF sensitization
Neonatal Tetanus (NNT)	➢ NNT elimination in 2002 (< 1 case/1000 life births). ➢ Availability of tetanus vaccine	➢ Weak diagnostic capacity at facility level ➢ Poor record keeping ➢ Declined TT2+ coverage rates in 2010 (75%)
Hepatitis B	➢ Attained and maintained high coverage rates 93% in 2010 ➢ Efficacy study conducted in 1986-1990	➢ High cost of the vaccine
Haemophilus Influenza type-b (Hib)	➢ GAVI vaccine support from 2002 to date ➢ No shortage from 2002 to date. ➢ High vaccination coverage rates of 97% (routine 2010) are maintained ➢ Reduction and elimination of carriage and invasive Hib disease	➢ High cost of the vaccine
Meningitis	➢ Surveillance of cerebro-spinal meningitis (CSM) strengthened at all levels ➢ Health staff trained in the early detection, notification, investigation and case management methods ➢ Efficacy study on Meningitis A is on-going	➢ Current combined serotypes A and C vaccine does not provide long term immunity (3-5) years ➢ Limited capacity to do lumber puncture at most of the health facilities ➢ Limited capacity to analyse samples at regional level ➢ High cost of the current polysaccharide vaccine.

Table 7: Cross cutting strengths and weaknesses that apply to accelerated disease control and surveillance.

Strengths	Weaknesses
➢ Committed and dedicated staff ➢ Existence of a responsive National Surveillance System (good network of HF/Health Staff) ➢ A network of laboratory services for surveillance ➢ Standard case definition developed for all priority diseases ➢ Effective case-based surveillance system in place ➢ Availability of a 5-year plan for surveillance	➢ Inadequate trained man power ➢ Inadequate mobility ➢ No government budget line item for th development, review and production of th data collection tools and maintenance c equipments ➢ Inadequate laminated case definition card at all levels

2.4 Vaccine Supply and Quality

Vaccine supply and quality is an important part of the EPI quality service delivery. The following strengths were revealed during the EPI Review and these are: the Gambia has a budget line for the procurement of traditional vaccines; vaccines for routine EPI services are procured through UNICEF from WHO approved sources; in country, vaccines are received and stored at the national cold room/store before distribution to the Regional level, where they are stored and distributed to the health facility on monthly basis; to ensure quality vaccines, temperatures are monitored twice daily at all levels; stock records are computerized at central level whilst vaccine ledgers are used at Regional and health facility levels; annual training of health staff on vaccine management conducted

However, the following weaknesses were noted during the review: Difficult to access funds to procure vaccines, there is limited capacity to forecast vaccine needs; limited monitoring of stocks at Regional and health facility levels, thus leading to either stock outs or over stocks; limited monitoring of vaccine wastage and utilization at all levels,

2.5 Cold Chain and Logistics

2.5.1 Cold Chain

Like any vaccination programme, this is the nerve centre of The Gambia EPI programme. The programme maintains a good cold chain network country wide. The strengths revealed during the EPI Review are: solarisation of all public health facilities; enough storage capacity to accommodate vaccines currently being used or planned at both central and regional level (see table 8); stand – by generators at central and Regional levels; presence of an up dated cold chain equipment distribution list (highlighting the level at which they are installed); a replacement plan for cold chain equipments is in place; presence of two cold chain technicians at central level; five of the six regions have stores for vaccine storage.

The review also showed the following weaknesses: no clear government budget line item for the procurement and maintenance of cold chain equipment; insufficient fuel for the stand-by generators; lack of cold van for vaccine transportation; and no cold chain technicians at Regional level; one of the six regions is without a vaccine store. Already UNICEF had procured cold chain equipment for use at regional and health facility levels.

Table 8: Cold Chain Storage Volume

Capacity for positive storage

National vaccine store

		Formula	2012	2013	2014	2015	2016
A	Annual positive volume requirement, including new vaccine (specify:_____) (litres or m3)	*Sum-product of total vaccine doses multiplied by unit packed volume of the vaccine*	3670	3773	4187	4338	4497
B	Existing net positive cold chain capacity (litres or m3)	*#*	7143	7143	7143	7143	7143
C	Estimated minimum number of shipments per year required for the actual cold chain capacity	*A/B*	0.51	0.53	0.59	0.61	0.63

D	Number of consignments / shipments per year	*Based on national vaccine shipment plan*	2	2	2	2	2
E	Gap in litres	*((A/D) - B)*	**-5308**	**-5256**	**-5049**	**-4974**	**-4894**

2.5.2 Logistics

The EPI Programme has in place a functioning logistic monitoring system with the following strengths: a national logistician at the central level; availability of adequate supplies, equipment and consumables at regional and health facility levels

The review also revealed that coordination between the central and Regional levels is weak; absence of logisticians at Regional level; lack of van for supply transportation.

2.5.3 WASTE MANAGEMENT:

The availability of a WDU in each of the six regions is a strength in the area of waste management. However the major health centres deserve to have a separate WDU to handle immunization and clinical wastes.

2.6 Advocacy and Communication

The role of advocacy and communication in the overall EPI service delivery cannot be over emphasized. These have been successfully used to sensitise decision/policy makers and the Gambian community, particularly women. The strengths revealed during the review include: existence of a Communication Officer at national level and in all the regions and the existence of a functional Inter-agency Coordinating Committee (ICC).

However, the major weaknesses revealed include: the lack of funds for the implementation of the EPI communication plan; absence of terms of reference (ToR) for the communication officers in the regions..

2.7 Programme Management

The EPI management is responsible for the planning, implementation, monitoring and evaluation of EPI activities. The unit conducts studies, operational researches, policy formulation and

periodic desk reviews with key stakeholders in the health sector to guide programme implementation.

Key positive issues highlighted in the review includes

- Joint monthly monitoring and supportive supervisory field visits countrywide with EDC and WHO,
- Existence of a National Health Policy that addresses the needs of the underserved populations and
- Availability of EPI Manuals/Guidelines at all levels
- .

However, the following weaknesses were noted:

- The Pneumo training manual has not been incorporated in to the main EPI training manual
- The EPI policy has still not been finalised
- Lack of concise and clear job descriptions for EPI staff
- No annual operational plans at Regional and health facility levels,
- Irregular and weak supportive supervisory visits by RHTs and
- Weak/limited stock and vaccine wastage monitoring at all levels
- Limited capacity for monitoring of drop out rates

2.8 Sustainable EPI Financing

The Government of the Gambia is highly committed to support sustainable vaccination/mmunisation services. In this regard MoH&SW would negotiate with MoFEA to continue increasing the budgetary allocation to purchase vaccine and consumables.

Furthermore, there would be continuous advocacy for partnership involvement in immunization services. In this regard joint public/ private sector resource mobilisation will be geared towards EPI sustainable financing. There is also a window of opportunity for cross cutting issues to be addressed by the Health System Strengthening through GAVI and various disease specific components of the Global Fund.

As a requirement for the introduction of new vaccines, a Financial Management Assessment (FMA) was conducted in 2010. The strengths revealed by the assessment are: adequate capacity at the EPI unit to implement the GAVI ISS funds; there has also been regular monitoring of immunization services at field level. However, the major weaknesses include:
all the expenditures were not approved by ICC; there was no regular bank reconciliation and also poor records keeping

During the development of cMYP, firm financial commitment were given by WHO and UNICEF that would make funds available to the country depending on the level of resources being mobilized. However, the country will continue to engage other partners including the private sector in local resource mobilization to ensure sustainability in support of EPI activities. Both the health master plan and the EPI cMYP will be used for resource mobilization to support immunization.

2.9 Human Resource and Institutional Strengthening

Human resource strengthening is a critical and integral part of any programme, especially EPI; therefore the training, re-training and motivation of staff at all levels cannot be overemphasized. Currently, staffs from health training institutions and Regional level are being involved in the Mid-Level-Management (MLM) training course at national and international levels. During the review, the following strengths and weaknesses were identified:

Strengths

- Existence of a Human Resource Policy and a 5 year strategic Plan.
- Availability of trained, committed and dedicated health staff at all levels
- Availability of a good network of hospitals, Health Centres and Reproductive and Child Health Clinics for EPI and related services
- Existence of a Budget Line for maintenance services.
- Availability of Special skills, hardship, risk, ISS and GF allowances

Weaknesses

- High staff attrition rate (30-60% with an annual increase of 4%)
- Weak community structures for implementing EPI activities in some of the regions
- Inadequate trained man power at all levels
- The human resources strategic plan not yet implemented
- Most of the Primary Health Care posts are in a poor state of repairs.
-

3.0 Mission

The mission of the immunization programme for the next five (5) years (2012 – 2016) is to improve the health and well being of the population by protecting more people using available and new vaccines and technologies in reducing the burden of Vaccine Preventable Diseases through high quality immunization services within the context of GIVS[1].

This cMYP will concentrate on:

- Strengthening the immunization services (training, retraining, expanding outreach services, strengthening supportive supervision etc)
- Surveillance and accelerating disease control (integration, eradication, and elimination of Measles/NNT)
- Advocating for increased political commitment and community involvement and participation
- Introducing new vaccines such as Measles second dose
- Conducting operational research on EPI activities and other relevant technologies

[1]Four strategic areas of GIVS

- **Protecting more people in a changing world**
- **Introducing new vaccines and technology**
- **Integrating immunization, other linked health interventions and surveillance in the health system context**
- **Immunizing in the context of global interdependent**

4.0 Goal and Objectives

4.0.1 Goal

The goal of the 5 year plan is to reduce morbidity and mortality due to vaccine preventable diseases such as Tuberculosis, Polio, Diphtheria, Pertusis, Tetanus, Measles, and Yellow Fever, Hepatitis B, Hib and Pneumococcal diseases.

4.0.2 Broad Objectives

1. To build capacity of health staff in EPI and related services and disease surveillance
2. To increase immunization coverage by raising awareness of Gambians on the benefits of immunization
3. To ensure sustainable supply and safety of vaccines and consumables in the programme
4. To introduce new vaccines, technologies and policies in a sustainable manner
5. To reduce drop-out and wastage rates

5.0 Programme Objectives, Targets and Milestones

National priorities	Programme objective	Targets and Milestones	Regional goals
Service delivery			

National priorities	Programme objective	Targets and Milestones	Regional goals
1. Maintaining national immunization coverage rates for all antigens	To increase immunization coverage to 90% or above for all the antigens by 2016	≥ 90% coverage for all the antigens attained by 2016	
2. Maintaining high national immunization coverage for Penta3	To attain Penta3 coverage of 95% nationally and 90% in all the health regions by 2016	95% and 90% Penta3 coverage attained nationally and Regionally respectively by 2016	90% DPT national Regional respective
3. Reducing wastage rates for all antigens by 2016	To reduce vaccine wastage rates (Measles and Yellow Fever-15%,, Polio and Penta 3,TT to 10% or below and (BCG to 25%) at all levels by 2016	Vaccine wastage rates reduced to: BCG 25%, Measles & Y. Fever 15%, OPV , TT & Hep.B and Pentavalent 10%,) by 2016	By 2016 a adopt the policy
4 Introducing New vaccine	To introduce Measles second dose by 2012, Men.A, 2013 and Rota in 2014.	Measles second dose, men.A & Rota vaccines introduced by the end of 2016	By 2016, encourage new vaccin
Surveillance and Accelerated Disease Control			
I. Surveillance			
1. Weak surveillance system	To strengthen and improve disease surveillance particularly EPI target diseases at all levels by 2016	Surveillance system for EPI target diseases strengthened at all levels by 2016	
	To improve/strengthen data management at Regional and health facility levels by 2016	Improved data management at Regional and health facility levels by 2016	
	To strengthen laboratory services at national and Regional levels by 2016	laboratory services at national and Regional levels strengthened by 2016	
ii. Accelerated Disease Control			
1. Polio eradication	To attain and maintain non Polio AFP rate of >2/100,000 population <15 years of age by 2016	>2/100,000 persons <15 years attained by all the regions, by 2016	Polio eradi
2. Measles elimination	To attain measles elimination status by 2016	measles elimination status attained by 2016	By 2016, at least 9 Measles compared
3. Neonatal Tetanus Elimination	To maintain the elimination status of <1/1000 live births by 2016	<1/1000 live births maintained by 100% of the regions, by 2016,	By 2016, countries v elimination
4. Yellow Fever control	To improve surveillance for yellow fever at all levels by 2016	80% of the districts will detect , notify, investigate	All priorit conduct Y

National priorities	Programme objective	Targets and Milestones	Regional goals
		cases and collect samples by 2016	
5. Meningitis control	To ensure that there is at least one medical doctor in each of the hospital to carry out lumbar puncture by 2016	At least four out of the five hospitals carry out lumbar puncture by 2016,	All priorit conduct M
6. Limited Routine Monitoring of Adverse Events Following Immunization (AEFI)	To strengthen AEFI monitoring at all health facilities by 2016	100% of health facilities will conduct AEFI surveillance, by 2016.	
Vaccine supply and quality			
1. Maintaining regular and quality vaccine supply by 2016	To maintain regular and quality vaccine supply at all levels by 2016	Regular and quality vaccine supply maintained at all levels by 2016	
2. Difficult to access funds to procure vaccines	To improve access to funds for vaccine procurement by 2016	Access to funds for vaccine procurement by 2016	
3. Limited stock monitoring at both Regional and h/facility levels (artificial shortage)	To strengthen stock monitoring at Regional and health facility levels by 2016	Vaccine stock monitoring strengthened in all regions and health facilities by 2016	
4. Irregular temperature monitoring and recording at Regional and health facility levels	To strengthen regular monitoring and recording of temperatures at Regional and health facility levels by 2016	Regular temperature monitoring and recording strengthened in all the regions and health facilities by 2016,	
5. lack of cold van for vaccine supply distribution	To procure one cold van for vaccine supply distribution	Cold van procured by the end of 2012	
COLD CHAIN			
1. Non utilization of one of the regional vaccine stores	To utilise one regional store 2016	.Vaccine stores utilised in one of the regions by end of 2016	
2. No cold chain technicians at Regional level	To recruit and train two cold chain technicians by 2016	Two cold chain technicians recruited and trained by 2016	
Logistics			

National priorities	Programme objective	Targets and Milestones	Regional goals
1.Weak logistics systems at Regional and health facility levels	To strengthen the existing logistics systems at regional and health facility levels by 2016	Logistics system strengthened at regional and health facility levels by 2016	
2. Improving waste management in all the regions	To ensure that the six major health facilities have incinerators	Incinerators are built in all the six major facilities	
Advocacy and communication			
1. Inadequate involvement and participation of senior government officials, politicians, communities/religious leaders and the private sector in EPI and related services	To increase the involvement and participation of senior government officials, politicians, communities/religious leaders and the private sector in EPI and related services by 2016	Senior government officials politicians, communities/religious leaders and the private sector actively involved and participated in 80% of the EPI and related activities by end of 2016	
2. Limited utilization of the Mass and electronic Media in routine immunization services 3. Limited technical support for the regional communication officers by central level	To increase the utilization of the mass and electronic media for routine immunization services by 2016 To provide technical support to the regional communication officers by 2016	Mass and electronic media utilized in 80% of routine immunization services by 2016, Technical support provided to the communication officers 2016	
Programme Management			
1. Improve the effectiveness and efficiency of the EPI programme	To increase the managerial capacity of the EPI programme by 2016	Managerial capacity of the EPI programme increased by 2016	
	To conduct operational research, programme review and assessment of the EPI services by 2016	Operational research, programme review and assessment of the EPI services conducted by 2016	

6.0 Introduction of new vaccines

The Gambia had and will continue to introduce new vaccines, in pursuance of implementing strategic area number 2 of GIVS (i.e. introducing new vaccines and new technologies). Following the successfully concluded PCV-9 trial, The Gambia introduced the PCV-7 valent

vaccine in August 2009 and switched to a 13 valent vaccine with more protective capacity in 2011. In line with GAVI co-financing principles, the country will continue to fulfill its commitment in this regard. The antigen (PCV-13) will be administered at 2, 3, and 4 months of age according to the schedule in table 3.

In a bid to further reduce the morbidity due to Measles, the country has introduced the Measles second dose in August 2012 and Rota in August 2013 in the routine immunization schedule. In addition Men. A preventive campaign was conducted in November/December 2013 targeting 1 – 29 years. It is envisage that The Gambia will conduct a Measles Rubella preventive campaign in November 2015 targeting 9 months to 14 years and subsequently introduced it into the routine immunisation programme in March 2016.

In order to introduce these vaccines successfully, the following pre-implementation activities will be carried out:

- *Consensus building with key partners*
- *Review and update of data collection tools and training manual*
- *Community sensitization and development of IEC materials*
- *Training of health staff*
- *Cold chain expansion*
- *Finalising the EPI Policy*

7.0 Objectives, Strategies and activities by system components

Service Delivery

Objectives	***Strategies***	***Key Activities***
1. To increase immunization coverage to 90% or more for all the antigens by 2016	Training and retraining of health staff in EPI/RCH services.	Train 100 staff per year on EPI/RCH services
2. To attain 95% Penta3 coverage at national level and 90% in all the health regions by 2016	Maintaining/improving community participation and involvement.	Sensitize men on the importance of immunization Expand outreach services to

3.To reduce wastage rates for (,Measles, Yellow Fever (15%), Penta 3, Polio and TT to 10% or below and (BCG to 25%) by 2016	Strengthening the out reach services. Strengthening supportive supervision Improving vaccine	under-served areas Conduct monthly supportive supervision at Regional and health facility levels Train health staff on the introduction of Measles second
4 To introduce Measles second dose vaccine by 2012		

	wastage and drop-out monitoring at all the health facilities Increasing the capacity of the immunization services for new vaccines introduction	dose Develop and print vaccine wastage and drop-out monitoring tools (1000 each) Increase storage capacity Sensitize communities and regional authorities Review and modify data collection tools	
5. To conduct supplemental Measles SIAs in 2011 and 2015	Supplementing routine immunization with Measles SIAs	Conduct measles SIAs Monitor Measles SIA programmatic impact (eg. AEFI)	

Surveillance and Accelerated Disease Control

Objectives	***Strategies***	***Key Activities***

1.To strengthen and improve disease surveillance particularly EPI target diseases at all levels by 2016	Increasing the capacity of health staff in EPI/IDSR surveillance techniques and data management (including case detection, management, investigation and reporting, as well as epidemic preparedness.) strengthening laboratory services at national and Regional levels by 2016 Motivating case investigators to conduct active case search. Improving community involvement and participation in EPI/IDSR disease surveillance Improving sample collection, transportation and provide feed back at all levels Building capacity of health staff on data management	Train 100 surveillance officers and case investigators on EPI/IDSR surveillance techniques yearly Conduct supportive supervision Organize sensitization meetings with clinicians and case investigators annually Print laminated case definitions for all EPI/IDSR diseases Conduct active case search in all the health facilities Conduct bi-monthly surveillance, (NCC, NPEC, NTF & EPI/EDC/lab) meetings Provide quarterly communication cards Organise advocacy and sensitization meetings for politicians and policy makers Sensitize communities on simple signs and symptoms of EPI diseases and the importance of timely reporting Transport samples to national and Regional laboratories on time Provide 40 stool carriers

2. To improve/strengthen data management at all levels by 2016		Procure 40 stool carriers Training and re-training of data entry clerks on data management Revise and print data collection tools
		Purchase additional data management equipment and accessories: i. Two computers and antivirus disc ii. Ten 2gb USB pots iii. Fifty printer cartridges iv. Fifty cartons of A4 paper

VACCINE SUPPLY		
Objectives	***Strategies***	***Key Activities***
To maintain regular and quality vaccine supply at all levels by 2016	Providing funds to procure vaccines Strengthening regular stock and temperature monitoring and recording at all levels Procuring a cold van for vaccine supply distribution Strengthening the monitoring of vaccine wastage at all levels	Advocacy meetings with policy makers Procure traditional vaccines and safe injection materials Transport vaccines and other supplies quarterly to the RHTs Train Regional and health facility staff in vaccine management Supervise Regional and health facility level staff in vaccine stock and supplies management Revise and print vaccine ledgers and temperature monitoring charts

Cold Chain		
Objectives	***Strategies***	***Key Activities***
To strengthen the existing cold chain systems at all levels by 2016	Increasing the vaccine storage capacity at all levels	Procure 20 solar refrigerators, 10 Freezers, 10 electric refrigerators, 20 cold boxes, and 100 thermometers Procure air conditioners for the regional cold stores
	Recruiting two cold chain technicians at the Regional level	Procure spare parts for the cold rooms and refrigerators Conduct quarterly cold chain maintenance Train two cold chain technicians by 2016
Logistics		
Objectives	***Strategies***	***Key Activities***
To strengthen the existing logistics systems at all levels by 2016	Providing protective gears and equipment for six incinerator attendants	Purchase 12 rain boots, 12 rakes, 24 rain coats, 48 gloves and 24 goggles

	Strengthening the injection waste disposal system	Rehabilitate the existing incinerators Build additional 6 incinerators at major health facilities Strengthen monthly collection mechanism of safety boxes from health facilities to the RHTs Regular supervision of incinerator attendants and also on the proper usage of the incinerators
	Strengthening mobility for EPI/RCH/EDC and related services	Purchase additional: i. one supervisory vehicle ii. fuel for outreach services and stand-by generators iii. Spare parts for vehicles/motorcycles and stand-by generators
Advocacy and Communication		
Objectives	***Strategies***	***Key Activities***
1. To increase the involvement and participation of senior government officials, politicians, communities/religious leaders and the private sector in EPI and related services by 2016	Improving communication skills of health workers at all levels Conducting advocacy meetings with senior government officials, and politicians	Organise advocacy meetings with senior government officials and politicians Organize sensitization and consensus building meetings

	Developing IEC materials and sensitizing communities/religious leaders in EPI and related services, .	Train health workers in communication skills
	Increasing community involvement and participation in EPI/RCH services.	Organise radio and TV discussions thrice a year (phone-in for 10 radio stations) and develop radio and television spots Print IEC materials
	Observing African Vaccination Week annually	Sensitize communities on the importance of immunization (open field days, press briefings)
3. To provide technical support to the communication officers at regional level by 2016	Advocating for the development of TOR for the communication officers at the regions.	Facilitate/conduct Regional meetings

	Building capacity of regional communication officers Creating health communication coordinating committees at Regional level.	
4.To increase the utilization of the mass and electronic media in routine EPI/IDSR activities by 2015	Increasing the use of mass and electronic media in promoting routine EPI/RCH service	Conduct radio and television programmes Conduct press briefings
1. To provide additional funding for EPI programme implementation by 2016	Intensifying MoH&SW and ICC/partners resource mobilization activities. Advocating for increased budgetary allocation for EPI	Organize donor conference Organize advocacy meetings with senior government officials and politicians
2. To develop clear and concise job description for the EPI staff by end 2016	Developing/ adopting job descriptions for EPI staff.	To develop job description of each staff
3. To increase the capacity of the programme staff by 2016	Training/retraining of staff in their specialized areas of work	train staff on programme management
4. To conduct operational research, programme review and assessment of the EPI services by 2016	Reviewing/updating the current EPI training manual. Conducting operational research, coverage surveys, rapid assessment on the extent of AEFI etc	revise the EPI training manual by 2011 Conduct biennial immunization coverage surveys

8.0 Log frame for the implementation of the cMYP

Operational Areas	Objectives	Activities	Outcomes	Indicators	Timeframe					Responsible Officers	Budget in US $	F S
					Y 1	Y 2	Y 3	Y 4	Y 5			
Service Delivery	To increase immunization coverage to 90% or more for all the antigens by 2016	Train 100 staff per year on EPI/RCH services	Training conducted	No. of staff trained	X	X	X	X	X	EPI Manager	60,000	G O F
		Expand outservices to under served populations	Outreach services expanded	No. of outreach services opend	x	x	x	x	x	EPI Manager	20,000	G O F
	To attain 97% penta 3 coverage at national level and 90% in all the health regions by 2016	Sensitize communities on the importance of immunization	sensitization meetings held	No. of meetings conducted	X	X	X	X	X	EPI Manager	10000	G N A

	To reduce wastage rates (Measles and Yellow Fever-10%, Polio Penta 3, and TT to 10% or below) and (BCG to 25%) by 2016	Train staff on vaccine management	Staff trained	Number trained		x	x			EPI Manager	10,000	G A
		Develop and print vaccine wastage and drop-out monitoring tools (1000 each)	Vaccine wastage and drop-out monitoring tools developed	No. of monitoring tools produced		X				EPI Manager	6830	G H
	To introduce Measles second dose by 2013, Meningitis A in 2014 and Rota in 2015	Procure 20 solar refrigerator, 10 freezers, electric refrigerators	Equipment procured	No. of equipment procured and installed	X	X	X			EPI Manager	150,000	G A
		Sensitise communities	Communities sensitized	No. of communities sensitized		X				EPI Manager	10,000	
		Review, finalise and print data collection tools	Data collection tools reviewed, finalised and printed	No. of tools printed			X	x	x	EPI Manager	15,000	
		Train 100 health staff	Training conducted	No. of staff trained		X	X			EPI Manager	10000	

		Strengthen AEFI surveillance	AEFI strengthened	No. of regions monitoring AEFIs			X	X	X	EPI Manager	15,000	G H
		Conduct monthly supportive supervision at Regional and health facility levels	Supervisory visits conducted	No. of supervisory visits conducted	X	X	X	X	X	EPI Manager	72000	
		conduct Measles SIAs	Measles SIAs conducted	Report produced and dessiminated		X			X	EPI Manager	500,000	
	5. To conduct supplemental Measles SIAs by 2011 and 2015	Procure loud hailers (100 hand held and 20 vehicle mount)	Loud hailers procured	Number of loud hailers procured and delivered	X	X				EPI	5000	U

Surveillance and Accelerated Disease Control	1. To strengthen and improve disease surveillance particularly EPI target diseases at all levels by 2016	Train 100 surveillance officers and case investigators in EPI/IDSR surveillance techniques	Health staff trained	No. of health staff trained	X	X	X	X	X	EPI Manager	70,000	W
		Print laminated case definitions for all EPI/IDSR diseases	Laminated case definition printed	No. printed and distribution	X	X	X	X	x	EPI MANAGER	2,675	W
		Organise sensitization meetings with clinicians and case investigators annually	sensitization meetings held	No. of meetings held	X	X	X	X	X	EPI/EDC Heads	4000	

		Conduct bi-monthly surveillance, (NCC, NPEC, NTF & EPI/EDC/lab) meetings	Meetings held	No. of meetings held and minutes	x	x	x	x	x	EPI/EDC Heads	83,000	W
		Organise advocacy and sensitization meetings for politicians and policy makers	Meetings held	No. of meetings held and minutes	x	x	x	x	x	EPI/EDC Heads	4000	W
		Transport samples to national and Regional laboratories on time	Samples transported	No. of samples collected and transported	x	x	x	x	x	EPI/EDC Heads	20,000	W
		Provide 40 stool carriers	Stool carriers provided	No. of carriers purchased	x	x	x	x	x	EPI/EDC Heads	5,000	W
		Provide quarterly communication cards	Cards provided	No. of cards purchased	x	x	x	x	x	EPI	50,000	W

		Sensitize communities on simple signs and symptoms of EPI diseases and the importance of timely reporting	sensitization meetings held	No. of meetings conducted and minutes	x	x	x	x	x	EPI/EDC Heads	50,000	W
		Conduct active case search in all the health facilities	Active case search conducted	No. of cases detected and reported	x	x	x	x	X	EPI MANAGER	44,700	W
	2. To strengthen data management at Regional and health facility levels by 2016	Revise and print data collection tools	Tools printed	Number printed	x	x	x	x	x	EPI MANAGER	5,000	G O
		Training and re-training data entry clerks on data management	Staff trained	Number trained	x		x	x	x	EPI MANAGER	10,000	W IC VI

Vaccine Supply and Quality		Purchase additional data management equipment and accessories (2 computers and antivirus disc, ten 2gb USB pots, 50 printer cartridges, 50 cartons of A4 paper)	Equipment and accessories purchased	Quantity of equipment and accessories purchased	X	X	X	X	X	EPI Manager	12420	G H E
		Procure traditional vaccines and safe injection materials	Vaccines and safe injection materials procured and distributed	Quantity of vaccines and safe injection materials procured and distributed	x	x	x	x	x	EPI	275,751	G A ef
		Transport vaccines and other supplies quarterly to the RHTs	Vaccines and other supplies transported	Quantity of vaccines and other supplies transported	x	x	x	x	x	EPI	11,780	G A

	To maintain regular and quality vaccine supply at all levels by 2016	Train Regional and health facility staff in vaccine forecasting	Regional and Health facility staff trained in vaccine forecasting	No. of Regional and health facility staff trained (	x	x	x	x	x	EPI	Costed under service delivery	G A ef
		Supervise Regional and health facility level staff in vaccine stock and supplies management by the EPI team	Regional and Health facility staff supervised in vaccine stock and supplies management	No. of supervisory visits conducted	x	x	x	x	x	EPI	16,027	G A ef
		Revise and print vaccine ledgers and temperature monitoring charts	Vaccine leadgers and temperature charts revised and printed	No. of revised vaccine ledgers and temperature charts printed	x	x	x	x	x	EPI	4,460	G A ef

Cold Chain		Procure 10 Electric refrigerators, 10 Freezers, 20 solar refrigerators, 20 cold boxes, 20 vaccine carriers and 100 thermometers	Equipment procured and delivered	No. of equipment procured and delivered	x	x	x	x	x	EPI	150,000	G AV ef
		Purchase sparepars ts for the central and regional cold rooms	Parts purchased	Quantity purchased	x	X	x	x	x	EPI	6,120	U AV
		Repair the national and regional cold rooms	Repairs provided	Number repaired	x		x		x	EPI	3000	G IC TC
		Procure a cold van for vaccine transport ation	Van procured	No. procured	x					EPI	17,000	G

	To strengthen the existing cold chain systems at all levels by 2016	Utilized one Regional store	Regional store utilized	No.utilized		X				EPI	3,060	G ce
		Conduct quarterly cold chain mainten ance	Cold chain maintena nce conducte d	No. of maintenan ce visits conducted	x	X	x	x	x	EPI	15,925	U
		Recruit and train two cold chain technicia ns by 2016	Two cold chain technicia ns recruited and trained	No. of cold chain technicians recruited and trained		x				EPI	1,091	G
Logistics		Purchas e 12 rain boots, 12 rakes, 24 rain coats, 48 gloves and 24 goggles	Protectiv e gears purchase d	No. of protective gears purchased	x					EPI	700	W VI
		Rehabilit ate the existing incinerat ors	Incinerat ors rehabilitat ed	No. incinerator s rehabilitate d	x					EPI	600	W VI
		Build addition al 6 incinerat ors in the major health facilities by 2016	12 additional incinerato rs built at the Regional and Major health facility levels	No. of incinerator s built		x	x	x	x	EPI	48,000	W VI

	To strengthen the existing logistics systems at all levels by 2016	Strengtn en monthly collectio n mechani sm of safety boxes from health facilities to the RHTs	Monthly collection mechanis m of safety boxes from health facilities to RHTs instituted	No. of safety boxes collected	x	x	x	x	x	EPI	15,272	U A
Advocacy and Communication		Organiz e advocac y meeting s with senior governm ent officials, politician s and the private sector	Advocacy meetings organize d	No. of meetings organized	X	X	X	X	X	EPI	25000	U
		Train health workers in commun ication skills	Health workers trained	No. of staff trained		X		X		EPI	2000	U

		Sensitize communities on the importance of immunization	Communities sensitized	No. of communities sensitized		X		X		EPI	2000	U
	To increase the involvement and participation of senior government officials, politicians, communities/religious leaders and the private sector in EPI and related services by 2016	Organize radio and TV discussions thrice a year (phone-in for 10 radio stations) and develop radio and television spots	Radio and TV programmes organized	No. of programmes organized	X	X	X	X	X	EPI	62594	G IC
	. To increase the awareness of communities on the benefit of immunization by 2016	Print IEC materials	IEC Materials printed	Number of materials printed and distributed	X	X	X	X	X	EPI	20182	U G
	To provide technical support for the regional communication officers by 2016	Provide technical support	Technical support provided	Number supported	x	x	x	x	x	EPI MANAGER	10,000	W VI

	To increase the utilization of the mass and electronic media in routine EPI/IDSR activities by 2016	Procure IEC Equipment	IEC equipment procured	Number of equipment procured	X					EPI	5100	UI
		Organize sensitization and consensus building meetings	Sensitization and consensus building meetings organized	No. of meetings organized and minutes produced		X		X		EPI	10000	UI GA
PROGRAMME MANAGEMENT		Organize donor conference thrice	Donor conference organized	No. of conferences organized	X		X		X	EPI	15000	UI GA
		provide additional training for EPI staff by 2016	Training supported	No. of staff trained		X	X	X	X	EPI	182600	GA OI
	To increase the managerial capacity of the EPI programme by 2016	Procure two desk top computers and printers, 1 fax machine, 2 lap top computers and 1 LCD projector	Office equipment procured	Quantity of equipment procured and delivered	X	X	X	X	X	EPI	18800	GA NI HC

	To conduct operational research, biennial immunization evaluation surveys, programme review and assessment of the EPI services by 2016	Purchase 6 photocopier and 5 printer cartridges	Office equipment procured	Quantity of equipment procured and delivered	X	X	X	X	X	EPI	2005	G N H
		Purchase 6 USB (2gb)	USB procured	No. of USB procured	X		X		X	EPI	2000	G O
		Purchase stationeries	Stationeries purchased	Quantity of stationeries purchased	X	X	X	X	X	EPI	1200	U G
		Revise the EPI training manual by 20011	Training manual revised	Revised manual printed and distributed		X				EPI	3500	G O
		Conduct rapid assessment on the extent of routine AEFI	Rapid assessment conducted	Report produced				x		EPI	12000	U G O
		Conduct EPI cluster survey	Survey conducted	Report produced		x		x		EPI	20,000	U G O
		Evaluate Measles SIA	Measles SIA evaluated	Report produced and distributed	x					EPI	10,000	W

9.0 Process Monitoring and Evaluation

The central level will continue to circulate annual targets to all regions and health facilities to ensure the monitoring of all antigens. Routine immunization coverage rates will be monitored monthly by the RHT and EPI Unit staff by health facility catchment area. Staff at both the regional and health facility levels were trained on DQA and the EPI management in collaboration with the RHts would ensure that this practice is enforced during routine supervisory trips. The central and Regional staff will continue to adequately ensure that the EPI service delivery data is received monthly from the Regional public health officers and health facility heads/focal persons. Feed –back will be provided by the central level to the regions and through them (regions) to the health facilities. Quarterly summaries will be provided by the regions from routine immunization and disease surveillance data. These reports will be used by the central level to assess Regional performance.

EPI monitoring charts will continue to be used at the health facilities with supervision from the regions. The primary focus will be on monthly review of key programme parameters such as:

Progress made towards the achievement of set targets.

- Immunization coverage rates
- Drop out rates
- Wastage and stock levels
- Clinic/immunization session cancellations especially for out reach services etc

The analysis of and feed back from such parameters will enable the Regional Management teams to quickly identify poor performing health facilities and target them for additional support and supportive supervision.

Meanwhile, the surveillance information on EPI preventable diseases sent to the Epidemiology and Disease Control Unit will be assessed through bi-monthly / quarterly meetings with EDC and /or RHTs.

The evaluation of the programme will continue to be conducted in both the short and the medium term by the staff through coverage surveys and operation research. Furthermore, the

information obtained from the research will be augmented by a more comprehensive review of the EPI programme to be conducted every four years.

THE GAMBIA - Composition of the Funding Gap (Immunization Specific C

Show the funding gap with secure funds only		Y	(Select N for displaying the funding gap w funds)

Composition of the funding gap	2012	2013	2014	2015
Vaccines and injection equipment	$1	$381	$0	

Personnel			$0	
Transport	$52,553	$51,732	$75,242	$49,721
Activities and other recurrent costs	$131,811	$51,449	$180,399	$86,343
Logistics (Vehicles, cold chain and other equipment)	$274,307	$213,114	$274,665	$216,884
Campaigns	$40,000	$51,675	$6,749,924	$73,787
Total Funding Gap*	**$498,671**	**$368,350**	**$7,280,230**	**$425,151**

* Immunization specific resource requirements, financing and gaps. Shared costs are not included.

10.0 Budget Summary and Graphic Representations

Table 9: Budget summary by cost centre and year

(A)

(B)

Figure 3: Projection of Future Resource requirements by year and cost centre

Insert graph from the costing tool

Figure 4: Composition of funding gap by year

INSERT GRAPH FROM THE COSTING TOOL

Figure 5: Future secure Financing and Gaps by years

INSERT GRAPH FROM THE COSTING TOOL

Figure 6: Future secure and Probable Financing and Gaps by Year and Funding source

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Figure 7: Baseline Cost Profile (Routine only) by cost centre

INSERT THE DIAGRAM FROM THE COSTING TOOL

Figure 8: Projection of Future requirements by year and cost centre

INSERT GRAPH FROM THE COSTING TOOL

Figure 9: Costs by strategy

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