

REPUBLIC OF ZIMBABWE

ZIMBABWE EXPANDED PROGRAMME ON IMMUNIZATION COMPREHENSIVE MULTI YEAR PLAN 2007 | 2011

Revised Nov 2008



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1. EXECUTIVE SUMMARY

In April 1980, the Government of Zimbabwe through the Ministry of Health & Child Welfare adopted the primary health care concept with the overall objective of providing affordable, acceptable and accessible quality health care to all Zimbabweans, particularly focusing on the previously underserved and marginalized sections of the populace. Emphasis was placed on investing more in childhood immunization than the minimum identified as being required, because of the accent on prevention in respect of childhood killer diseases.

The programme made tremendous achievements during the first two decades of independence. However, in recent years, the country has been facing serious challenges. These have resulted in severe foreign currency shortages that have caused a ripple effect on the running of the ZEPI programme, such as direct importation of all vaccines and cold chain equipment. Skills shortages are a continuing problem as healthcare professionals have tended to leave the country for better pay and conditions.

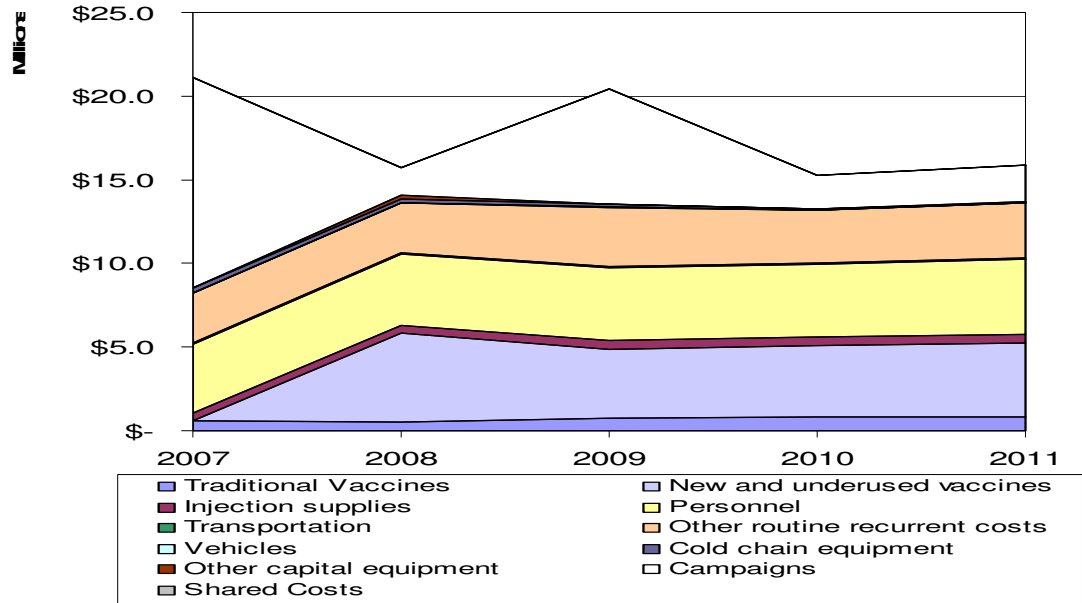
Efforts made to address most of these problems include EPI task force partners rallying behind ZEPI and assisting the programme with many of its critical needs. These challenges necessitate the solicitation of external assistance to close existing financial gaps, especially if the ZEPI programme is to successfully introduce new antigens as well as potential new combinations.

The 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 GIVS, this comprehensive multi year plan 2007 - 2011 will focus on key actions to achieve the five goals. The key objective of the ZEPI programme is to reduce morbidity and mortality from seven major childhood killer diseases. Specifically the objectives are:

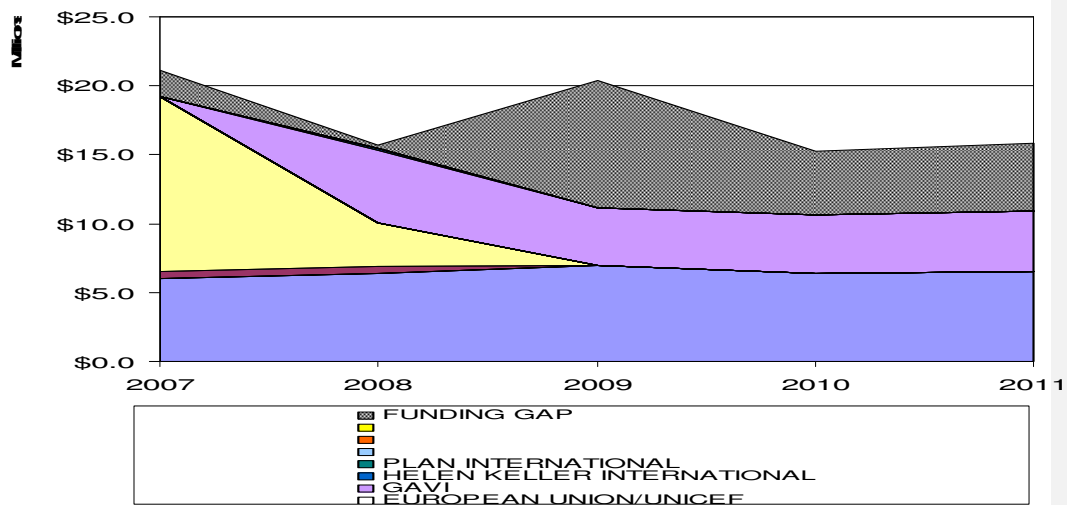
1. Protect more people and save lives by widespread use of safe vaccines
2. Accelerate the reduction of morbidity and mortality from vaccine preventable diseases
3. Introduce new and under – utilized vaccines
4. Strengthen EPI surveillance, health information and data management
5. Integrate EPI with other interventions

Although the ZEPI program required on average US\$6-9 million per year from 2000-2005, this is likely to increase in the next few years because there are a number of planned activities that will result in significant increase in overall costs. These include re-organization of the cold chain in line with recommendations made in the cold chain review process, the introduction of Hib vaccine in the ZEPI schedule (DPT-HepB-Hib) and in addition the implementation of the RED approach to improve coverage. The projected programme costs taking into consideration the above activities are expected to range from US\$13m to \$14 m 2007 and 2011 and will increase to US\$18m (2010), when there are National Immunization Measles campaign days.

Projection of Future Resource Requirements



Future Secure Financing and Gaps



It is important to note that the illustrated funding gap is a reflection of:

1. Increasing programme costs due to new strategies and interventions, and
2. Difficulty in predicting future financing sources, and amounts.

The major financial gaps will require concerted support efforts by partners like WHO, who normally provides technical support, and UNICEF who largely rely on donor support. The Government has shown a strong commitment to health and this is evidenced by the health expenditure as a share of total Government expenditure that has been increasing and is currently at 12%. 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. However, the government still has high hopes on the return of key partners like DANIDA, USAID, NORAD, CIDA, SIDA etc to support the health sector and particularly ZEPI.

The biggest threat posed by the debilitating human resource shortage is being addressed by ongoing organizational reforms that will ultimately streamline service delivery. The establishment of the Health Service Board is expected to provide the health sector with more independence and better control of its own decisions. The immediate requirement will be to ensure that the ZEPI team at national level is enlarged and provided with increased capacity to be able to adequately manage the major challenges currently being faced by the programme.

The strategy to achieve financial sustainability covers three main areas:

- Mobilization of Additional Resources
 1. Discuss needs with key stakeholders and ask for additional resources to support new programme strategies
 2. Reconfirm Government commitment to funding traditional vaccines and ask partners to continue assisting with for Aid Agency commitment to assisting with vaccine procurement
 3. Cold chain – confirm UNICEF and JICA commitment to upgrade funding.
 4. Vehicles – ongoing commitment from WHO to replace aging surveillance vehicles. UNICEF to assist with mobilization of resources from donors to provide additional vehicles for districts.
 5. Mass immunization campaigns – assistance to be requested from partners such as Measles Partnership, Helen Keller International (HKI).
- Resource reliability – no problems have been experienced or are expected in respect of the reliability of committed funds.
- Programme Efficiency
 1. Human resources issues to be addressed, including recruitment, training and retention.
 2. Cold chain rehabilitation is being carried out as planned.
 3. In respect of immunization, vial sizes are to be standardized, the number and type of antigens in the programme are to be rationalized.
 4. Data management should be substantially improved, particularly as regards to data completeness, timeliness and vaccine wastage monitoring
 5. Advocacy and communication for EPI strengthening

The financial sustainability programme as a whole already has Government support. Thus, funding is confirmed for all supplies and services which can be bought or provided locally. The key focus areas are therefore the availability of funds for new projects, and the availability of foreign currency to purchase import needs both for the ongoing programme and for new projects. In both the short and the long term, close links are being maintained with likely donors and support agencies. The Inter Agency Coordinating Committee plays a key role in acting as a catalyst in this process. Timelines are difficult in the present environment, as much of the support is provided on a relatively short term basis as required. As noted, the key is to hold regular ICC and one to one donor meetings and to obtain commitments as early as possible for support of the individual needs.

2. INTRODUCTION

Background

In April 1980, the Government of Zimbabwe through the Ministry of Health & Child Welfare adopted the primary health care concept with the overall objective of providing affordable, acceptable and accessible quality health care to all Zimbabweans, particularly focusing on the previously underserved and marginalized sections of the populace. Emphasis was placed on investing more in childhood immunization than the minimum identified as being required, because of the accent on prevention in respect of childhood killer diseases.

The Ministry of Health & Child Welfare remains committed to the Immunization programme as a pillar for child survival and improvement of child health, as immunization contributes significantly to the reduction of infant and child morbidity and mortality and thus contributing to the attainment of MDG 4. The biggest challenge has been to raise significant resources to meet these expensive activities. Because of Government commitment, resources had to be found internally, whilst assistance from interested development partners was also welcomed. From the time the commitment was initially made, substantial financial resources were allocated to the Ministry of Health & Child Welfare. Within a decade this translated into Zimbabwe having arguably the best performing health delivery system in Sub-Saharan Africa and provided a leading example to other developing countries' health systems. Over 70% of the overall expenditure on health has been from Government's own resources. The Ministry of Health & Child Welfare now receives an allocation of at least 12% of the available GDP and funding for the Zimbabwe Expanded Programme for Immunization (ZEPI) continues to grow demonstrating the government's commitment to the immunization programme. Partner assistance has included significant technical content, together with hard currency financial support. Traditional partners in the immunization programme, such as EU, DFID, UNICEF, WHO continue to support, with new partners like Helen Keller International, Plan International and the Government of Japan being brought aboard.

Despite these tremendous achievements and the gains realized during the first two decades of independence, in recent years the country has been facing serious challenges. These have resulted in severe foreign currency shortages that have caused a ripple effect on the running of the ZEPI programme, reliant as it is on direct importation of all vaccines and cold chain equipment. Skills shortages are a continuing problem as healthcare professionals have tended to leave the country for better pay and conditions. The crippling foreign currency shortages resulted in erratic fuel supplies negatively affected the smooth running of the ZEPI outreach programmes.

Tremendous efforts have been made to address most of these problems. EPI task force partners have rallied behind ZEPI and have assisted the programme by fulfilling many critical needs. Major challenges however, remain which necessitate the solicitation of external assistance to close existing financial gaps, especially if the ZEPI programme is to successfully introduce new antigens as well as potential new combinations.

Key programme Strategic Goals and objectives

In line with GIVS and also with the government plan to synchronize EPI interventions, this comprehensive multi year plan 2007-2011 was conceived by the ICC. The process of developing the document started with consultative processes with donor agencies as well as other stakeholders and partners in EPI. In addition to the programmatic component of the plan, it also includes costing and strategies to successfully see through the plan.

Key Programme Objectives

The key objective of the ZEPI programme is to reduce morbidity and mortality from seven major childhood killer diseases. Specifically the objectives are:

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

Key Challenges and Opportunities Affecting Financing and Operations

Although the ZEPI programme was one of Africa's best performing programmes during the first two decades of political independence there have been serious challenges since year 2000. The worst performing year was 2001 when DTP 3 coverage was 52%. Coverage improved to 85% in 2006, then declined to 75% in 2007 - thanks to concerted efforts being undertaken to address some of the causative factors, including the introduction of Child Health Days which provide an opportunity for communities to catch up with due or overdue vaccinations. The ultimate aim is to achieve minimum vaccination coverage of 95% by 2011. Aggressive measures to reduce vaccine wastage are also beginning to show some positive results. Strong social mobilization using ZEPI advocacy and communication strategy at all levels has begun to bear fruit as the demand for immunization services is increasing. The introduction of pentavalent vaccine with the support of GAVI took place in January 2008.

The perennial problem of high attrition of experienced staff is likely to be addressed with the coming in of the Health Service Board that became operational in June 2005. But before the Board stabilises the situation on the ground, such as improving conditions of service, continuous training will be required to address the skills shortage created by the current high staff turnover levels. Meanwhile the Ministry of Health and Child Welfare has already started training a new cadre, Primary Care Nurse (PCN), to man the lower levels of the health delivery system. In terms of capital investment required for the ZEPI cold chain and the ageing vehicle fleet, there will be need for additional funding. More than 50% of the cold chain equipment is due for replacement, whilst the ZEPI vehicle fleet is also inadequate. In the meantime a stopgap measure is to integrate ZEPI program activities with other vehicle-resource-rich programmes.

Due to continuing shortages of foreign currency, additional support is required especially from partners like UNICEF, WHO, EU, Rotary International, DFID, Government of Japan, Helen Keller, Plan International, GAVI etc. for vaccines, equipment and other logistics requirements that need foreign currency. Government will however continue to allocate adequate funds to a local currency budget for vaccine procurement which will however be used for strengthening other aspects of immunization programme locally.

One of the key financing problems is that apart from Government, it has not been possible to obtain any long term commitment from partners and donor agencies in respect of the funding of the programme. Although partners are proving very helpful in providing short term support, the lack of firm forward commitment means that long term programme planning can only be carried out using assumptions of what finance will become available. However the number of partners to ZEPI is increasing.

As support is received from partners in the form of foreign currency to facilitate importation of vaccines and ZEPI cold chain equipment, the allocated Z\$ budget is used for ZEPI related activities that might not require foreign currency e.g. training, maintenance and supervision/disease surveillance activities. It should be emphasized that central government funding for the ZEPI program did not reduce but rather evolved in line with the macroeconomic situation prevailing in the country, to reflect funding for program investments not requiring foreign currency exchange.

The Zimbabwean economy is still operating in a hyperinflationary environment, though the Reserve Bank continues to put fiscal and monetary policy measures to address current inflation levels which are above 1 000%. Efforts to improve foreign currency inflows by the central bank have met with some marginal success. The macroeconomic factors that are fuelling inflation are being targeted by the central bank. If these current efforts are sustained it should be possible that in the long term the Government can resume funding and importation of vaccines to meet part of its requirements.

3. SITUATION ANALYSIS

Country profile

Zimbabwe is a landlocked country of 390 580 square kilometers, bordered by Mozambique in the east, South Africa in the south, Botswana in the west and Zambia in the north and northwest. It is part of the great plateau of the Southern African region. Almost all of the country is more than 300 metres above sea level with 80 percent lying more than 900 metres above sea level and about 5% lying 1500 metres above sea level.

The total population of Zimbabwe was estimated to be about 12 2224988 in 2007 based on the 2002 census. The current rate of natural increase is 2.25, with an average annual inter-censal growth rate of 1.1%. The country's administrative structure consists of the national level, 11 provinces, 62 districts and 1536 health centers. Of the 11 provinces, 3 are classified as cities.

The Zimbabwean population is largely rural with only 32 percent of the population living in urban areas as per the 2002 census (31% recorded in the 1992 census). There is substantial provincial variation in the degree of urbanization, with the proportion of the living in urban areas ranging from as high as 59 percent in Mashonaland East to 6 percent in Masvingo and less than 3 percent in Matebeleland South.

Socio economic profile

The Zimbabwe economy is fairly diversified, with relatively well-developed commercial, industrial, mining and agricultural sectors. Mining and agriculture are the leading producers for both domestic and export markets, with mining contributing more to export earnings than to the domestic economy.

Agriculture forms an important part of the country's economy, both for internal consumption of food and cash crops, for export. The country's soil types range from sandy/loamy in the high veld to sandy in the west. The sunny, temperate to hot climate provides the basis for agricultural production, especially along the central ridge. Generally, temperature decreases and rainfall increases with altitude, ranging from the cool, wet eastern highlands to the hot, dry river valleys of the Zambezi, Limpopo and Sabi rivers. The main agricultural exports include tobacco, cotton, sugar and groundnuts. The agricultural sector has a well-developed commercial component, co-existing with subsistence farming.

Currently the country is operating in a hyper inflationary environment. Fiscal and monetary authorities have put measures in place to bring inflation levels under control. The rate of inflation is over 1 000% (October 2006).

Health status and demographic indicators

The health status of the Zimbabwean people is low as compared to other higher income countries, but compares well with sub Saharan African countries of similar status.

Table 3.1: Key health indicators

Indicator	Value
Infant mortality rate	60/1000
Maternal mortality rate	555/100,000
Access to health care	85%
Life expectancy at birth	46*

Source: Zimbabwe Demography and Health Survey (ZDHS) 2005-2006

**Source Zimbabwe 2002 Central statistical Report*

As with many of the similar countries, basic population indicators are on the decline. Infant Mortality Rate has increased by 21.4% from 66 to 80 per 1000 live births and the Child Mortality Rate by 38.5% from 26 to 36 per 1000 live births in the period 1992 to 1997¹. This has been mainly due to the consequences of the HIV/AIDS epidemic¹. Life expectancy at birth for Zimbabwean males had dropped from 58 to 52.6 years, and for Zimbabwean females from 62 years to 57.2 years, between 1997 and 2002 at the time of the Census.

¹ Official population projections beyond 2002 have generally not taken into account the demographic effect of HIV/AIDS. Several projections (calculated by the Blair Research Institute, the National AIDS Coordination Programme (NACP) and the United Nations Population Division)

Disaggregated data by gender and age indicates that about one in two Zimbabweans is under 18 years and about one in five is under 5 years. The sex ratio is about 92 males to 100 females. From the 1997 Inter-Censal Demographic Survey, 43.9% of Zimbabweans were under 15 years old and 6% were over 65% old, giving a dependency ratio of 98.4, an increase of 4.25% from the 1992 dependency ratio of 94.4.

The health system and health sector reforms

The national health system is based on primary health care, of which immunization is a key component, as reflected in the 5 year National Health Strategic plan(2008-2012). The health sector reform plan initiated in 1990 has a decentralized provision of health care with much emphasis on the districts. Provision of health care is very efficient with 85% of the population living within 8 – 10 kilometres from health facilities.

The Ministry of Health and Child Welfare has a 5 year strategic planning system, with the current one running from 2008-2012. This plan encompasses all priority activities, including EPI. The key indicators, objectives and strategies of the EPI programme as articulated in the multi year plan will be reflected in this strategic plan

Beginning in 1991, the country has been going through Economic Structural Adjustment Programmes, which encompasses fiscal and monetary, as well as legal and institutional reforms that are meant to promote productive investment and employment creation.

The Health Sector has been undergoing reforms in line with recommendations of the 1998 Health Review Commission. The on going reforms in the health delivery system have seen the establishment of a Health Services Board in 2005 that is responsible for the conditions of services for all health personnel in the ministry. It is anticipated that with the establishment of the Health Services Board the loss of skilled personnel in the Health Sector will be reduced.

Government planning and budgeting process

The Government of Zimbabwe through the Ministry of Finance and Economic Development has implemented Financial Management Reforms in the Public Sector and this has seen the introduction of the Public Financial Management System. The system allows budget holders to procure goods/services and also to process payments. The Public Services Financial Management system was successfully rolled out within the Ministry of Health and Child Welfare on 1 September 2004.

3.2 Health sector financing

Health sector activities have been largely funded with Government's own resources (see table 2 below)². Of the overall central level expenditure on health, over 95% has been from Government's own resources.

Table 3.2: Funding for central level expenditures, 2001 – 2005 (ZWS)

	2001	2002	2003	2004	2005
Government own resources	13,535,961,000	34,962,997,000	132,280,708,000	882,287,949,297.15	3,104,236,568,371.13
Partner resources	1,457,337,000	330,992,210	3,532,496,000	19,068,197,200	40,460,733,435.48
Total expenditure	14,026,298,000	35,293,989,210	135,813,204,000	901,356,146,497.15	3,144,697,301,806.61

suggest that the population growth rate will fall to between zero and 1.5% by the year 2002 as AIDS-related deaths in Zimbabwe continue to mount.

² This represents those partner resources that are known. Some may not be reflected in these estimates

The Government resources allocated to health have been increasing exponentially over the years. Partner resources to health had reduced significantly in 2002, but increased from 2003. Partner support is largely technical, in addition to the financial support provided. The proportion of the Government budget for health has remained similar in the recent past. There is equitable apportioning of the Government resources to the health sector.

Funding for EPI has been increasing in the past years as a result of the changes in currency valuation. However, the increases, when compared against the Government health expenditure as illustrated in table 1.3 below, indicate that there has been a decrease in real terms.

Table 3.3: Government expenditure for EPI program in relation to total health, and Government expenditure, 2001 – 2005

	2001	2002	2003	2004	2005
Amount spent on EPI	198,314,000	259,919,528	600,000,000	5,112,937,200	6,000,000,000
Proportion of Government health expenditure	1.47%	0.74%	0.45%	0,58%	0,19%

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 killer diseases which are currently tuberculosis, diphtheria, tetanus, pertussis, poliomyelitis, measles and hepatitis B. 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

3.3 Access to immunisation and other health services.

The ZEPI was launched in 1981 with the main focus being prevention and control of vaccine preventable diseases. Before 1981, vaccination centres were few and the vaccination coverage was 28% for DTP 3 in 1982. After the introduction of primary health care, there was concerted effort to expand the health care delivery system as more health facilities were built, outreach and mobile services introduced particularly for the immunization programme. Immunization services are offered at all public (MOHCW, Missions and local authorities) health facilities and some private health facilities. The provision of immunization services are guided by several policy guidelines. The current vaccination schedules for children and women of child bearing age are reflected in tables 2.4, 2.5 and 2.6. Only qualified nurses give vaccinations at both static and outreach services.

Table 3.4: Current Vaccination Schedule for Children

Antigen	Number of doses	Amount of dose	Time when provided	Site	Route
BCG	1	0,05 ml	At Birth/First contact	Intersection of deltoid muscle Rt arm	Intradermal
Penta	3	0,5 ml	3, 4, and 5 months	Antero lateral aspect of mid thigh	Intramuscular
DPT Booster	1	0.5ml	18 months	Antero lateral aspect of mid thigh	Intramuscular

OPV	5	2 – 3 drops	3, 4, 5, 18 months & 5 years	Mouth	Orally
Measles	1	0,5 ml	9 months	Deltoid muscle Lt arm	Subcutaneous
DT	1	0,5 ml	5 years	Antero lateral aspect of mid thigh	Intramuscular
Vitamin A	2 per year at 6 mths interval	50 000 iu	Before 6 mths if not breastfed	Mouth	Orally
		100 000 iu	6 – 11 months	Mouth	Orally
		200 000 iu	12 – 59 months	Mouth	Orally

The program has always provided DT, and Hepatitis B antigens using Government's own resources. DT is a booster dose. Hepatitis B has in the past been provided as a tetravalent antigen with DTP (DTP-HepB). However, starting 2008, it is now provided within Penta.

In addition to these in the routine program are supplemental immunization activities aimed at boosting coverage for specific antigens.

Table 3.5: TT schedule for women of child bearing age

Dose number	Interval between doses	Amount of dose	Site	Route
TT 1	15 years/1 st contact	0,5 ml	Deltoid muscle	Intramuscular
TT 2	28 days after TT1	0,5 ml	Deltoid muscle	Intramuscular
TT 3	6 moths after TT2	0,5 ml	Deltoid muscle	Intramuscular
TT 4	1 year after TT3	0,5 ml	Deltoid muscle	Intramuscular
TT 5	1 year after TT4	0,5 ml	Deltoid muscle	Intramuscular

Table 3.6: TT schedule for women with childhood DTP vaccinations

No childhood DTP	All 5 doses as in table 5
3 primary DTP doses	2 doses TT 1month apart and 1 dose a year later
3 primary DTP doses and 1 DTP booster dose	2 doses TT 1 year apart
	1 dose TT at first contact during child bearing age

Vaccines are delivered from the Central Vaccine Store at national level to provincial stores. Districts collect the vaccines and other logistics from the provincial stores to the district stores before distributing them to the health facilities.

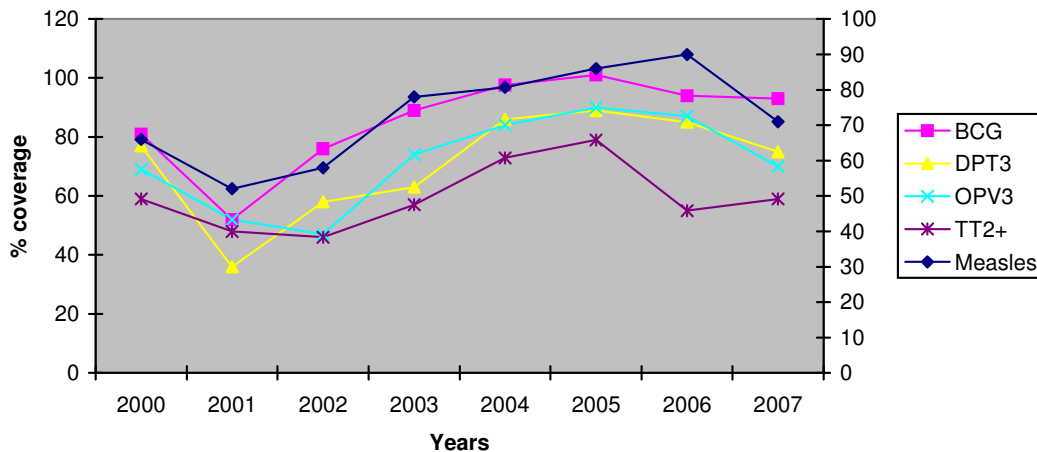
Program achievements against targets

The program has managed a series of achievements. These are illustrated in this section.

Coverage achievements

The figure below shows the immunization coverage by antigen since the MYP was started.

Figure 2.1: EPI coverage by antigen 2000 to 2007
Source: MOHCW



Coverage is high but there was a decrease in 2001 – 2, then 2007. Some of the reasons for the decrease include; incomplete data reporting, high staff attrition rate and inadequate transport and fuel for EPI service delivery.

National coverage figures mask differences among districts. Analysis of coverage by district shows that some districts have very low coverage (below 60%) hence the importance of assessing districts with low coverage and conduct supplementary campaigns. The RED approach has been introduced to 20 low performing districts in a bid to strengthen immunization services and raise the coverage. Twice a year Child Health Days were also introduced to provide an opportunity for children to catch up with their vaccinations. Hard to reach areas and communities are given a particular focus during these days.

Regarding efficiency of vaccine use, wastage has varied in the past. Vaccine wastage is monitored efficiently at health centre, district and provincial levels. Most districts and provinces have high wastage in all antigens and measures are being put in place to reduce wastage at all levels to at least 15% for vaccines under multidose vial policy, BCG to 60% and measles to 40%.

Disease Elimination/Eradication Strategies

Polio

Strengthening Acute Flaccid Paralysis (AFP) surveillance, conducting supplemental OPV vaccination and maintaining high routine OPV coverage are key strategies for polio eradication. Zimbabwe conducted a successful national polio immunization campaign in 1996 (96% coverage) followed by sub national polio immunization days in 1997) followed by national polio campaign during the 2007 Child Health Days. Although no wild poliovirus has been detected in Zimbabwe since 1989 there is need to strengthen surveillance and maintain polio free certification

criteria. In 2007 Zimbabwe met one out of the three main criteria for polio free certification i.e. stool adequacy rate of 80% and needs to strengthen AFP detection rate as well as district reporting timeliness

Measles

The country is implementing a measles elimination strategy that focus on achieving and maintaining a high routine coverage of 80% in all districts and 95% nationally, case based surveillance and providing a second opportunity to all children. In 1998, the country conducted a measles catch up campaign. Follow up campaigns were conducted in 2002 and 2006, with mop up activities carried out in 2003 in districts that had low coverage during the campaign. Follow up campaigns shall be conducted every 3-4 years based on epidemiological data and next follow up campaign has been moved forward to 2009.

Maternal and Neonatal Tetanus Elimination

A Lot quality assessment was conducted in 2000, the results showed that Zimbabwe had eliminated Neonatal tetanus, as the NNT rate was below 1/1 000 live births in every district. The challenge is to sustain that status, by having at least 80% TT2 coverage among women of childbearing age. The country is strengthening the aspect of monitoring babies protected against NNT as a way of validating TT2+ coverage.

Capacity building

The MLM courses are ongoing for building capacity among the national level staff in management and Nurse Tutors in Nurses Training Schools. It is expected that the tutors will have enough knowledge and skills to train the nurses on immunization during the pre-service period. Immunization in practice modular training for district health workers commenced in July 2008 and will continue until all relevant service level personnel are covered. Continuous in service training has to be instituted to keep health workers abreast with new developments in vaccines and technology. With the high attrition rate, Zimbabwe continues to lose skilled manpower and the need to continue training to strengthen immunization knowledge and skills in the newly qualified health workers.

Program efficiency

In 2004 and 2007 MOHCW and WHO conducted vaccine management assessments that revealed the need to strengthen vaccine stock management and wastage monitoring. MOHCW employed a logistician whose mandate is to strengthen this aspect through training and supervision of health workers at all levels. WHO has also recruited another logistician to work hand in hand with the Ministry's logistician. Some of their responsibilities include vaccine forecasting, ordering, distribution, and appropriate maintenance of cold chain at all levels. Multi-dose vial policy is being reinforced in an attempt to minimize vaccine wastage.

Social Mobilization

There is high political will at all levels towards disease control, elimination, and eradication through immunization. There is currently good community knowledge and awareness on immunization with high demand for EPI services. However there is a need to maintain these high levels where they exist, i.e. in high performing districts and increase EPI activities in low performing districts.

An integrated EPI advocacy and communication strategy is in place to strengthen the immunization program at these levels:

- Advocacy level
- Social mobilization level
- And program communication level

Future program activities and strategies

The program will pursue the objectives and strategies as outlined in this document, as it strives to improve service delivery for vaccines. Targets will be modified according to performance so far achieved.

Vaccines and injection supplies for the routine program and SIA's

Targeted coverage levels are outlined in the table below:

Table 4.1 Coverage targets for different antigens in the National Immunization Program, 2007 – 2011

Type of Vaccine	2007	2008	2009	2010	2011
BCG	100%	100%	100%	100%	100%
TT2+ - Pregnant Women	55%	56%	56%	57%	58%
Measles	71%	78%	84%	90%	90%
OPV(1)	88%	91%	93%	95%	97%
Measles Campaigns				100%	
DTP-Hep B-Hib (3)	75%	80%	85%	90%	95%

Zimbabwe introduced the Hib vaccine in the immunization program in 2008, with GAVI support. The country is committed to the protection of its children from vaccine preventable diseases thereby reducing morbidity and mortality in children.

In addition to achieving these high targets, the program shall seek to reduce wastage of vaccines as outlined below.

Table 4.2 Vaccine wastage targets for the National Immunization Program, 2007 – 2011

Type of Vaccine	2007	2008	2009	2010	2011
BCG	60%	55%	50%	45%	40%
TT	15%	15%	15%	15%	15%
Measles	40%	40%	40%	40%	40%
OPV	15%	15%	15%	15%	15%
DTP – Hep B –Hib	10%	10%	10%	10%	10%
Measles Campaigns				15%	

Personnel improvements

The shortage of manpower has continued to plague the EPI program. In addition to this, there is a significant level of attrition especially for nursing staff at the implementation level. In line with this, the program plans:

- To recruit, at the central level, a deputy program manager (operations), data manager, surveillance officer and a secretary to boost the capacity of the central level,
- Ensure nurses and nurse aides are adequately recruited to fill vacant posts, and replace those leaving the service. In addition, better ways to ensure staff are maintained will be explored

Capital investments

Vehicles are managed in a central pool at the implementation level. These are however largely utilised for EPI activities. For effective implementation of EPI activities, the program plans to have a 4WD vehicle at each provincial, and district level. This is to be phased in over a 5-year period, such that by 2015, all districts and provinces shall have a vehicle from the EPI program. These shall be replaced basing on a 5 year useful life. These vehicles are maintained by Riders for Health.

Regarding the cold chain, a cold chain assessment for EPI was completed in 2004. This showed that a lot of the cold chain equipment is old, not in conformity to the agreed standards, and the capacity far higher than what is required. As such a plan is developed to ensure adequate equipment is purchased in line with the assessment recommendations. Replacement commenced in 2004 with UNICEF support for the 2004 and 2005 needs. It is anticipated that by 2009, all the cold chain equipment shall be replaced with recommended, adequate equipment as per the cold chain replacement plan.

Disease surveillance

Disease surveillance activities are important for the EPI program in Zimbabwe. The program shall aim for a target of 80% of health facilities completing the weekly rapid disease notification forms and submit to the next level weekly. Regarding the specific diseases, surveillance targets shall be as follows:

AFP Surveillance

- Non-polio AFP detection rate of at least 2/100,000 in the children under 15 years.
- 80% of AFP cases investigated within 14 days of onset of paralysis (2 stool specimens collected 24 hours apart within 14 days of paralysis)
- 80% of AFP specimens to arrive at the National Virology Laboratory in good condition within three days of collection.
- 80% of AFP cases investigated within 48 hours of notification.
- All AFP cases with late stool specimens to be followed up after 60 days.
- 80% of districts reports, including zero reporting, to be received by the 15th of each month at provincial level.
- All districts will receive results of AFP investigation within one week of receipt at national level.

Measles Surveillance

- Every district to achieve detection rate of 2 cases per 100 000 population per year.
- Every suspected measles case should be investigated (serum specimens for virology collected from every case) at all levels.

MNT Surveillance Targets

- 100% of neonatal cases reported and investigated.
- MNT elimination status to be maintained (less than one NNT case per 1000 live deliveries per district).

4.1 Strategies to achieve the above targets

To be able to achieve these targets, a series of specific activities are to be employed. These shall include for the routine programme:

1. Strengthen capacity for EPI management at national, provincial, district and health facility levels (immunization policy, technical guidelines and quality assurance, integrated communication, integrated surveillance, logistics/supply management, cold chain maintenance).
2. Strengthen supportive supervision to all health facilities by District Health Teams.
3. Conduct monthly outreach sessions and identify new outreach sites in the new resettlement areas.
4. Conduct rapid assessments in low performing districts to establish reasons and take corrective action.
5. Improve operational and supervisory capacity at all levels through provision of transport, means of communication and office equipment
6. Strengthen logistics distribution system, from central and provincial to district level and to all health facilities.
7. Ensure availability of the new IEC materials at every level to address immunization services.
8. Implement the activities/strategies as outlined in the cold chain assessment report.
9. Ensure availability of EPI vaccines, injection and cold chain equipment and other EPI logistics at every level all the time.

Regarding supplemental immunization activities, the targets shall be achieved through:

1. Conducting local immunization campaigns for all antigens in the at risk areas.
2. Conducting measles mop up campaigns and vitamin A supplementation in the low coverage districts.
3. Commemorating an EPI week at provincial and district level.

4. Strengthening district capacities for micro planning to facilitate effective implementation of all the EPI related activities.
5. Holding post- supplementary campaigns evaluation meetings.
6. Creating demand for EPI services from clients at all levels

For the disease surveillance activities, strategies shall be:

1. Target all health workers including senior managers during sensitization of clinicians on EPI disease surveillance (includes laboratory surveillance).
2. EPI disease surveillance focal persons to conduct active surveillance for EPI target diseases.
3. Conduct on-job training of all health workers and induction for new recruits.
4. EPI disease surveillance focal persons to sensitize core health workers and the community on EPI Disease surveillance.
5. Maximize use of available limited transport for EPI service delivery and integrate with other programs such as Malaria.
6. Improve communication among colleagues.

Financing of program strategies

In addition to Government, the other partners supporting the National Immunization program are UNICEF and WHO. A number of bilateral partners, such as DfID, and the European Union are providing support to the program through these two agencies. Additionally, significant support has come from Rotary International. It should be noted that the EPI program was largely Government funded until recently. This change is due to:

- The introduction of GAVI support for injection safety, and Immunization System Strengthening, and
- The need to obtain scarce foreign exchange to purchase import requirements.
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Table 1.1: Situation analysis by Routine EPI system components, 2003-2007

Component	Suggested indicators	National status				
		2003	2004	2005	2006	2007
	National HepB3 coverage					
	Proportion of districts with DPT3 coverage \geq 80%	10%	54%	80.3 %	74.2%	40.3%
Service delivery	National DPT3 coverage	63	86	90	87	74
	National Pentavalent coverage (New vaccine)	NA	NA	NA	NA	NA
	National DPT1-3 dropout rate	18%	16%	14.8 %	11.5%	15.5%
	Proportion of districts with DPT1-3 dropout rate more than 10%	77%	79%	66.4 %	49%	82%
	Introduction of Pneumo and Rota Virus	NA	NA	NA	NA	NA
	Number of districts with RED micro-plans on immunization	0	0	61	61	62
Transport for outreach and inputs distribution	Proportion of Districts with EPI transport					
		3	0	0	0	0
		0	0	0	0	0
Vaccine supply, quality and logistics	National stock out of vaccines reported during the year	NDyes	Yes _o	Neno	Yesno	Neno
	How many months were stock outs experienced for:	NA	NA	NA	NA	No
	BCG		0	0	0	0
	DTP	0	0	0	0	0
	HepB	NA	NA	NA	NA	No
	OPV					
	Measles					
	TT					
	Reported vaccine wastage in %:	ND	ND	ND	ND	ND
	BCG	ND	ND	ND	ND	ND
DTP	ND	ND	ND	ND	ND	
HepB	ND	ND	ND	ND	ND	
OPV	ND	ND	ND	ND	ND	
Measles	ND	ND	ND	ND	ND	
TT	ND	ND	ND	ND	ND	
	Is there a national system to monitor AEFI	Yes	Yes	Yes	Yes	Yes
	Number of regions using AD syringes for immunization (Public facilities only)	0	11	11	11	11
	Is there a waste management plan	No	No	No	No	No

Table 2.3: Situation analysis by Routine EPI system components, 2003-2007

Component	Suggested Indicators	National Status				
		2003	2004	2005	2006	2007
Cold Chain /Logistics	% of regions with adequate functional cold chain equipment	100%	100%	100%	100%	100%
Advocacy and communication	Availability of a communication plan at national level	Yes	Yes	Yes	Yes	Yes
	Was there a budget for advocacy and communication	Yes	Yes	Yes	Yes	Yes
Surveillance	Completeness of regions reporting to national level	79%	80%	100%	96%	89%
	Timeliness of regions reporting to national level	%	%	%	%	%
	Written feedback on immunization system and surveillance provided to regions level	Yes	Yes	Yes	Yes	Yes
	How many times in a year	4	46	46	46	46
Programme Management	Number of ICC meetings held	42	32	24	5+	3+
Sustainable financing*	Percentage of total routine vaccine spending financed using government funds	0+100%	0 v+100%	0+100%	0+100%	0+100%
Linkage to other health interventions	Immunization services systematically linked health intervention (malaria, nutrition, child and maternal health)	Yes	Yes	Yes	Yes	Yes
Human Resource Capacity *	Number of health workers per 10,000 population	16.9	16.9	16.9	16.9	16.9
Management Planning*	Are series of provincial indicators collected regularly at national level (Y/N)	Yes	Yes	Yes	Yes	Yes

Table 2.4: Situation analysis by Accelerated Disease Control Initiatives, 2003-2007

Component	Suggested indicators	National status				
		2003	2004	2005	2006	2007
Polio Eradication	National OPV3 coverage	74%	84%	90%	85%	70%
	Proportion of regions with OPV3 coverage ≥ 80%	27%	55%	82%	64%	27%
	Non-polio AFP rate per 100,000 children under 15 years of age	1.9	2.2	2.4	2.6	1.7
	Proportion of regions with non-polio AFP rate > 1 per 100,000	45%	64%	64%	82%	45%
	Number of confirmed wild polio virus cases	0	0	0	0	0
	NIDS/ SNIDS conducted	10	0	0	10	2
Maternal and Neonatal Tetanus Elimination	TT2+ pregnant women coverage	57%	73%	71%	55%	59%
	Number of regions reporting > 1 case per 1,000 live births	0	0	0	0	0
	SIAs conducted	0	0	0	0	0
Measles Control	Measles coverage	78%	81%	80%	90%	71%
	Proportion of regions with measles coverage ≥	6%	20%	36%	43%	10%

	90%					
	Reported suspected measles cases (Surveillance)	998	1212	375	211	245
	Proportion of suspected measles cases with serum investigation	202	90	98	90	98
	Proportion of regions that have investigated at least 1 measles case	100	100	100	100	100
	NIDS/ SNIDS conducted; Coverage attained	0	0	0	1	0

Table 2.5. Summary of Strengths and Weakness of the Immunization Programme

Component	Strengths	Weaknesses
<p>1. Service Delivery</p>	<ul style="list-style-type: none"> ▪ <u>Government committed to funding EPI programme</u> ▪ <u>Injection safety and proper waste disposal practised</u> ▪ <u>EPI services now offered at clinics which had no qualified nurses after deployment of the new Primary Care Nurses</u> ▪ <u>Child Health days conducted twice yearly (2005 - 2007)</u> ▪ <u>Integration of vitamin A in EPI</u> ▪ <u>Immunizations provided in a supermarket approach</u> ▪ <u>District and clinic staff know their catchment and hard to reach areas</u> ▪ <u>Integration of EPI with other health linked programmes</u> ▪ <u>Various assessments carried out</u> ▪ <u>Pentavalent vaccine introduced in Jan 2008</u> • <u>Countrywide availability of EPI services</u> • <u>Integration of child survival interventions with routine EPI and SIAs egg. Vitamin A, Albendazole, PMTCT (CTX), ITN distribution</u> • <u>Political Commitment</u> • <u>Reliable telecommunication system</u> • <u>Support from partners and stakeholders</u> • <u>Technical Support from IST/EPI Officers</u> • <u>Dropout rates less than 10% at the national level</u> ▪ <u>Re-establishment and opening of new outreach sites</u> 	<ul style="list-style-type: none"> ▪ <u>High proportion of districts with DPT3 below 80%</u> ▪ <u>Weak defaulter tracing system due to lack of training, communication and transport</u> ▪ <u>High drop out rates in some districts</u> ▪ <u>Failing to access hard to reach populations with EPI vaccinations</u> ▪ <u>Nurses and cold chain technicians trained in EPI long back</u> ▪ <u>Outreach work that reach more than half of the target children in some districts has almost collapsed</u> • <u>Coverage rate less than 80%</u> • <u>Inadequate staff at all levels</u> • <u>No regional RED micro plans at regional and health facility levels</u> • <u>Old EPI guidelines</u> • <u></u>
<p>Vaccine supply, quality and logistics</p>	<ul style="list-style-type: none"> ▪ <u>No vaccine stock outs and other immunisation supplies were reported</u> ▪ <u>Procurement and use of AD syringes countrywide</u> ▪ <u>Efficient cold chain maintenance</u> ▪ <u>cold chain assessment done in 2004</u> ▪ <u>Nurses and cold chain technicians trained in EPI</u> ▪ <u>All health facilities have a functioning refrigerator</u> • <u>Adequate storage capacity</u> • <u>Back-up power supply facility at central level</u> • <u>Availability of cold boxes, carriers and thermometers</u> • <u>Computerised stock management system at central</u> • <u>Vaccine managers trained at central and regional level</u> • <u>New cold chain equipment at central and regional depots (less than 5 yrs)</u> • <u>Logistics position created and supported by UNICEF</u> • <u>100% of all regions using AD syringes and safety boxes</u> 	<ul style="list-style-type: none"> ▪ <u>Lack of carrier boxes for the standard reverse for cold chain for stock specimen shipment</u> ▪ <u>Inadequate vehicles and shortage of fuel</u> ▪ <u>Poor vaccine forecasting at district level resulting in uneven distribution of supplies</u> ▪ <u>No continuous temperature recorders at CVS Shortage of Child Health Cards</u> ▪ <u>Status of freeze indicators and VVMs not monitored at all levels</u> ▪ <u>Written contingency plans for cold chain stores not available</u> ▪ <u>Diluent stock not matching the vaccine stock at all levels</u> ▪ <u>Inadequate calculation of vaccine needs</u> • <u>Vaccine wastage not monitored or calculated to acceptable standards Inadequate supportive supervision</u> • <u>Vaccine wastage not monitored</u> • <u>Inappropriate waste management system at all levels</u> • <u>No National Regulatory</u>

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		<p>Authority (NRA) Poor stock management system at health facility level</p> <ul style="list-style-type: none"> No cold chain inventory system and maintenance/replacement plan No Standard Operational Plan Only one cold chain technician for the entire country
Advocacy and communication	<ul style="list-style-type: none"> Good communication information dissemination system although rather slow Regular meetings held with district and health facility staff, ward and community leaders, NGOs and other groups EPI communication Strategy in place Support from partners in mobilizing resources for social mobilization Some media houses readily available to support EPI activities Availability of RHM and other community structures to support social mobilization Funding available for IEC 	<ul style="list-style-type: none"> Slow communication as there are inadequate computers, e-mail services, telephones to communicate health information data Parents/caregivers lack knowledge on timing and schedules of vaccinations and vaccine side effects Ad hoc implementation of the communication plan Lack of funds to engage other media houses (TV and print media) National advocacy and communication policy and plan integrated with health promotion plan in draft only Inadequate communication link with the communities
Disease Surveillance and Accelerated Control	<ul style="list-style-type: none"> EPI disease surveillance integrated into a rapid notification and the NHIS, IDSR systems Suspected AFP, measles and NNT are notified immediately for investigations as policy is available (SOPs in place) Feedback is provided through weekly and monthly bulletins to provinces, districts and health facilities Provincial laboratories support disease surveillance at all levels All provinces and main cities have coordinating activities Last case of suspected polio virus was in 1999 Zimbabwe presented documentation on polio free status to ARCC in 2005 NTF for laboratory containment of polio infectious material established in 2002 and well functioning NCC committee established in 2003 and well functioning National polio expert committee established in 1996 well functioning Availability of performance indicators Presence of Active Surveillance System Integration of surveillance component with other child survival programmes. Availability of Regional Epidemic Task Force Community-based surveillance initiated National measles laboratory well-equipped and functional Expansion of Hib sentinel sites to 2 Regular bi-monthly meetings with the regional Epidemic taskforce 	<ul style="list-style-type: none"> No surveillance officer for EPI at central level in the Ministry Inadequate involvement of health workers from private clinics in disease surveillance Limited supportive supervision on active case search Community based health care providers such as traditional healers, TBA etc are rarely visited on case search Inadequate supportive supervision for surveillance Gaps in data entry and transmission of measles and Hib data Irregular meetings between laboratory and EPI programme staff
Programme	<ul style="list-style-type: none"> Efficient cold chain maintenance 	<ul style="list-style-type: none"> Supervision systems weak at

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<p>Management</p>	<ul style="list-style-type: none"> ▪ <u>Vaccine management assessment in 2007</u> ▪ <u>At least 90% off health facilities have a functioning refrigerators</u> ▪ <u>Efficient service delivery structure</u> ▪ <u>Good management of human and material resources</u> ▪ <u>Have a decentralised structure and planning also decentralised at provincial and district levels in some clinics</u> ▪ <u>EPI monitoring charts displayed, with most data graphed correctly</u> ● <u>New HMIS linked with EPI at National Level</u> ● <u>Opportunities for continuous training</u> ● <u>Finance available for the introduction of Hib and Pneumococcal (2 years).</u> ● <u>Consistent staff at EPI programme</u> 	<ul style="list-style-type: none"> <u>all levels</u> ▪ <u>Inadequate fuel and transport</u> ▪ <u>Standard checklist not used during supervision</u> ▪ <u>Scheduled visits cancelled or postponed</u> ▪ <u>Documentation of findings at supervisory visits lacking</u> ▪ <u>Failure to access and vaccinate hard to reach population</u> ▪ <u>High staff attrition rates</u> ▪ <u>Replacement staff not trained in EPI</u> ▪ <u>Weak teamwork between senior officers and subordinates in planning and implementing EPI</u> ▪ <u>Integrated district work plans not comprehensive enough to cover all key component of EPI</u> ▪ <u>Poor data management (incompleteness, inaccuracy, poor analysis, untimely)</u> ▪ <u>Nurses and cold chain technicians trained long back in EPI</u> ● <u>Inadequate supervision due to staff shortage</u> ● <u>Irregular ICC meetings</u> ● <u>Inadequate number of technical staff</u> ● <u>Inadequate office equipments</u> ● <u>High staff turnover</u> ● <u>Slow adoption of policies</u>
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3. NATIONAL PRIORITIES, OBJECTIVES AND MILESTONES, ~~XXXX~~2007-2011

Table 3.1 National Priorities, Objectives and Milestones, ~~XXXX~~ 2007-2011

Description of problem of national priority	National objectives based on national priority	Targets and Milestones	Regional and Global goals	Order of Priority
1. Low routine immunization coverage and high dropout rate Sharp decline in routine immunisation coverage and high dropout rate.	To increase and sustain routine immunization Pentavalent 3 coverage to 95% by 2011. To include Vitamin A, A, Albendazole, CTX and reduce drop out rate Penta 1-3 to below 10 % by 2011.	20078 : At least 80% coverage and at most 10%14% dropout in every region 20089 : At least 835% coverage and at most 128% dropout in every region 20109 : At least 8590% coverage and at most 106% dropout in every region 20101 : At least 87%95% coverage and at most 84% dropout in every region 2011 : At least 90% coverage and at most 2% dropout in every region		1
	To ensure adequate and effective vaccine and cold chain management	2008 – 2011: Forecast, procure and distribute vaccines, vitamin A and supplies		
	Ensure safe injection practice and safe waste disposal	2008 – 2011: Exclusive use of AD syringes and safety boxes, safe disposal of waste		
2. Lack of vaccine management capacity at regional and health facility levels Inability of Gvt to procure vaccines and supplies	To increase vaccine management capacity at regional and health facility levels advocate for programme support at highest level	2008 - 2009 : Establish the position of EPI Logistician by end of year. 2008 : Fill the position and train the incumbent by end of year Sensitize key stakeholders on the need for Gvt to co-finance vaccines and supplies procurement 2010: Vaccine co-financing included in the Gvt budget estimates 2011: Gvt co-financing the purchasing of vaccines and supplies 2009 : Train all health workers on vaccine management		32
3. Lack of cold chain maintenance and replacement plan	4. To develop cold chain maintenance and replacement plan	5. 2008 : Put in place an operational cold chain maintenance and replacement plan by December 2008. 6. —	7. —	8. — 9. —4
10. There is general problem of safe disposal of clinical waste. Inadequate cold chain capacity to accommodate introduction of new	To procure adequate storage capacity for introduction of new vaccines To increase the safe disposal of AD syringes at health facilities	2008 : sensitize ICC on need for <u>additional cold chain capacity for new vaccines</u> 2009 : development of proposal and <u>plan fo cold chain capacity and advocate for support</u> 2010 : expansion of infrastructure- <u>erection of buildings and purchasing and installation of cold chain equipment</u> 2011 : <u>Introduce new</u>		49

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<p>vaccines</p> <p>3. _____</p>		<p>vaccines2007: 60% use safe disposal of AD syringes in all health facilities</p> <p>2008: 70% and safe disposal of AD syringes in all health facilities</p> <p>2009: 80% use d safe disposal of AD syringes in all health facilities</p> <p>2010: 90% use safe disposal of AD syringes in all health facilities</p> <p>2011: 100% safe disposal of AD syringes in all health facilities</p>		
<p>11.4. _____ Lack of in-country financial capacity to sustain the introduction of pneumococcal after 2 years of UNICEF support. Knowledge gap among health workers due to high attrition rate.</p>	<p>To train health facility staff in IIP and MLM. To introduce at least two new vaccine by the end of the planned period.</p>	<p>2009: at least 50% of RHC and FCH staff trained in IIP. 100% of Provincial EPI managers trained in MLM. Introduce pneumococcal conjugate vaccines by December 2010.</p> <p>2010: At least 80% of RHC and FCH staff trained in IIP. 100% of hospital matrons and tutors trained in MLM.</p> <p>2011: Training of new recruits in EPI.</p>		<p>65</p>

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Table 3.2 National Priorities, Objectives and Milestones, ~~XXXX~~ 2007~~8~~-2011

Description of problem of national priority	National objectives based on national priority	Targets and Milestones	Regional and Global goals	Order of Priority
57. Inadequate advocacy, social mobilisation and communication activities at all level community level	To advocate for mobilization offer financial resources to support electronic TV and Print media slots.	By end of 2008-2011 should have quarterly EPI programme advert s on electronic TV and print media.		56
	To enhance communication and advocacy for EPI services especially at community level	20079 - 2011: 100%-regions review communication plans and operationalise yearly of provinces and districts carrying out community sensitisation activities		
	To advocate for introduction of new vaccines	By December 20078 all major EPI partners should be sensitised on the introduction of Pentavalent new vaccines By December 2008 all major EPI partners should be sensitised on the introduction of pneumococcal conjugate vaccine-2009-2011: Sensitisation of all Provinces, Districts and Communities on introduction of new vaccines		
6 Failure to meet standard EPI Disease Surveillance indicators 8 . Sustainability of high quality Disease Surveillance	To sustain high quality AFP surveillance	20078 - 2011: Non-polio AFP rate of 2/100 000 children < 15years at national and in every region		23
	To sustain high quality Measles surveillance indicators	20078 - 2011 : 100% of regions reporting 1 investigated case/year		
	To strengthen measles laboratory functionality surveillance	20078-2011: 80% of all suspected measles cases with blood collected and results within 7 days 20088 -2011: 100% of all suspected measles cases with blood collected and results within 7 days		
	To sustain NNT elimination status	20078 – 2011: < 1 case/1000 live births at each region/yr		
	To improve Hib Sentinel and measles laboratory surveillance	2008: 2 lab personnel trained from the 2 sentinel sites. 20078-2011: Improved management and transmission of Hib and measles data 20078-2011: 80% of all suspected cases with CSF collected		
7. Inadequate transport and fuel for EPI service delivery	To provide adequate transport and fuel for EPI service delivery at central and sub-	2008-2011 Provision of fuel for EPI services at all levels 2008: 31 vehicles procured.		7

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	<u>national levels</u>	<u>2009: 20 vehicles procured</u> <u>2010: 9 lorries procured</u> <u>2011: 17 old vehicles replaced</u>		
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4. STRATEGIES, KEY ACTIVITIES AND TIMELINES

Table 4.1. Service Delivery						
Programme objective	Strategies	Key Activities	Time line			
			2008	2009	2010	2011
To increase and sustain routine immunization <u>Pentavalent 3 coverage to 95% by 2011.</u> <u>To include Vitamin A, Albendazole, CTX</u> and <u>reduce drop out rate Pentavalent 3 to below 10 % by 2011.</u>	Use combination of approaches (static facilities, outreach and SIAs) for immunization	Sustain existing static facilities and revitalise outreach services				
		Ensure supermarket approach at static facilities				
		Conduct biannual Child Health Days and SIAs				
		Establish the proportion of hard to reach populations by district				
	Reach the under reached in every region (RED Strategy)	Train health workers on micro planning				
		Print and distribute EPI registers defaulter tracing				
		Reduce number of immunization drop outs through management, defaulter tracing				
		Update supervisory tools				
		Supportive supervision to regional health facilities				

Table 4.2. Vaccine supply quality and logistics						
Programme objective	Strategies	Key Activities	Time line			
			2008	2009	2010	2011
To ensure adequate and effective vaccine and cold chain management	Improve and strengthen vaccine and cold chain management systems	Establish reliable demand forecasting at national and provincial level to ensure uninterrupted supply of vaccines, AD syringes and safety boxes				
		Order and procure required vaccines, vitamin A capsules, cold chain equipment and supplies				
		Timely distribute vaccines, vitamin A and supplies to all levels				
		Vaccine stock management and				

		wastage monitoring					
		Introduce computer-based vaccine stock monitoring at sub-national					
		Procure and distribute LP gas					
Ensure safe injection practice and safe waste disposal	Improve injection safety	Establish reliable demand forecasting at national and provincial level to ensure uninterrupted supply of AD syringes and safety boxes					
		Sustain use of AD syringes and safety boxes					
		Train health workers on waste management					
		Procure low cost incinerators					
To procure adequate storage capacity for introduction of new vaccines	Ensure effective and sustainable introduction of new vaccines and technologies	Conduct a cold chain and buildings inventory to establish gaps					
		Develop a proposal and plan for upgrading cold chain capacity and solicit support					
		Erect necessary buildings, purchase and install required cold chain equipment					
		Introduce new vaccines					
To advocate for programme support at highest level	Strengthen advocacy with key stakeholders	Sensitise key stakeholder on the need for Gvt to co-finance procurement of vaccines					
		Include co-financing of vaccines in the Gvt budget estimates					
		Gvt co-finances vaccine procurement					
<u>To provide adequate transport and fuel for EPI service delivery at central and sub-national levels</u>	Strengthen transport for EPI services	Source funding for procurement of vehicles and procure the vehicles					
		Continue sourcing and distributing fuel for EPI services					

Table 4.3. Advocacy, Social Mobilisation and Communication

Objective	Strategy	Key Activities	Time line
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			2008	2009	2010	2011	
To advocate for introduction of new vaccines	Advocacy for resources	Hold meetings with policy makers and stake holders to mobilise resources for TV and print media adverts (ICC meetings)					
		Broaden ICC membership					
		Produce IEC materials to ensure good understanding of the benefits of new vaccines					
		Monitor progress for preparedness					
	Advocacy at community level	Sensitise communities on the importance/benefits of new vaccines					
		Hold press conferences and press releases on new vaccines					
To enhance communication and advocacy for EPI services especially at community level	More involvement of TMTs, PHTs, DHTs, EPI partners and Non Governmental Organizations (NGOs)	Engage TMTs, PHTs, DHTs, EPI partners and Non Governmental Organizations communities and NGOs in immunization advocacy					
		Provide feedback to health workers following supervisory visits or any other activity					
		Review meetings with stakeholders on quarterly basis					
		Develop key messages and IEC materials on routine immunization and surveillance					
		Sensitise communities on the importance/benefits of completing immunization					
		Drama performances on the importance of vaccination					
To advocate for mobilization of resources to support electronic and Print media slots.	Advocacy at policy level	Advocate, through ICC, financial support for social mobilisation activities					
		Produce IEC materials for electronic and print media					
		Conduct social mobilization activities on immunization and					

		surveillance through print and electronic media					
		Train health workers on communication (Interpersonal communication)					

Table 4.4. Disease Surveillance and Accelerated Disease Control							
Programme objective	Strategies	Key Activities	Time line				
			2008	2009	2010	2011	
To sustain high quality AFP surveillance	Capacity building	Train and sensitise clinicians on AFP, measles and NNT surveillance					
	Strengthen AFP surveillance	Conduct active search for AFP, measles and NNT surveillance in priority sites					
		Conduct community search for AFP, measles and NNT surveillance					
		Procure replacement surveillance vehicles					
To sustain high quality Measles surveillance indicators	Measles SIAs	Conduct measles campaign					
	Measles laboratory	Purchase and maintain equipment for measles laboratory including consumables					
		Train laboratory staff on new technologies					
To sustain NNT elimination status	Strengthen MNT Surveillance	Identify high risk areas					
		Sensitise Traditional Healer, Faith Based Organizations and other CBAs					
		Intensify active search for NNT in hospitals					
		Investigate neonatal deaths with unknown causes					
		Conduct community investigation of neonatal deaths					
To improve Hib and Rotavirus Sentinel surveillance	Strengthen Hib. and Rotavirus Surveillance	Orient clinicians and laboratory staff on Hib and Rota surveillance					
		Provide the necessary equipment for Hib and Rota surveillance					
		Expand sentinel sites					
To monitor AEFIs	Strengthen AEFIs surveillance	Train health workers on AEFIs surveillance					
		Investigate and report					

		AEFIs					
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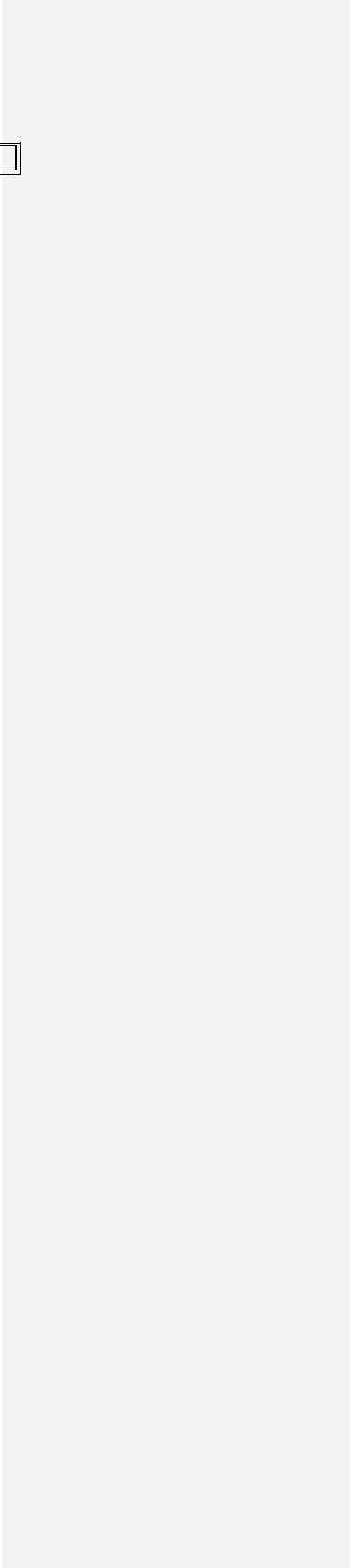


Table 4.5. Programme management							
Objective	Strategy	Key Activities	Timeline				
			2008	2009	2010	2011	
To promote the integration of immunisation with other child survival services e.g. Vitamin A	Assess and develop appropriate interventions for integration	Promote integrated packages of interventions to meet local needs					
To conduct periodic EPI reviews	Operational Research	Review Impact of RED Strategy					
		Conduct periodic EPI reviews					
		Coverage survey					
		Vitamin A systems review					
		Vaccine management assessment					
		Data Quality Self Assessment					
		Data Quality Audit					
		Post-introduction evaluation of Pentavalent					
To train health facility staff in IIP and MLM	Build Capacity	MLM and IIP training					
		Review and train staff on EPI Policy, guidelines and manuals					
		Include EPI in pre-service curricular					
To provide basic office equipment	Procure basic office equipment	Procure necessary office equipment (computers accessories, fax, photocopier)					

Costing and Financing

Annual work plan for 2009

