REPUBLIC OF ZIMBABWE

ZIMBABWE EXPANDED PROGRAMME ON IMMUNIZATION

COMPREHENSIVE MULTI YEAR PLAN
2012 I 2016

Developed April 2011

Prepared by
Ministry of Health and Child Welfare

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EXECUTIVE SUMMARY

This comprehensive Multi Year Plan (cMYP) which covers the period 2012 to 2016 is the culmination of several developments and updates since 2005 when the country first developed the Zimbabwe Financial Sustainability Plan of 2005 to 2009. The first cMYP covered the period 2007 – 2011. During this period, the country went through severe socio-economic challenges which had a crippling effect on the running of the immunization programme. The programme had made tremendous achievements during the first two decade of independence under the auspices of the Primary Health Care concept which the Government of Zimbabwe adopted in 1980. Universal Childhood Immunization Coverage was achieved by 1990. Morbidity and mortality due to vaccine preventable diseases greatly decreased, indeed the last clinical polio case was seen in 1989. The interval of measles outbreaks which used to occur very frequently increased to at least 5 years as the measles coverage improved.

The socio-economic challenges which began in the late nineties resulted in severe foreign currency shortage which impacted negatively on the programme. The programme could no longer import vaccines and other supplies directly. There was also high attrition of experienced and skilled personnel. All these challenges resulted in the immunization coverage decreasing; and in 2009 - 2010; the country was affected by the worst measles outbreak since the beginning of the second millennium.

The Government of Zimbabwe, through the Ministry of Health and Child Welfare, in partnership with UN Agencies and other development partners is working towards redressing some of these challenges. The National Health Strategy of 2008 – 2013 calls for universal immunization against vaccine preventable diseases. There has been several reviews of the immunization programme and the recommendations from these reviews were considered in the development of this cMYP.

In the lifetime of this cMYP, Zimbabwe will introduce pneumococcal and rotavirus vaccines. The Child Survival Strategy (2009 – 2015) reports that pneumonia and diarrhea are the third and fourth leading causes of morbidity and mortality in under fives contributing to 9% of childhood diseases. Zimbabwe introduced Hib as pentavalent vaccine in 2008 in an effort to reduce the incidence of pneumonia and this will be further lowered with the introduction of pneumococcal vaccine in 2012, and the introduction of rotavirus vaccine in 2013 will lower the incidence of diarrhoeal diseases in under fives. It is important to note that the country has adequate cold chain capacity at all levels (according to the WHO Logistics forecasting tool) but we are replacing cold chain equipment that has reached ten years.

This comprehensive Multi Year Plan (cMYP) presents the strategic goals, objectives as well as the cost and financing implications of the major initiatives required to improve the health of Zimbabweans through a strong and sustainable immunization programme. In line with Global Immunization Vision and Strategy (GIVS), this comprehensive multiyear plan 2012 - 2016 will focus on key actions to achieve the five goals of:

1. Protecting more people and saving lives by widespread use of safe vaccines
2. Accelerating the reduction of morbidity and mortality from vaccine preventable diseases
3. Introducing new vaccines
4. Strengthening EPI surveillance, health information and data management
5. Integrating EPI with other interventions.

The ZEPI program requires between US$31,030,742 to US$36,677,592 from 2012 - 2016, to meet the cost of running the immunization programme. This cost has risen substantially from the previous years due to cost of introducing new vaccines. The major financial gaps will require concerted support efforts by partners like UNICEF who largely rely on donor support and WHO, who normally provides technical support. Although the Government has shown a strong commitment to health, its efforts have been hampered by the prevailing unfavorable socio-economic environment. The Government's demonstrated commitment to the health service, even during this most difficult period, has encouraged partners to support the ZEPI program. In addition there is a close interaction with UN Inter-country teams that form the backbone of the Inter Agency Coordination Committee on EPI. The Ministry of Health and Child Welfare has developed a proposal for the Health Transition Fund which has been submitted to donors for fundraising. The fund will be administered through UNICEF and will run from 2011 – 2015.

CONTEXT FOR THE COMPREHENSIVE MULTI YEAR PLAN

Background

One out of every eleven Zimbabwean children dies each year before their fifth birthday (approximately 35 500 children per year). With an under-5 mortality rate estimated at 86 per 1,000 live births (MIMS 2009), Zimbabwe ranks within the top 50 countries in the world for high early childhood mortality. Over 65% of these deaths occur within the first year of life, as estimated by an infant mortality of 60 per 1,000 live births (MIMS, 2009). In order to effectively reduce the childhood mortality trends in the country, a child survival strategy outlining the major target killers, key intervention strategies and actions was developed. The Zimbabwe Expanded Programme on Immunization is one of the key interventions aiming at reducing vaccine preventable diseases such as pneumonia, diarrhea and measles which are the third, fourth and fifth leading causes of under five mortality.

Geographic and Demographic Situation

Zimbabwe is a landlocked country in central Southern Africa, with a total land area of 390,757 square kilometers and a population density of 30 people per square kilometers. It shares borders with Zambia, Mozambique, South Africa, Botswana, and Namibia. The country's population for 2010 is estimated to be 12,595,418, of which 3.1 percent are children under 1 year of age and 14% are children under 5 years of age, According to the World Health Report of 2009, the life expectancy at birth in Zimbabwe for both sexes was estimated at 45 years. The healthy life expectancy i.e. an estimate of how many years a person might live in good health, was estimated at 39 years. Females have a lower healthy life expectancy of 38 years compared to 40 years for males. The total fertility rate was estimated at 3.2 in 2007. The total fertility rate has declined from 5.2 in 1990 to 3.2 in 2007. Approximately 21 percent of women aged 20-24 have their first child at 18 years. The median birth interval in Zimbabwe is 41.6 months. About one in ten children are born after too short an interval (less than 24 months) (ZDHS 2005/6).

Socio – economic Context

Delivery of quality Maternal and Child Health (MCH) services and improvement in the health status of women and children not only rest with immediate environmental and health systems, but also with socioeconomic factors including the performance of macroeconomic factors which have a bearing on health access, improvement in education levels, women's empowerment and optimization of public financing mechanisms. Since the late 1990s the country's economy, which is mostly agriculture based, began to decline. In subsequent years the country's real economic growth rates declined to negative values estimated at -12.1 percent in 2003 to the lowest rate of -14.1 percent in early 2009, ranking 215th in the world. The negative economic growth resulted in the highest inflation record in the country's history, massive devaluation of the currency, low productive capacity, and loss of jobs, food shortages, poverty, massive de-industrialization and general despondency. The hyperinflation officially ended in February 2009 when the country changed the Zimbabwean dollar for a multi-currency economy based mainly on the United States dollar and the South African rand. The economic decline has had a profound effect on child survival through a strained health delivery system due to shortage of both human and material resources, failing health delivery infrastructure, community inability to pay for health services and general household level food insecurity.

The recent economic situation has also seen a decline in the country's expenditure on health in real terms. The general government expenditure on health as a percentage of general government expenditure did not change significantly from 7.3% in 2000 to 8.9% in 2006 (World Health Report 2009). This is not reflective of meaningful funding in health as all sectors were being affected by a hyperinflationary economic environment.

Current Challenges to Health Service

Health Services Structures

At national level, maternal and child health (MCH) services are coordinated by officers who have different reporting hierarchies, resulting in a fragmented response to MCH needs. The post for Child Welfare Coordinator has been vacant since 2007 and this has negatively impacted on the coordination of IMNCI, Reproductive Health, Nutrition, EPI and malaria programmes within the MOHCW.

Human Resources

From the late 1990s there has been a marked increase in the vacancy rates of health professionals in Zimbabwe. This peaked in 2009 when the economic situation in the country deteriorated significantly. According to the Human Resources Department's report in December 2010, the vacancy levels in the public health sector were 87 percent for nursing among others. Massive health professional migration resulted in the decimation of the experienced cadre, leaving those with skills strained to train new cadres well enough to meet the national demands. This has resulted in the loss of quality cadres capable of working with minimum supervision, and inadequately trained cadres at the point of care. The Primary Care Nurses who staff the rural health centers have limited knowledge and skills in EPI. The Village Health Workers, who provide basic maternal and child health care, are inadequate in number and receive very minimal allowances which do not motivate them.

Health Financing and Budgeting

The MOHCW was initially allocated US$ 157,673,800 for the 2009 budget which was revised down to US$ 121,000,000. The actual expenditure for the year 2009 was US$75,000,000, which translates to per capita expenditure of US$5.77. This is way below the minimum of US$34 recommended by WHO. The trend has been for budget disbursements to be below 15% of allocation over the years. In the 2010 budget allocation, Ministry of Health and Child Welfare was allocated USD285 million, which represented approximately 12.7 percent of the national budget. While in the past the Government of Zimbabwe funded the majority of health related activities with partners filling in the gaps, in recent past decade funding from donors – including bilateral agencies and the United Nations Family - has been critical in the provision of Health Services in Zimbabwe. However, it is important to note that it is difficult to obtain long term funding commitment from these partners. According to the World Health Report of 2009, Zimbabwe's total health expenditure of 2006 was 9.3% of the gross domestic product. General government expenditure on health was 48.3% of the total expenditure on health, with the remainder 51.3% being private expenditure. The external resources accounted for 17.3% of the total expenditure, a significant increase from 1.6% in 2000.

Monitoring, Evaluation and Health Management Information Systems

Zimbabwe's public health information system is based on the T (Tally) form system. Health information is increasingly less complete at District, Province and National levels, because of failure to update with late returns received at lower levels. Timeliness and stability of the system have been compromised by poor telecommunication especially from the rural health facilities to the district.

Community Challenges in Accessing Health Services

There are challenges faced by the community in accessing health services including:

- Distance to the clinic; some mothers are walking 30 km to the nearest clinic.
- Financial barriers such as user fees and transport costs
- Shortages of health commodities such as vaccines and drugs
- Acute shortage of human resources.

SITUATION ANALYSIS

Morbidity and Mortality Trends in Children

According to the Ministry of Health and Child Welfare's National Health Profile of 2006 respiratory conditions, diarrhoea, malaria and skin conditions rank among the top five causes of morbidity in children under-5 years in Zimbabwe. Acute respiratory infections account for most outpatient attendances. A significant proportion of children present with pneumonia, often of the severe form. Figure 1 shows the adjusted trends in infant and under-5 mortality from 1990 to 2008 as point estimates from the ZDHS surveys and other data sources. The graphs show fairly constant mortality rates from the year 2000 onwards. The dotted lines show the expected drop in mortality rates in order to meet the MDGs of 2015. This illustrates the need for urgent and concerted effort to realize the required impact and reach the MDGs.

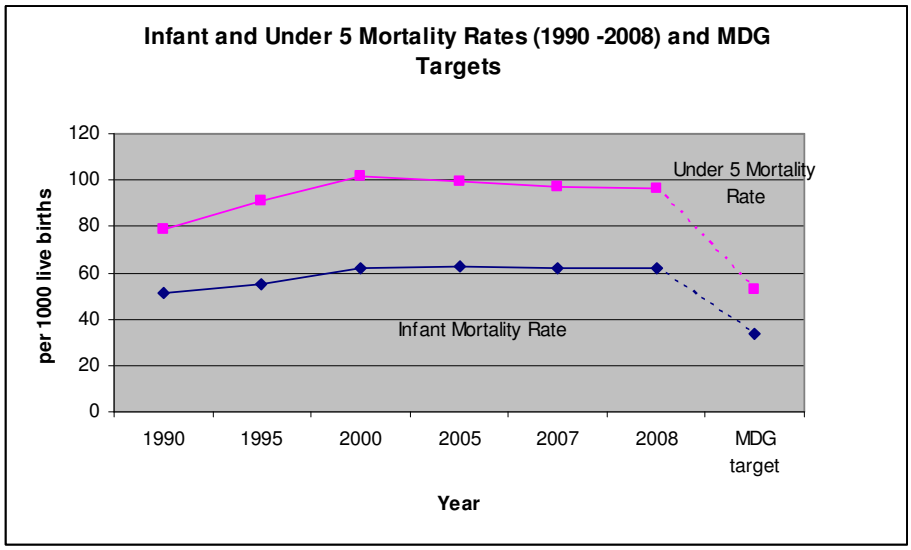


Figure 1: Early childhood mortality indicators over the years in relation to the MDG targets

Source: Inter-agency Group for Child Mortality Estimation (IGME), 2009.

The Zimbabwean infant mortality rate is estimated at 60 per 1,000 live births. The under-5 mortality rate is estimated at 86 per 1,000 live births (MIMS 2009). These figures demonstrate little change since the ZDHS of 2005/6 which reported an infant mortality rate of 60 per 1,000 live births and under-5 mortality rate of 82 per 1,000 live births respectively. The single leading cause of child mortality in Zimbabwe is HIV and AIDS which contributes 21 percent of deaths. The other major contributions to under-5 mortality are pneumonia, diarrhoea and measles, although HIV and AIDS may also underlie deaths recorded under pneumonia and diarrhoea. Malaria contributes 3% of under-5 mortality. Malnutrition is an underlying factor in most of these deaths.

Service Delivery

The UNICEF/WHO Joint Reporting Form reported an increase in routine immunization (Pentavalent 3) coverage from 72% in 2008 to 83% with a dropout rate of 18% in 2010. However, the country has not yet achieved the regional and global goal of 90% at national level and at least 80% in each district; only 58% of the districts achieved 80% coverage. The measles coverage also increased from 64% in 2008 to 84% in 2010. The Comprehensive EPI coverage Survey of 2010 reported 62% children as fully immunized, an increase from 53% reported in the 2005/2006 Zimbabwe Demographic and Health Survey (DHS). The country is recovering from the challenges of the past decade and is making concerted efforts to meet regional and global goals. Figure 2 below shows the performance trends in the immunization programme 2000 – 2010. The country has been training districts on the RED strategy since 2003 but unfortunately the high staff attrition has necessitated re –training of staff in RED, IIP and MLM to equip them with knowledge and skills necessary to improve service delivery. The EPI policy document was reviewed and updated and policy implementation guidelines developed in 2011.

Surveillance

Zimbabwe has maintained polio free status since 2005 and has been meeting the non polio AFP standard performance indicators. In 2010, the annualized non polio AFP rate was 3.4 with a stool adequacy rate of 87%. Due to the measles outbreak, the country met the standard performance indicator of at least 2 cases per 100,000 population and failed to meet the standard performance indicator for measles incidence. Zimbabwe had 48 cases per 100,000 population instead of less than 5 per 100,000 population. The country is now in the pre elimination phase for measles and has to meet all the pre elimination targets by 2012. Maternal and neonatal tetanus status was achieved in 2002 and has been maintained ever since. Zimbabwe has sentinel surveillance sites for Hib and rotavirus put in place to monitor disease burden and the impact of vaccination.

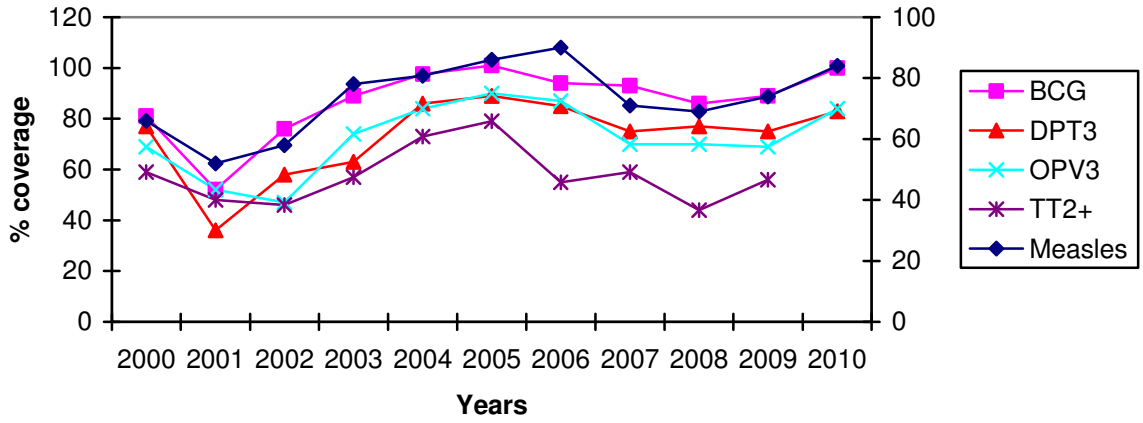


Figure 2: Trends in EPI coverage during the last decade by antigen (2000-2010)

Source: UNICEF/WHO JRF/MOHCW NHIS 2000 - 2010

Advocacy and Communication

High level advocacy involving the policy makers in MOHCW and Ministry of Finance and other stakeholders which culminated in the country introducing Hib in 2008 and agreeing to introduce pneumococcal and rotavirus vaccines in 2012 and 2013 respectively. In response to the 2009 – 2010 measles outbreak, consultations with the Parliamentary Portfolio on Health, Prime Minister's Office and religious leaders of the population segment that refuses vaccinations (Apostolic Sects). This all culminated into the first ever National Consultative Conference on Child Health with the Apostolic Sects, hosted by the Prime Minister. This resulted in the Apostolic Sects bringing their children for vaccination during the measles national immunization days' campaign. Dialogue with these sects is continuing in the provinces in which they reside. Social mobilization activities are being conducted at all levels to garner support for the immunization programme from local partners and other stakeholders. During the consultations for the draft national constitution, the communities, including children themselves advocated for immunization to be made mandatory for all children in the constitution. The EPI Communication Strategy has been reviewed and is awaiting printing and distribution to all levels.

Vaccine Supply and Logistics

As mentioned previously, the country depends of one of its major partners, UNICEF, to procure all the traditional vaccines (except for pentavalent which is fully supported by GAVI until 2013), injection safety material and cold chain equipment. While there has been limited vaccine stock out at National level (DTP for 2 months in 2010), the Post Introduction Evaluation of pentavalent in 2010, revealed a 26% stock out at health facilities. This is attributed to poor forecasting and ordering at sub national levels and challenges in distribution due to transport problems. UNICEF has been responding to the cold chain needs according

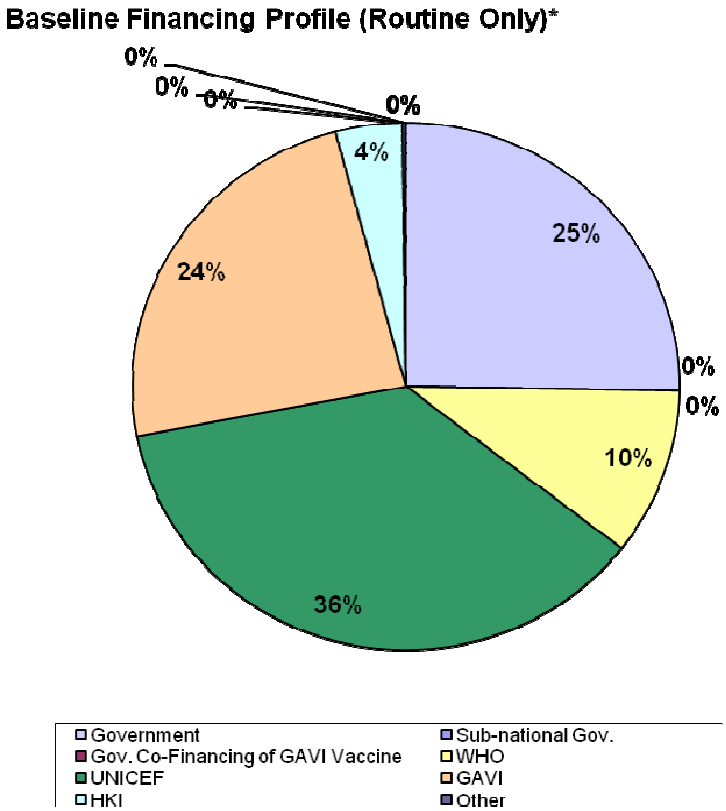
to the 2005 – 2009 National Replacement and Refurbishment Plan, hence the country has adequate cold chain capacity at all levels. The country conducted a Cold Chain Assessment in 2010 and the results will be used to develop another 5 year National Replacement and Refurbishment Plan. To counter the challenges of power cuts, the country intends to mobilize resources for standby generators for district vaccine stores. Currently the national, all provincial and some district stores have standby generators.

Program Management

The country is experiencing challenges in data management as health information is increasingly less complete at District, Province and National levels, because of failure to update with late returns received at lower levels. The country achieved 86% completeness in 2010. The programme has embarked on training health workers on RED strategy but has not been able to mobilize resources for training middle managers in programme management. Quarterly support supervisory visits and review meetings are conducted at national and provincial levels to monitor and evaluate the programme's performance.The country undertook a number of assessments in the past years and some of the recommendations have been implemented to improve the programme's performance.

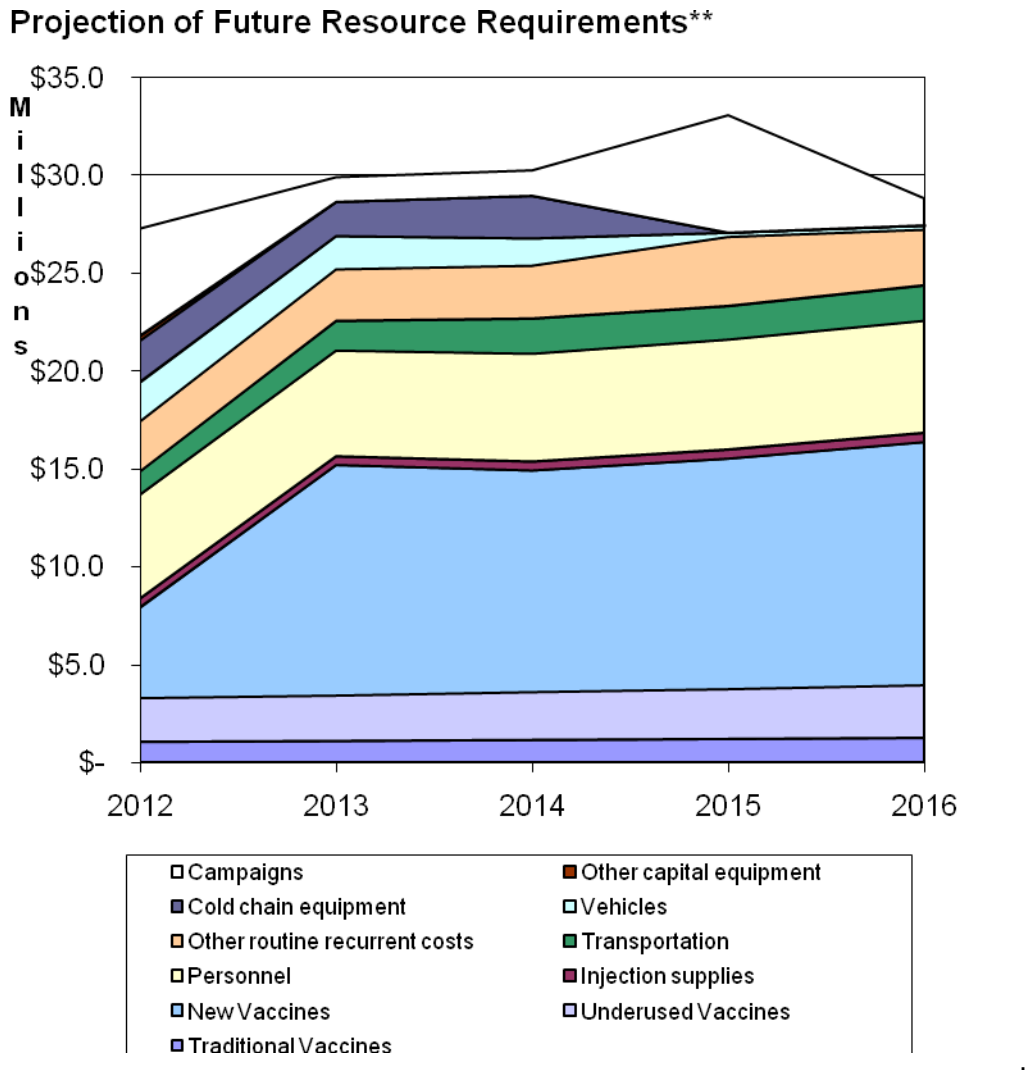
Cost and Financing

While the Government of Zimbabwe is committed to the immunization programme as a pillar for child survival, the current economic situation has rendered it unable to fund most of the programmes requirement. Partners such as UNICEF, WHO and GAVI have been supporting the programme. According to the baseline information available, the Government contributed 25% of the programmes' requirements in 2010, with UNICEF contributing 36%, GAVI 24%, WHO 10% and Helen Keller International 4%.



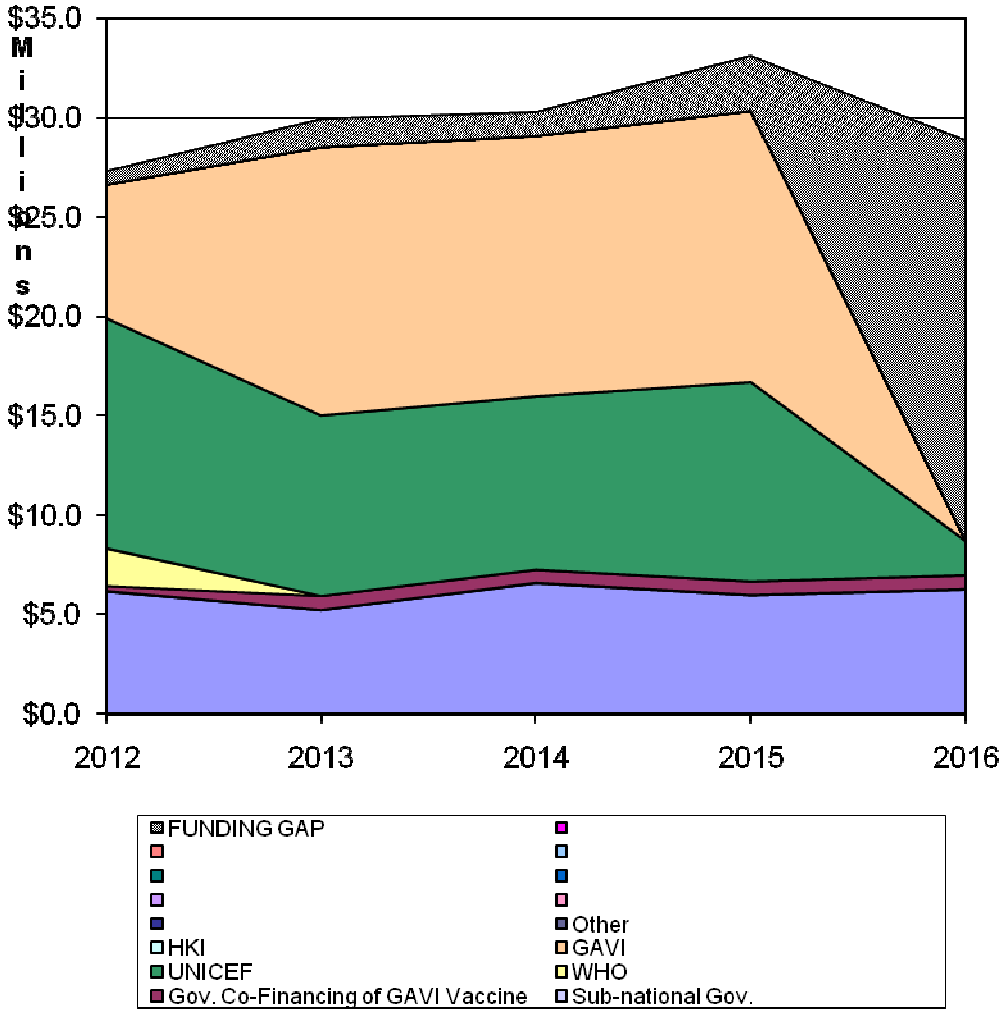
The cost of introducing new vaccines in 2012 and 2013 will drive the cost of the routine immunization programme from US$23,346,468 in 2010 to US$32,496,310 in 2016. The cost will peak in 2012 when

pneumococcal vaccine is introduced and an integrated measles supplementary activities; in 2013 when there is introduction of rotavirus vaccine and in 2015 when integrated measles supplementary activities are going to be conducted. Vitamin A supplementation is conducted twice a year every year. The graph below depicts the future resource requirements.



The country expects that UNICEF will continue funding the procurement of traditional vaccines until such a time the government is in a position to take over. The Government of Zimbabwe will mobilize resources within the country for the co-financing requirements. As the graph below shows, the gap when taking into consideration secure financing only, ranges from 1,5% in 2012 to 29% in 2016. The large gap in 2016 is due to the fact that the Health Transtion Fund ends in 2015 but fundraising efforts will continue to bridge the gap. It is also expected that the Health Transition Fund if still operational will then be administered by the Ministry of Health and Child Welfare. If both secure and probable financing are considered then there are no funding gaps. It is envisaged that the economic situation will improve and Government of Zimbabwe will be able to put more funds in the immunization programme and partners such as UNICEF will continue to mobilize resources for the programme.

Future Secure Financing and Gaps**



PROGRAM CHARACTERISTICS, OBJECTIVES AND STRATEGIES

The Government of Zimbabwe through the Ministry of Health and Child Welfare is committed to the Immunization programme as a pillar for child survival and improvement of child health. The main objective of EPI is to reduce morbidity and mortality from vaccine preventable childhood diseases. New vaccines will be introduced as necessary. The ZEPI has the following broad objectives:

1. Protect more children and women of child bearing age with safe vaccines
2. Accelerate the reduction of morbidity and mortality from vaccine preventable diseases
3. Introduce new and under – utilized vaccines
4. Strengthen EPI surveillance, health information and data management
5. Integrate EPI with other interventions
6. Strengthen advocacy and communication

Protecting more children and women of child bearing age with safe vaccines

The current immunization coverage stands at 83% (Pentavalent 3) and only 58% of the districts achieved at least 80%, which shows that there are still some populations that are not being reached by the programme. The country plans to reach more children and women of child bearing age with vaccines by strengthening the routine immunization. The outreach services that have been revitalized through implementation of the RED strategy will continue throughout the lifespan of this plan. Ward Health Teams will be revived to link the services with the communities. Efforts will be made to reduce the high dropout rate through tracking of defaulters by the Village Health Workers and integrating the services and other interventions.

Accelerating reduction of morbidity and mortality from vaccine preventable diseases

Zimbabwe achieved elimination status for maternal and neonatal tetanus in 2000; is in the pre elimination phase for measles and achieved polio free certification status. The country has plans to maintain the elimination status for maternal and neonatal tetanus and the polio free certification status. Supplementary immunization activities (SIA) for measles will be conducted in 2012 and 2015 to ensure that children under five get a second dose in order to increase their immunity, these SIAs will be integrated with polio and vitamin A supplementation.

Introducing new vaccines

Zimbabwe joins other countries in the world in introducing new vaccines in order to reduce morbidity and mortality in under fives. The country plans to introduce pneumococcal and rotavirus vaccines in 2012 and 2013 respectively.

Strengthening EPI Surveillance, Health Information and Data Management

The country has been achieving the standard surveillance performance indicators for AFP and measles; these will continue to be strengthened until all provinces achieve the set performance indicators. The quality of surveillance data will be improved through training of health workers and reinforced during supportive supervision.

Integration of EPI with other interventions

Zimbabwe practices supermarket approach and it is easy to integrate with other interventions to provide holistic care to the child and also maximize use of resources. The programme has already integrated with vitamin A supplementation and plans are underway to integrate with the Early Infant Diagnosis (HIV and AIDS) and the Community Management of Acute Malnutrition.

Strengthening Advocacy and Communication

The EPI Communication Strategy has been reviewed and these are going to be printed and distributed to all health facilities. The strategy guides all the advocacy and communication activities at all levels. The community will be mobilized to accept the new vaccines and demand immunization services.

Table 1: Situational analysis by accelerated disease control initiatives, based on previous years' data (2008-2010)

System components	Suggested indicators	National*		
		2008	**2009**	**2010**
Polio	*OPV3 coverage*	65%	69%	84%
	% of districts with > 80% coverage		33%	63%
	Non polio AFP rate per 100,000 children under 15 yrs. of age	1.6	2.1	3.4
	Coverage of NID (one round)		91%: one round	
MNT	*TT2+ coverage*	43%	41%	28%
	Number of districts reporting > 1case per 1,000 live births	0	0	0
	Was there an SIA? (Y/N)	N	N	N
Measles	*Measles coverage*	64%	76%	84%
	No. of outbreaks reported	0	117	57
	NID: age group *Coverage*		6-59 months 90%	6 months – 14 years 97%
	MCV2 introduced	N	N	N

* It is useful to include the data source for each data set.

Table 2: Situational analysis of routine EPI by system components based on previous years' data (2007-2009)

System components	Suggested indicators	National*		
		2008	2009	2010
Routine Coverage	*National DTP-HepB-Hib3 (Pentavalent3)coverage*	72	73	83%
	% of districts with > 80% coverage	42%	45%	58%
	National Pentavalent1-Pentavalent3 dropout rate		16%	18%
	Percentage of districts with dropout rate Pentavalent1-Pentavalent3>10%	85%	82%	85%
Vitamin A supplementation	*National vitamin A coverage: 6 – 11months*	85%		78%
	National vitamin A coverage: 12 – 59 months	80%		89%
New vaccines	*Hib introduced*	Y	N/A	N/A
	Pneumococcal introduced	N	N	N
	Rotavirus introduced	N	N	N
Routine Surveillance	*% of surveillance reports received at national level from districts compared to number of reports expected*	87%	92%	86%
	Quality of surveillance data sufficient? (Y/N)	N	N	N
Lab Surveillance	*% of suspected meningitis cases with CSF collected*			100%
	% of stool specimen collected from diarrhoeal cases in under fives			100%
Cold chain/Logistics	*Percentage of districts with adequate number of functional cold chain equipment (awaiting cold chain assessment report of 2010)*	100%	100%	100%
Immunization safety	*Percentage of districts supplied with adequate (equal or more) number of AD*	100%	100%	90% (BCG

* It is useful to include the data source for each data set.

	syringes for all routine immunizations			syringe)
	Percentage of districts supplied with safety boxes	100%	100%	100%
	Immunization safety Assessment conducted	N	N	N
Waste Management	*Percentage of districts with proper sharps waste management systems*			100%
Vaccine supply	*Was there a stock-out at national level during last year? (Y/N)*	N	N	Y
	If yes, specify duration in months			2 months
	If yes, specify which antigen(s).			DTP
	Proportion of health facilities reporting stock outs (PIE report showed 26% of some vaccine stock outs in last 6 months)			26%
Communication	*Availability of a plan? (Y/N)*	Y	Y	Y
	Percentage of districts which have developed EPI communication plans	100%	100%	100%
	Percentage of caretakers of children < 1yr understanding the importance of routine immunization.			91%
Financial sustainability	*What percentage of total routine vaccine spending was financed using Government funds?(including loans and excluding external public financing)*	0%	0%	0%
Management planning	*Are a series of district indicators collected regularly at national level?(Y/N)*	Y	Y	Y
	% of reports received at national level from districts compared to number of reports expected (Completeness of reporting)	87%	92%	86%
	Percentage of all districts with microplans.			20%
Research/studies	*Number of vaccine related studies conducted/being conducted* *2008: Vaccine Management Assessment* *2009: Post campaign evaluation survey and EPI Review* *2010: PIE for Pentavalent vaccine, EPI Coverage Survey, Post Campaign evaluation survey and Cold Chain Assessment*	1	2	4
NRA	*Number of functions conducted*	5/6	5/6	5/6
National ICC	*Number of meetings held last year*	4/4	3/4	2/4
Human Resources availability	*Percentage of sanctioned posts of vaccinators filled*	67%	51%	87%
	Percentage of health facilities with at least 1 vaccinator	100%	100%	100%

	Percentage of vaccinators time available for routine EPI	5%	5%	5%
	Number of vaccinators / 10.000 population	6	5	8
Transport / Mobility	*Percentage of districts with a sufficient number of supervisory/EPI field activity vehicles/motorbikes/bicycles in working condition*	0	0	0
Waste Management	*Availability of a waste management plan*	Y	Y	Y
	Vaccine wastage monitoring at national level for all vaccines? (Y/N)	Y	Y	Y
Linking to other Health Interventions	*Were immunization services systematically linked with delivery of other interventions (Malaria, Nutrition, Child health etc)?*	Y	Y	Y
Programme Efficiency	*Timeliness of disbursement of funds to district and service delivery level*	N	N	N
	All health facilities monitoring AEFI	N	N	N
	Data Quality Self Assessment conducted in all districts	N	N	N
	Effective Vaccine Management Assessment conducted	N	N	N
	Review of IIP modules	N	N	N

Table 3: National objectives and milestones, AFR regional and global goals

National priorities	NIP Objectives	NIP Milestones	AFRO Regional goals	Order of Priority
Routine Coverage/Service Delivery **National Pentavalent 3 coverage 84%** **42% districts have not achieved at least 80% coverage in 2010** **National Pentavalent 1 – Pentavalent 3 dropout rate is 18%**	Increase proportion of districts with 80% Pentavalent 3 coverage from 58% in 2010 to 90% in 2016 Reduce dropout rate from 18% in 2010 to less than 10% in 2016	2012: 70% 2013: 75% 2014: 80% 2015: 85% 2016: 90% 2012: 16% 2013: 14% 2014: 12% 2015: 10% 2016: 8%	By 2015 all countries will have routine immunization coverage of 90% nationally with at least 80% coverage in every district.	**1**
Polio **37% districts did not achieve at least 80% coverage in 2010**	Increase proportion of districts with 80% OPV 3 coverage from 63% in 2010 to 90% in 2016 To attain ≥95% OPV SIA coverage in all districts	2012: 70% 2013: 75% 2014: 80% 2015: 85% 2016: 90% 2012: ≥95% 2015: ≥95%	.	**1**
Measles **42% districts did not achieve at least 80% coverage in 2010**	Increase proportion of districts with at least 80% measles coverage from 58% in 2010 to 100% in 2016	2012: 75% 2013: 80% 2014: 85% 2015: 95% 2016: 100%	Greater than 90% MCV1 national level coverage with at least 80% coverage in every district. Greater than 95% measles SIAs coverage in all districts	**1**

National priorities	NIP Objectives	NIP Milestones	AFRO Regional goals	Order of Priority
Outbreaks experienced from 2009 - 2010	To attain ≥95% measles SIA coverage in all districts	2012: ≥95% 2015: ≥95%		
MNT **Persistently low national TT2+ coverage**	Increase national TT2+ coverage from 43% in 2010 to 49% by 2016 To achieve and maintain at least 85% proportion Babies Born Protected from 2012 to 2016	2012: 45% 2013: 46% 2014: 47% 2015: 48% 2016: 49% 2012: 85% 2016: 85%	Eliminate NNT by 2015	**2**
Vitamin A Supplementation Low routine vitamin A supplementation coverage	Increase national vitamin A supplementation coverage from 78% in 2010 to 95% in 2016	2012: 80% 2013: 83% 2014: 85% 2015: 90% 2016: 95%		**2**
Pneumo **Pneumonia ranks 3rd leading cause of morbidity and mortality in under fives**	To introduce Pneumococcal vaccine in 2012 To attain at least 88% coverage in 2012 To increase Pneumo 3 coverage from 88% 2012 to 95% in 2016	2012 2012: 88% 2013: 90% 2014: 92% 2015: 93% 2016: 95%		**1**
Rota **Diarrhoeal ranks 4th leading cause of morbidity and mortality in under fives**	To introduce rotavirus vaccine in 2013 To attain at least 90% coverage in 2013 To increas Rota 3 coverage 90% from 2013 to 95% in 2016	2013 2013: 90% 2014: 92% 2015: 93% 2016: 95%		**2**

National priorities	NIP Objectives	NIP Milestones	AFRO Regional goals	Order of Priority
Immunization Safety **Adherence to immunisation safety practices not known: Immunisation Safety Assessment last conducted in 2006** **Not all health facilities monitoring AEFI**	Maintain 100% districts using AD syringes Conduct immunisation safety assessment in 2016 All health facilities monitoring AEFI from 2012	2012: 100% 2013: 100% 2014: 100% 2015: 100% 2016: 100% 2016 2012: 100% 2013: 100% 2014: 100% 2015: 100% 2016; 100%	By the end of 2008, all immunization injections are administered safely.	**1**
Waste Management **17% of health facilities have closed off disposal sites**	To increase the proportion of health facilities with closed off disposal sites from 17% in 2010 to 35% in 2016	2012: 23% 2013: 26% 2014: 29% 2015: 31% 2016: 35%		**3**
EPI Disease Surveillance **Not all provinces meeting standard EPI diseases surveillance performance indicators**	To increase proportion of provinces with AFP detection rate of 2 cases per 100,000 population of children < 15years from 91% in 2010 to 100% from 2012 To increase proportion of provinces with stool adequacy rate of at least 80% from 82% in 2010 to 100% from 2012	2012: 100% 2013: 100% 2014: 100% 2015: 100% 2016: 100% 2012: 100% 2013: 100% 2014: 100% 2015: 100%		**1**

National priorities	NIP Objectives	NIP Milestones	AFRO Regional goals	Order of Priority
Lab Based Sentinel Surveillance **All suspected meningitis cases to have CSF specimen collected** **All diarrhoeal cases in under fives to have stool specimen collected and tested**	Increase proportion of districts reporting at least 2 suspected measles cases per year from 65% in 2009 to 100% in 2016 **(NB 2009 data used as baseline for measles since 2010 was outbreak data)** To maintain 100% districts reporting less than 1 MNT case per 1000 live births To have at least 80% of all suspected cases of meningitis with CSF collected for Hib To maintain testing for Rotavirus on specimen from diarrhoeal cases at 100% from 2012 through 2016	2016: 100% 2012: 70% 2013: 75% 2014: 80% 2015: 90% 2016: 100% 2012: 100% 2013: 100% 2014: 100% 2015: 100% 2016: 100% 2012: 2013: 2014: 2015: 2016: 2012: 2013: 2014: 2015: 2016	Measles incidence <5 cases/100,000 per year	
Vaccine Supply Vaccine stock outs at all levels **Inadequate vaccine ordering and distribution at sub national**	Reduce proportion of health facilities reporting vaccine stock outs from 26% in 2010 to 0% from 2012	2012: 0% 2013: 0% 2014: 0% 2015: 0% 2016: 0%		**1**

National priorities	NIP Objectives	NIP Milestones	AFRO Regional goals	Order of Priority
level.				
Cold Chain / Logistics **Adequacy of cold chain capacity**	Maintain proportion of health facilities with functional cold chain equipment from 2012 through 2016.	2012: 100% 2013: 100% 2014: 100% 2015: 100% 2016: 100%		**1**
Advocacy and Communications **Inadequate resources for the EPI programme** **Existence of vaccination objectors** **Pneumonia and diarrhoeal diseases rank high among the top five conditions causing morbidity and mortality of under fives.**	To engage policy makers in resource mobilization to support EPI services To maintain 100% provinces and districts carrying out community sensitization activities All major EPI partners, CSO, health workers and communities sensitized on the introduction of new vaccines	2012: 80% policy makers engaged 2012: 100% 2013: 100% 2014: 100% 2015: 100% 2016: 100% 2011: pneumococcal vaccine 2012: rotavirus vaccine		**1**

National priorities	NIP Objectives	NIP Milestones	AFRO Regional goals	Order of Priority
Management and Planning **Poor data management at all levels** **80% districts not trained in RED**	Increase completeness of reporting from 86% in 2010 to 100% in 2016 Increase proportion of districts with microplans from 20% to 100% by 2013	2012: 90% 2013: 95% 2014: 100% 2015: 100% 2016: 100% 2012: 75% 2013: 100% 2014: 100% 2015: 100% 2016: 100%		**1**
Programme Efficiency **Vaccine Management Assessment last conducted in 2009** **Data Quality Audit last conducted in 2006** **No training material for EPI in pre service training**	To conduct EVMA in 2012 Conduct Data Quality Audit in 2016 Review IIP module to suit pre service training needs in 2012	2012 2016 2013		**1**
Financial Sustainability **Co financing for new and**	To achieve 100% co financing for new all new vaccines	2012: pneumococcal vaccine 2013: rotavirus and pentavalent vaccine		**1**

National priorities	NIP Objectives	NIP Milestones	AFRO Regional goals	Order of Priority
underutilized vaccines not yet secured				
Training and Supervision **With high staff turnover, the new recruits have inadequate knowledge in EPI**	To conduct training in EPI for health workers at all levels from 2012 To achieve inclusion of a well structured EPI training (IIP module) in the pre service curricula from 2012 To achieve quality supervision of EPI services in all facilities at least quarterly from 2012	2012 2012 2012		**1**
Research / **Studies** **With each introduction of new vaccines, it is recommended to conduct Post Introduction Evaluation**	Conduct post introduction evaluation for new vaccines six months post introduction	2012: pneumococcal 2013: rotavirus vaccine		**1**
Linking to Other Health Interventions **Integration of cost effective intervention to maximise use of resources**	To integrate EPI services with other interventions such as Early Infant Diagnosis (EID), Community Management of Acute Malnutrition (CMAM), IMNCI, malaria and deworming from 2012	2012: EPI integrated with other interventions		**2**

KEY ACTIVITIES AND TIMELINES

Table 4A: Service delivery

National Objective	Strategy	Key Activities	Timelines					
			2011	2012	2013	2014	2015	2016
Increase proportion of districts with 80% Pentavalent 3 coverage from 58% in 2010 to 90% in 2016	RED Implementation	Mobilize resources						
		Conduct training on microplanning						
		Conduct regular outreach activities						
		Monitor EPI coverage and dropout rate						
		Revive Ward Health Team						
		Sensitize communities						
Reduce dropout rate from 18% in 2010 to less than 10% in 2016	Capacity building	Review IIP module						
		Conduct training in MLM, IIP and Data Quality Self Assessment						
		Conduct supportive supervision						
		Train health workers and VHWs on use of EPI registers						
Increase proportion of districts with 80% OPV 3 coverage from 63% in 2010 to 90% in 2016	Defaulter tracking	Print VHW EPI registers						
		Register target populations						
		Track defaulters						
		Conduct meetings with VHWs at clinic level						
		Reconcile clinic and VHW registers						
	Resource mobilization	Conduct meetings with Top Management Team (MOHCW), ICC and Ministry of Finance						
		Joint planning with local partners and other stakeholders at all levels						
Increase proportion of districts with 80% measles coverage from 58% in 2010 to 100% in 2016	Public Private sector partnership	Train/Orient private sector practitioners						
To attain ≥95% for integrated measles/OPV SIA coverage in all districts in 2012 and 2015	Resource mobilization	Conduct meetings with Top Management Team (MOHCW), ICC and Ministry of Finance						
		Joint planning with local partners and other stakeholders at all levels						
	Capacity Building	Conduct training for health workers and community based health workers						
		Identify, produce and distribute relevant IEC Material						
	Social Mobilization and	Meetings and holding dialogue with traditional and religious leaders						

	Programme Communication Monitoring and evaluation	Train health workers on IPC						
		Conduct supportive supervision Collect, compile and analyze in and end process data						
		Conduct daily feedback meetings						
		Conduct the measles campaign in all districts						
		Conduct independent monitoring						
		Conduct post campaign evaluation						
Increase national TT2+ coverage from 45% in 2010 to 65% among pregnant women by 2016	RED implementation	Mobilize resources						
		Conduct training on microplanning						
		Conduct regular outreach activities						
		Monitor EPI coverage						
		Revive Ward Health Team						
		Sensitize communities						
	Capacity Building	Conduct training on data capturing and reporting						
	Monitoring Babies Born Protected	Document all TT vaccinations given to women						
		Provide take home cards to all women						
		Educate mothers on importance of childhood immunization cards retention						
To introduce Pneumococcal vaccine (PCV 13) nationally in 2012 To attain at least 88% pneumococcal 3 coverage at national level in 2012 To increase national Pneumo 3 coverage from 88%	Resource Mobilization	Develop proposal						
		Convene ICC meeting to endorse proposal						
		Conduct meetings with Top Management Team (MOHCW), ICC and Ministry of Finance						
		Joint planning with local partners and other stakeholders at all levels						
	Capacity Building	Train health workers on new vaccine introduction						
		Modify, print and distribute data collection tools						
		Review, modify, print and distribute Child Health Cards						
		Develop IEC messages for the print and electronic media						
	Social mobilization and Communication	Sensitize communities on new vaccine						
		Conduct public media campaign						
		Conduct focus group discussion						
		Mobilize resources						
		Conduct training on microplanning						
		Conduct regular outreach activities						

2012 to 95% in 2016	RED strategy	Monitor EPI coverage							
		Revive Ward Health Team							
	Monitoring and Evaluation	Conduct supportive supervision							
		Collect, compile and analyze data							
		Monitor and report AEFI							
		Conduct feedback meetings							
		Conduct post introduction evaluation							
Increase national vitamin A supplementation coverage from 78% in 2010 to 95% in 2016	RED Implementation	Mobilize resources							
		Conduct training on microplanning							
		Conduct regular outreach activities							
		Monitor EPI coverage							
		Sensitize communities							
		Tracking of defaulters by VHW							
	Defaulter tracking	Reconcile VHW and clinic EPI Registers							
To introduce rotavirus vaccine in 2013 To attain at least 90% coverage in 2013 To increase Rota 3 coverage 90% from 2013 to 95% in 2016	Resource mobilization	Develop proposal							
		Convene ICC meeting to endorse proposal							
		Conduct meetings with Top Management Team (MOHCW), ICC and Ministry of Finance							
		Joint planning with local partners and other stakeholders at all levels							
	Capacity building	Train health workers on new vaccine introduction							
		Modify, print and distribute data collection tools							
		Review, modify, print and distribute Child Health Cards							
		Develop IEC messages for the print and electronic media							
	Social mobilization and Communication	Sensitize communities on new vaccine							
		Conduct public media campaign							
		Conduct focus group discussion							
		Mobilize resources							
		Conduct training on microplanning							
		Conduct regular outreach activities							
		Monitor EPI coverage							
		Sensitize communities							

	RED Implementation	Conduct supportive supervision						
		Collect, compile and analyze data						
		Monitor and report AEFI						
		Conduct feedback meetings						
		Conduct post introduction evaluation						

Table 4B: Advocacy and Communications

National Objective	Strategy	Key Activities	Timelines					
			2011	2012	2013	2014	2016	2016
To engage policy makers in resource mobilization to support EPI services To maintain 100% provinces and districts carrying out community sensitization activities All major EPI partners, CSO, health workers and communities sensitized on the introduction of new vaccines	Advocacy and communication	Convene meetings with policy makers, ICC and stakeholders						
		Develop and package relevant IEC material						
		Conduct public media campaign						
		Conduct focus group discussion						
	Training	Training of health workers and partners in IPC						
	Commemoration Africa Vaccination week	Meetings with religious leaders from vaccination objectors						
		Conduct public media campaign						
		Conduct focus group discussion						
	Programme communication	Conduct focus group discussions						
		Train of community mobilizers						
		Orient media personnel						

Table 4C: Surveillance

National Objective	Strategy	Key Activities	Timelines					
			2011	2012	2013	2014	2015	2016
To increase proportion of provinces with AFP detection rate of 2 cases per 100,000 population of children < 15years from 91% in 2010 to 100% from 2012 To increase proportion of provinces with stool adequacy rate of at least 80% from 82% in 2010 to 100% from 2012 Increase proportion of districts reporting at least 2 suspected measles cases per	Capacity Building	Conduct training for health and community health workers						
	Active Surveillance	Distribute standard case definitions to all health facilities						
		Sensitize communities on EPI disease surveillance						
		Conduct integrated active search for VPD						
		Document findings and report						
		Conduct Lab and EPI data harmonization meetings						
	Monitoring	Give feedback on performance to lower levels, ,communities and stakeholders						
		Conduct NPEC, NTF and NCC meetings quarterly						
		Collect and analyze data on performance indicators						
		Convene surveillance review meetings						

year from 65% in 2009 to 100% in 2016 **(NB 2009 data used as baseline for measles since 2010 was outbreak data)** To maintain 100% districts reporting less than 1 MNT case per 1000 live births		Give feedback on performance to lower levels, communities and stakeholders						
To have at least 80% of all suspected cases of meningitis with CSF collected for Hib To maintain testing for Rotavirus on specimen from diarrhoeal cases at 100% from 2012 through 2016	Resource mobilization Laboratory Case Based Surveillance	Develop proposals for fundraising						
		Procure supplies and other logistics						
		Convene meetings with partners						
		Prepare and submit costed plans						
		Train lab personnel on Hib and Rota surveillance						
		Conduct relevant tests						
		Collect and analyze data on performance indicators						
		Convene surveillance review meetings Give feedback on performance to all levels, communities and stakeholders						

Table 4D: Vaccine supply, quality and logistics

National Objective	Strategy	Key Activities	Timelines					
			2011	2012	2013	2014	2015	2016
Reduce proportion of health facilities reporting vaccine stock outs from 26% in 2010 to 0% from 2012	Effective Vaccine Management	Train EPI managers on vaccine management and vaccine forecasting						
		Train vaccine stores managers on the stock management tool						
		Introduce electronic stock management tool to district and provincial level						
		Conduct supportive supervision at all levels						
		Review monthly vaccine ordering forms to identify stock outs						
		Conduct effective vaccine management assessment						
Maintain proportion of health facilities with functional cold chain equipment from 2012 through 2016	Cold Chain Replacement Plan	Procure and distribute cold chain equipment as per Cold Chain Replacement Plan						
		Develop and implement preventive maintenance plan						
		Procure and distribute spare parts to all levels						
		Maintain cold chain equipment inventory at all levels						
	Capacity Building	Train cold chain technicians at district and provincial level						
		Orient health workers at health facility level on basic cold chain equipment maintenance						
Maintain 100% districts using AD syringes	Improve Immunization Safety	Sustain and monitor safe injections practices						
		Monitor injection waste disposal						
		Investigate, respond to and report AEFI						
Conduct immunisation safety assessment in 2016		Develop proposal for fundraising						
		Conduct assessment						
		Give feedback to all levels						

Table 4E: Programme Management

National Objective	Strategy	Key Activities	Timelines					
			2011	2012	2013	2014	2015	2016
Increase completeness of reporting from 86% in 2010 to 100% in 2016	Strengthen management, analysis, interpretation use and dissemination of data	Distribute adequate data collection tools						
		Train health workers on data collection, compilation, analysis and use						
		Put in place tools for timeliness and completeness of data submission						
		Follow up on outstanding data						
		Update databases at all levels						
		Provide feedback to all levels on completeness and timeliness of data						
Maintain proportion of health facilities with EPI microplans at 100%	Programme Planning	Train health workers on microplanning						
		Conduct supportive supervision						
To conduct EVMA in 2012 Conduct Data Quality Audit in 2016 All health facilities monitoring AEFI from 2012 Review IIP module to suit pre service training needs in 2012	Strengthen management, analysis, interpretation use and dissemination of data Capacity Building	Develop proposals for fundraising						
		Conduct assessments						
		Feedback results to all levels						
		Monitor AEFI						
		Investigate, respond to and report AEFI						
		Maintain a register of AEFI						
		Review and update IIP module						
		Print and distribute IIP modules to all Schools of Nursing						
		Conduct training of trainers for Schools of Nursing						
Advocate with Government to co finance all new vaccines	Ensure effective and sustainable introduction of new vaccines	Conduct meetings with policy makers at MOHCW and MOF						
		Involve ICC in advocacy						
		Share relevant documents such as cMYP						

		Submit EPI budget estimates annually						
		Follow up on budget allocations						
Conduct post introduction evaluation for new vaccines six months post introduction	Ensure effective and sustainable introduction of new vaccines	Develop proposal for fundraising						
		Train enumerators						
		Conduct evaluation						
		Give feedback to stakeholders						
To integrate EPI services with other interventions such as Early Infant Diagnosis (EID), Community Management of Acute Malnutrition (CMAM) and deworming from 2012	Maximize the synergy from integrating interventions	Include joint interventions in all plans at all levels						
		Involve all stakeholders in formulation and implementation of integrated interventions						
		Monitor and evaluate integration for efficiency, effectiveness and impact						
Mobilize resources for training in EPI at all levels from 2012 Advocate for inclusion of a well structured EPI training (IIP module) in the pre service curricula from 2012 All levels to supervise EPI services in all facilities at least quarterly from 2012	Capacity Building	Develop fundraising proposals						
		Review and update IIP module						
		Print and distribute IIP modules to all Schools of Nursing						
		Advocate for inclusion of IIP module in all nurses curricula						
		Conduct training of trainers for Schools of Nursing						
		Conduct supportive supervision quarterly						
		Document findings and follow up on outstanding issues						
		Give feedback to lower levels						

Annex 3: Using the GIVS framework as a checklist

GIVS strategies	Key activities	Activity included in MYP			
Strategic Area One: Protecting more people in a changing world		**Y**	**N**	**Not applicable**	**New activity needed**
Strategy 1: Commit and plan to reach everyone	Strengthen human resources and financial planning	Y			
	Protect persons outside the infant age group	Y			
	Improve data analysis and problem solving	Y			
	Sustain high vaccination coverage where it has been achieved	Y			
	Include supplemental immunization activities	Y			
Strategy 2: Stimulate community demand for immunization	Assess the existing communication gaps in reaching all communities		N		No
	Engage community members and non-governmental organizations	Y			
	Develop communication and social mobilization plan	Y			
	Match the demand	Y			
Strategy 3: Reinforce efforts to reach the unreached in every district	Micro-planning at the district or local level to reach the unreached	Y			
	Reduce drop-outs	Y			
	Strengthen the managerial skills	Y			
	Timely funding, logistic support and supplies	Y			
Strategy 4: Enhance injection and immunization safety	Procure vaccines from sources that meet internationally recognized quality standards	Y			
	Ensure safe storage and transport of biological products under prescribed conditions	Y			

GIVS strategies	Key activities	Activity included in MYP			
Strategic Area One: Protecting more people in a changing world		**Y**	**N**	**Not applicable**	**New activity needed**
	Introduce, sustain and monitor safe injection practices	Y			
	Establish surveillance and response to adverse events following immunization	Y			
Strategy 5: Strengthen and sustain cold chain and logistics	Conducting accurate demand forecasting activities	Y			
	Building capacity for stock management	Y			
	Effective planning and monitoring of cold chain storage capacity	Y			
	Firm management system of transportation and communication equipment		N		
Strategy 6: Learn from experience	Regular immunization programme reviews	Y			
	Operations research and evaluation	Y			
	Model disease and economic burden as well as the impact		N		

ZIMBABWE EPI ANNUAL PLANS FOR 2012

National Objectives	Indicators	Strategies	Key Activities	Timeline by Quarter			
				1	2	3	4
Increase proportion of districts with 80% Pentavalent 3 coverage from 58% in 2010 to 70% in 2012	Proportion of districts with >80% coverage	RED Implementation	Mobilize resources				
			Conduct training on micro-planning				
			Conduct regular outreach activities				
			Monitor EPI coverage and dropout rate				
			Revive Ward Health Team				
			Sensitize communities				
		Capacity building	Review IIP module				
Reduce dropout rate from 18% in 2010 to less than 16% in 2012	Drop out rate		Conduct training in MLM, IIP and Data Quality Self Assessment				
			Conduct supportive supervision				
			Train health workers and VHWs on use of EPI registers				
		Defaulter tracking	Update and Print EPI registers				
Increase proportion of districts with 80% OPV 3 coverage from 63% in 2010 to 70% in 2012	Proportion of districts with> 80% OPV3 coverage		Register target populations				
			Track defaulters				
			Conduct meetings with VHWs at clinic level				
			Reconcile clinic and VHW registers				
		Resource mobilization	Conduct meetings with Top Management Team (MOHCW), ICC and Ministry of Finance				
Increase proportion of districts with 80% measles coverage from 58% in 2010 to 75% in 2012	Proportion of districts with> 80% OPV3 coverage		Joint planning with local partners and other stakeholders at all levels				
		Public Private sector partnership	Train/Orient private sector practitioners				
To attain ≥95% measles SIA coverage in all districts in 2012	Number of meetings	Resource mobilization	Conduct meetings with Top Management Team (MOHCW), ICC and Ministry of Finance				
			Joint planning with local partners and other stakeholders at all levels				
	SIAs coverage		Conduct training for health workers and community based health workers				
			Identify, produce and distribute relevant IEC Material				
	Number of HW trained	Capacity Building	Meetings and holding dialogue with traditional and religious leaders				
		Social Mobilization and Programme	Train health workers on IPC				
			Conduct integrated SIAs in all the 62 districts				

	% coverage	Communication	Conduct supportive supervision				
			Collect, compile and analyze in and end process data				
		Monitoring and evaluation	Conduct daily feedback meetings				
			Conduct independent monitoring				
			Conduct post campaign evaluation				
Maintain national TT2+ coverage at 45% in 2012 among pregnant women	Number of trainings	RED implementation	Mobilize resources				
			Conduct training on micro-planning				
			Conduct regular outreach activities				
			Monitor EPI coverage				
			Revive Ward Health Team				
			Sensitize communities				
	Proportion of babies born protected	Capacity Building	Conduct training on data capturing and reporting				
		Monitoring Babies Born Protected	Document all TT vaccinations given to women				
			Provide take home cards to all women				
	TT2+ coverage		Educate mothers on importance of childhood immunization cards retention				
To introduce Pneumococcal vaccine (PCV 13) nationally in 2012	Number of health workers trained	Resource Mobilization	Conduct meetings with Top Management Team (MOHCW), ICC and Ministry of Finance				
			Joint planning with local partners and other stakeholders at all levels				
	Number of meetings		Develop training guidelines on new vaccines introduction				
		Capacity Building	Train health workers on new vaccine introduction				
			Modify, print and distribute data collection tools				
To attain at least 90% pneumococcal 3 coverage at national level in 2012			Review, modify, print and distribute Child Health Cards				
	Availability of IEC materials		Develop IEC messages for the print and electronic media				
			Sensitize communities on new vaccine				
		Social mobilization and Communication	Conduct public media campaign				
			Conduct focus group discussion				
			Mobilize resources				
			Conduct training on micro-planning				
			Conduct regular outreach activities				
		RED strategy	Monitor EPI coverage				
			Revive Ward Health Team Conduct supportive supervision				
		Monitoring and Evaluation	Collect, compile and analyze data				
			Monitor and report AEFI				
			Conduct feedback meetings				

	Number of supervisory visits % of pneumococcal 3 covearge		Conduct post introduction evaluation				
Increase national vitamin A supplementation coverage from 78% in 2010 to 80% in 2012		RED Implementation	Mobilize resources				
			Conduct training on micro-planning				
			Conduct regular outreach activities				
			Monitor EPI coverage				
			Sensitize communities				
			Tracking of defaulters by VHW				
		Defaulter tracking	Reconcile VHW and clinic EPI Registers				
To introduce rotavirus vaccine in 2013	Number of meetings Number of health workers trained on new vaccine introduction Availability of IEC Materials Availability of revised data collection tools Number of training on micro-planning	Capacity building	Joint planning with local partners and other stakeholders at all level				
		Social mobilization and Communication	Train health workers on new vaccine introduction				
			Modify, print and distribute data collection tools				
			Review, modify, print and distribute Child Health Cards				
			Develop IEC messages for the print and electronic media				
			Sensitize communities on new vaccine				
			Conduct public media campaign				
		RED Implementation	Conduct focus group discussion				
			Mobilize resources				
			Conduct training on micro-planning				
			Sensitize communities				
To engage policy makers in resource mobilization to	Number of advocacy meetings	Advocacy and communication	Convene meetings with policy makers, ICC and stakeholders				
			Develop and package relevant IEC material				

support EPI *services* To maintain 100% provinces and districts carrying out community sensitization activities All major EPI partners, CSO, health workers and communities sensitized on the introduction of new vaccines	convened Number of health workers and partners trained in IPC Number of meetings with vaccination objectors Number of community mobilizers trained Number of community mobilizers trained		Conduct public media campaign				
			Conduct focus group discussion				
		Training	Training of health workers and partners in IPC				
		Commemoration Africa Vaccination week	Meetings with religious leaders from vaccination objectors				
			Conduct public media campaign				
			Conduct focus group discussion				
		Programme communication	Conduct focus group discussions				
			Train of community mobilizers Orient media personnel				
To increase proportion of provinces with AFP detection rate of 2 cases per 100,000 population of children < 15years from 91% in 2010 to 100% from 2012 To increase proportion of provinces with stool adequacy rate of at least 80% from 82% in 2010 to 100% from 2012	Number of health workers trained Numbers of community persons sensitized Availabilty case definitions % of active searches conducted Number of lab and	Capacity Building	Conduct training for health and community health workers				
			Distribute standard case definitions to all health facilities				
			Sensitize communities on EPI disease surveillance				
		Active Surveillance	Conduct integrated active search for VPD				
			Document findings and report				
			Conduct Lab and EPI data harmonization meetings				
			Give feedback on performance to lower levels, communities and stakeholders				
			Conduct NPEC, NTF and NCC meetings quarterly				

Increase proportion of districts reporting at least 2 suspected measles cases per year from 65% in 2009 to 100% in 2012 **(NB 2009 data used as baseline for measles since 2010 was outbreak data)** To maintain 100% districts reporting less than 1 MNT case per 1000 live birth	EPI data harmonization meetings Number of NPEC,NCC and NTF meetings convened Number of surveillance review meetings	Monitoring	Collect and analyze data on performance indicators				
			Convene surveilla**n**ce review meetings				
			Give feedback on performance to lower levels, communities and stakeholders				
To have at least 80% of all suspected cases of meningitis with CSF collected for Hib testing in 2012 Maintain proportion of stool specimen collection(for rota virus testing) from all diarrhoeal cases at 100%	Availability of lab supplies and logistics Number of Lab/EPI meetings convened Number of lab personnel trained Number of surveillance review meetings	Resource mobilization Laboratory Case Based Surveillance	Develop proposals for fundraising				
			Procure supplies and other logistics				
			Convene meetings with partners Convene Lab and EPI monthly meetings				
			Prepare and submit coasted plans				
			Train lab personnel on Hib and Rota surveillance				
			Conduct relevant tests				
			Collect and analyze data on performance indicators				
			Convene surveilla**n**ce review meetings Give feedback on performance to all levels, communities and stakeholders				
Reduce proportion of health facilities reporting vaccine stock outs from 26% in 2010 to 0% from 2012	Availability of vaccine at national level Number of EPI managers trained	Effective Vaccine Management	Forecast vaccines at national level				
			Train EPI managers on vaccine management and vaccine forecasting				
			Train vaccine stores managers on the stock management tool				
			Introduce electronic stock management tool to district and provincial level				

	Number of provinces and districts using the SMT Number of supervisory visits Proportion of facilities with 0% stock outs		Conduct supportive supervision at all levels				
			Review monthly vaccine ordering forms to identify stock outs				
			Conduct effective vaccine management				
Increase proportion of districts with adequate number of functional cold chain equipment	Number of cold chain equipment procured and distributed Proportion of districts with preventive maintenance plans in place Number of cold chain technicians trained Number of health workers at lower level trained on basic cold chain equipment maintenance	Cold Chain Assessment	Procure and distribute cold chain equipment as per Cold Chain Replacement Plan				
			Develop and implement preventive maintenance plan				
			Procure and distribute spare parts to all levels				
			Maintain cold chain equipment inventory at all levels				
		Capacity Building	Train cold chain technicians at district and provincial level				
			Orient health workers at health facility level on basic cold chain equipment maintenance				
Maintain 100% districts using AD syringes	Proportion of facilities with safe injection practices Number of facilities with proper waste disposal Proportion of AEFIs properly investigated	Improve Immunization Safety	Sustain and monitor safe injections practices				
			Monitor injection waste disposal				
			Investigate, respond to and report AEFI				
Increase completeness of	Number of health	Strengthen	Distribute adequate data collection tools				

reporting from 86% in 2010 to 90% in 2012	workers trained Proportion of facilities monitoring timeliness and completeness of reporting % of reporting completeness	management, analysis, interpretation use and dissemination of data	Train health workers on data collection, compilation, analysis and use				
			Put in place tools for timeliness and completeness of data submission				
			Follow up on outstanding data				
			Update databases at all levels				
			Provide feedback to all levels on completeness and timeliness of data				
Maintain proportion of health facilities with EPI micro-plans at 100%	Proportion of facilities with	Programme Planning	Train health workers on micro-planning				
			Conduct supportive supervision				
To conduct EVMA in 2012	Vaccine management assessment report	Strengthen management, analysis, interpretation use and dissemination of data	Develop proposals for fundraising				
			Conduct VM assessments				
			Feedback results to all levels				
All health facilities monitoring AEFI from 2012	Proportion of AEFIs investigated properly		Monitor AEFIs Investigate, respond to and report AEFI Maintain a register of AEFI				
Review IIP module to suit pre service training needs in 2012			Review and update IIP module				
		Capacity Building	Print and distribute IIP modules to all Schools of Nursing				
	Availability of updated IIP module Number of TOT trained		Conduct training of trainers for Schools of Nursing				
Advocate with Government to co finance all new vaccines	Number of meetings convened	Ensure effective and sustainable introduction of new vaccines	Conduct meetings with policy makers at MOHCW and MOF				
			Involve ICC in advocacy				
			Share relevant documents such as cMYP				
			Submit EPI budget estimates annually				

			Follow up on budget allocations				
Conduct post introduction evaluation for new vaccines six months post introduction	Evaluation report	Ensure effective and sustainable introduction of new vaccines	Develop proposal for fundraising Train enumerators Conduct evaluation Give feedback to stakeholders				
To integrate EPI services with other interventions such as Early Infant Diagnosis (EID), Community Management of Acute Malnutrition (CMAM) and de-worming from 2012	Number of joint interventions	Maximize the synergy from integrating interventions	Include joint interventions in all plans at all levels				
			Involve all stakeholders in formulation and implementation of integrated interventions				
			Monitor and evaluate integration for efficiency, effectiveness and impact				
Mobilize resources for training in EPI at all levels from 2012 Advocate for inclusion of a well structured EPI training (IIP module) in the pre service curricula from 2012 All levels to supervise EPI services in all facilities at least quarterly from 2012	Number of trainings done Number of training schools with structured EPI training Number of supportive supervision visits conducted	Capacity Building	Develop fundraising proposals				
			Review and update IIP module				
			Print and distribute IIP modules to all Schools of Nursing				
			Advocate for inclusion of IIP module in all nurses curricula				
			Conduct training of trainers for Schools of Nursing				
			Conduct supportive supervision quarterly				
			Document findings and follow up on outstanding issues				
			Give feedback to lower levels				