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**ATTENDANCE AT 6TH MEETING OF THE TASK
FORCE ON IMMUNIZATION (TFI) AND
MEETING OF AFRICA REGIONAL IMMUNIZATION
COORDINATING COMMITTEE**

Harare, Zimbabwe

December 1-4, 1998

Rebecca Fields

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ACRONYMS

AEFI	Adverse Events Following Immunization
AFP	Acute Flaccid Paralysis
AFRO	Africa Regional Office of WHO
ARICC	Africa Regional Immunization Coordinating Committee
BASICS	Basics Support for Institutionalizing Child Survival
DfID	Department for International Development (U K)
EPI	Expanded Program on Immunization
GPV	Global Programme for Vaccines and Immunization
HSR	Health Sector Reform
NID	National Immunization Day
SNID	Subnational Immunization Day
TFI	Task Force for Immunization for Africa
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

BASICS Technical Officer Rebecca Fields attended the sixth annual meeting of the Task Force on Immunization in Africa (TFI) and the meeting of the Africa Regional Interagency Coordinating Committee (ARICC), December 1-4, 1998, in Harare, Zimbabwe. Major topics of discussion during the meeting included—

- the general status of routine immunization in Africa, including stagnating vaccination coverage levels, the need to reposition immunization within health sector reform, and urgent needs for injection safety and cold chain rehabilitation
- progress in polio eradication, especially in the areas of national immunization days (NIDs), surveillance, and laboratory capabilities
- the special needs of countries in conflict, especially Angola and Democratic Republic of Congo
- possible approaches to measles control in Africa

Concern was widely expressed about the status of routine immunization services and management, and the need to rapidly prepare a five-year strategy and plan of action for EPI was underscored. Great enthusiasm was in evidence regarding the substantial recent progress in polio eradication, especially in surveillance, and the need for a final major push to achieve polio eradication goals was made clear. This will require a great deal more supplemental immunization in almost all countries during the next three years. The joint UNICEF/WHO five-year plan of action for acceleration of measles control was the subject of much controversy and consensus was not achieved among partners regarding their support for the strategy or next steps to be taken with it.

PURPOSE OF TRIP

The purpose of this trip was to attend the sixth meeting of the Task Force on Immunization in Africa (TFI) and the meeting of the Africa Regional Inter-Agency Coordination Committee (ARICC).

The stated objectives of this year's TFI meeting were—

- agree on the main strategies for improving the management and the delivery of EPI in the Member States and for expanding the benefits of immunization with the introduction of new vaccines

- review progress made and the remaining challenges regarding the achievement of the polio eradication goal in the African region
- agree on the 1999 EPI and the 1999-2001 polio eradication priority actions to be conducted at country, inter-country, and regional levels

TRIP ACTIVITIES

The author participated in the TFI meeting and attended the ARICC meeting as an observer. In addition, she participated in a meeting of an ad hoc injection safety committee that was established immediately following TFI presentations on that subject. She also took part in a number of side discussions with various personnel from WHO, UNICEF, and other organizations.

OBSERVATIONS AND FINDINGS

A list of participants and agendas for the meetings are included in Appendixes A and B. Several WHO representatives attended, as did Rotarians from about 10 African countries.

The official report and recommendations of the TFI meeting were still undergoing extensive revision when the meeting ended and they will be issued separately. Some specific points and issues raised during the meeting included the following:

- ***Review of EPI in the AFRO region and overarching issues*** This study, conducted in October 1998, noted the substantial progress made in the areas of NIDs, surveillance for acute flaccid paralysis (AFP), and development of laboratory capability in connection with AFP surveillance. Areas of particular concern requiring additional attention noted in the review are cold chain/logistics management, communications/social mobilization, and training to assure adequate quality of services.

WHO/AFRO has undergone tremendous growth in the past five years, with a hired or seconded professional staff of five in 1993, 69 in 1998, and an anticipated 117 in 1999. Financing flowing regionally through WHO or UNICEF for EPI and polio eradication (excluding country-level UNICEF or WHO support) has grown from \$7 million in 1995 to \$73 million in 1998 and to an expected \$110 million in 1999. The management structure of the EPI unit has not changed throughout this growth. WHO bureaucratic procedures remain too unwieldy to serve the fast pace and campaign orientation of polio eradication (PE). Hiring practices, especially use of the short term professional mechanism, serve as disincentives to recruiting and retaining high caliber personnel. Among the recommendations of the EPI review were that these mechanisms be changed to serve the current needs.

- ***Immunization program management and performance*** Measles coverage, currently estimated at 57 percent, is at its highest level ever in AFRO. However, coverage has only increased by about 8 percentage points since 1990 and has generally stagnated at the regional level and shown decreases in some countries. A (wildly) estimated half of focal points for immunization program management at the level of health center or higher have not been trained in immunization. Political and security problems affecting 14 of the 47 countries in the region further hamper efforts to improve routine immunization management and performance. It was noted that under these circumstances, it is impossible to put forth any standard prescription that is applicable to all countries. To allow comparisons to be made among countries, however, WHO/AFRO has proposed a set of indicators that describe a country profile (see Appendix C).

The recommendation from the 1997 TFI meeting to prepare plans of action for both polio eradication and EPI overall was carried out for polio eradication, but not for immunization. The outstanding need for this overall strategic plan of action for EPI was stressed repeatedly throughout the meeting and a recommendation was put forth to this effect. The "0-10-20" document currently under preparation by WHO/Geneva and WHO/AFRO was frequently referred to as the possible basis on which the requested strategic plan could be built. While the 0-10-20 document was distributed during meeting, it was described as not yet ready for discussion.

- The issue of the impact of ***health sector reform*** (HSR) on EPI was presented by Bjorn Melgaard of WHO/GPV/Geneva. In addition to the studies on HSR and EPI conducted in Zambia and Uganda with BASICS input, some six or seven other studies have been conducted in Latin America. The greater emphasis on districts in HSR fosters greater local autonomy and participation in health decisionmaking, but requires more effort to assure technical capability at decentralized levels. Decentralized management also poses a challenge for controlling infectious diseases that follow epidemic patterns. Both the lack of technical capacity at the district level and insufficient funds being directed toward districts to assure technical quality were points noted by TFI participants. WHO/GPV/Geneva intends to issue guidelines to assist national governments undergoing HSR in adjusting immunization program management and WHO/GPV may conduct a meeting in the first quarter of 1999 on this subject. Recommendations from the TFI include that certain functions should be retained at the central level and that a set of indicators be adopted for monitoring health outcome and immunization program performance.

The author discussed with East Africa block epidemiologist Doug Klaucke the possibility of including a session on HSR and EPI in the next EPI managers' meeting for that block and providing consultant Rachel Feilden to facilitate that session. He expressed interest as long as the funding did not come from his budget.

- ***Injection safety*** There is increasing awareness of the gravity of the situation regarding injection safety as additional studies are carried out on this subject. One study was recently completed in Uganda and others will be carried out in early 1999 in Tanzania and Madagascar. Modibo Dicko pointed out that safe injections result from the synthesis of efforts in logistics, nursing practice and social mobilization. The need for effective communications and advocacy to help improve injection safety was raised by several meeting participants, although caution was urged.

Some selected results reported by Lionel Pierre on the Uganda injection safety assessment included—

- 14% of health centers sampled reported needle/syringe shortages for 1-20 weeks
- 63% of health workers had received no in-service training in the past three years
- 14% of steam sterilizers were not working
- 14% of health workers had incorrect knowledge of carrying out steam sterilization
- 40% of health workers had observed adverse events following immunization during the previous six months
- Districts had no schedule for systematic replacement of injection equipment, and spare parts for steam sterilizers are not provided to health centers despite their being available at the district level. Unlike vaccine distribution, which follows a “push” system, injection equipment follows a “pull” system that does not appear to function well.
- Parallel practices (i.e., different injection practices for different health programs) were observed at some health facilities.

These findings elicited strong concern from the TFI and a committee to discuss injection safety was set up on the spot. It was chaired by Stan Foster and included representatives from WHO, UNICEF, USAID, EPI managers from Zimbabwe and Ethiopia, and BASICS (the author). The report of this group is found in Appendix D and its recommendations were officially adopted by the TFI. One recommendation, that autodestruct syringes and needles become national policy in all African countries, is at least partly contingent on price considerations. UNICEF estimates that their price should fall to six cents apiece in very high volumes.

The author discussed with Modibo Dicko, Grace Kagundu, and Margret Phiri of the East, Central, and Southern African College of Nurses (ECSACON) the possibility of developing a multi-faceted, country-level strategy for injection safety in Uganda, where both logistics survey data and qualitative and knowledge-attitudes-practices data are already available. It is unlikely that this could be undertaken during the final days of the BASICS project, but groundwork could be laid for activity during the future child survival flagship project.

- ***Cold chain rehabilitation*** With 36 countries carrying out NIDs in 1998, the attention of WHO/AFRO cold chain staff has been focused on campaign preparations and implementation. Over the past few years, however, WHO/AFRO has conducted cold chain inventories in 13 countries. Between aging equipment and the international requirement to provide new CFC-free refrigeration equipment, the financial needs for rehabilitating the cold chain just in these 13 countries come to an estimated \$57 million. At this point, no major donors have responded favorably to WHO/AFRO requests to underwrite substantially these costs.

Additional well-trained logisticians are greatly needed at the country level to manage cold chain and logistics for EPI. WHO/AFRO has prepared a job description outlining 16 essential tasks that such logisticians should carry out. In a survey of 7 East African countries, it was found that only 4-6 of the 15 essential tasks were being carried out in these countries, except for in Ethiopia, where only one function is being conducted. In none of these countries, including Zambia, Uganda, or Tanzania, was the essential task of assisting district health teams in problem identification or problemsolving being conducted.

- ***Polio eradication*** Great progress was reported on polio eradication and this was received with much enthusiasm and optimism by the plenary.

Supplemental immunization Thirty-six countries conducted NIDs in 1998 and at this point, only Democratic Republic of Congo, Sierra Leone, and Liberia have yet to conduct them. The next few years will require a great deal more supplemental immunization in the form of "regular" NIDs, extra rounds of NIDs, SNIDs, and mopping up. The estimated budget for this activity is approximately \$105 million. A schedule of anticipated supplemental immunization is shown in Appendix E.

Surveillance AFP reporting for the period of January-October 1998 stands at 0.7 cases per 100,000 children under 15, a substantial increase from the 0.2 rate reported in 1997. By epidemiologic block, the rates are—

- 0.8 for the Southern Africa block
- 0.6 for the Eastern Africa block
- 0.6 for the Central African block
- 0.4 for the East African block

Wild polio virus transmission is believed to be interrupted in southern Africa, which last isolated wild virus from a stool sample in 1993. In the Eastern Africa block, despite a considerable number of stool samples collected and analyzed, wild virus was last isolated in late 1996. The geographic scope of surveillance has recently increased, with Mozambique and Angola embarking on surveillance efforts. Nigeria has recently greatly increased its staffing for AFP surveillance, resulting in over 460 AFP cases being

identified (with stool samples collected) and a non-polio AFP rate close to the goal of 1.0. New efforts are under way to make sure that cases more than 60 days old are excluded from reporting and that the case definition is adhered to more carefully in some East African countries.

Surveillance reviews are expected to take place in 1999 in Kenya, Zambia, Uganda, and six West African countries. Top geographic priority will be given to surveillance in the countries of West Africa but particularly to the Democratic Republic of Congo and Angola. AFP reporting has greatly increased in the past year with the infusion of considerably more funds and the hiring of many dedicated personnel to work on surveillance. WHO/AFRO aims to have, ultimately, 150 national level officers dedicated to surveillance, plus 5 African regional or intercountry advisors and 5 non-African advisors. This was contrasted with the 50 non-African technical staff brought to Africa during smallpox eradication.

Laboratory Considerable progress has also been made with regard to laboratory confirmation of cases. A steadily increasing proportion of AFP cases have stool samples collected and an increasing number of countries are conducting surveillance with laboratory confirmation.

1996 - 19 countries
1997 - 26 countries
1998 - 33 countries

Thirteen laboratories for poliovirus confirmation have been established in Africa, of which four are fully accredited, four are partially accredited, and five are not accredited at this time. Achieving and maintaining accreditation is a top priority, as is training of laboratory personnel a priority. While over 100 personnel have been trained to date and there are plans to expand this number, there has also been a very high turnover rate. As AFP reporting and stool samples collected continue to rise, it will be critical to increase the capacity of laboratories to handle the larger workload. The Ibadan lab in Nigeria became backlogged this year with the receipt of over 850 specimens.

- **Adverse events following immunization** Adelaide Shearley, Zimbabwe's EPI manager, presented on the topic of adverse events following immunization (AEFI) in connection with Zimbabwe's 1998 measles NID. The campaign targeted children 9 months to 14 years of age, totaling approximately 5.3 million children, of whom 93 percent (close to 5 million) were reached. Fifty-one adverse events were reported, including four deaths. Of the four, two were thought to have been vaccine induced. Robin Biellik clarified that those cases, in older, HIV-positive children, were eventually reclassified as coincidental. AEFI had been actively addressed during planning phases of the campaign: a field guide for nurses was developed and nurses and other clinicians were trained. This concept of the different categories of AEFI (programmatic error, vaccine induced, and coincidental)

was difficult to convey to nurses and the field guide will require substantial revision. Investigations of AEFI were difficult to conduct because history-taking during busy campaigns was not possible, patients' notes were inadequate, and junior medical officers had difficulty conducting post mortem examinations. Health workers were reluctant to discuss AEFI with clients and injectable vaccine during the mass campaign was not found readily acceptable by parents.

The issues of AEFI generally and the interaction between live viral vaccines in HIV-positive older children are the subject of documents and guidelines to be published in the near future by WHO/GPV/Geneva.

- ***Measles control.*** Olusegun Babaniyi of WHO and Suomi Sakai of UNICEF presented an updated version of the five-year plan of action on acceleration of measles mortality reduction and measles elimination in the African region. It was strongly stated during the presentation that strengthening of routine services is the key to the strategy and that supplemental immunization is a must, even if it is not a popular option. The presentation elicited strong reactions from TFI members, with WHO, UNICEF, and CDC favoring its adoption and USAID and DfID registering strong doubts because of concerns that campaigns would overshadow the urgent need, described earlier in the week, to strengthen the routine immunization system.

Arguments raised in favor of the strategy

- Countries desperately want to move ahead with measles control and are seeking (and WHO/AFRO must provide them with) guidance and leadership
- Africa has not seen an increase in routine coverage in several years, so something new must be tried
- Polio eradication brought new funding to EPI and so will this
- Polio eradication helped raise coverage in Laos and Cambodia and so will this (no mention was made of the equivocal results of the Tanzania study on this subject)
- Measles campaigns should raise awareness of vaccine safety issues overall, not just injection safety (although presumably it will do that, as well)
- Measles campaigns galvanized people around immunization in S. Africa
- Plan is much improved from last year, but surveillance should be introduced earlier

Arguments raised against the strategy

- The phasing of the plan needs to be reworked so as to squarely put initial emphasis on routine system strengthening
- The strategy needs to be situated within the context of an overall strategic plan for immunization which has not yet been prepared
- The technical capacity noted as lacking earlier in the TFI must first be available if the supplemental immunization is to be productive. The current timeline of the plan does not support this notion.

- The strategy implicitly supports a goal of measles elimination in Africa that has not been agreed to or formally adopted
- Strengthening of routine is stated as central to the strategy but the budget does not reflect that Of the \$162 million budget over five years, \$84 million (52%) is for campaigns in West and Central African countries—the countries identified as having the weakest routine immunization programs Given the appearance of choice between a long process of strengthening routine or embarking on campaigns, a health minister would be likely to respond more positively to the campaigns
- In the past 25 years, measles coverage on 2 occasions has been rapidly raised only to fall to lower levels We risk losing the trust of African parents
- Need to hasten the time for strengthening routine and need a blueprint for doing so
- Strong concerns about injection safety

Consensus on some aspects

- Something needs to be done about measles and the top priority is on reducing measles mortality, especially in West and Central Africa, where the toll is highest
- A regional strategic plan for EPI overall needs to be prepared at once

As of the closing of the meeting, two major donors (USAID and DfID) had expressed their intention to not support the strategy as it is currently written CDC committed to supporting it with several million dollars However, there was no consensus as to next steps or recommendations for action by the meeting's end

- ***Communications/social mobilization*** Grace Kagondou described the substantial expansion of social mobilization activities in AFRO during the past year, including, most recently, the series of social mobilization workshops to expand the number and capabilities of social mobilization focal points for immunization The communications handbook under development this past year now has a target completion date of second quarter 1999 The sheer volume of activity was clearly a surprise to many TFI members and inquiries were made about setting priorities based on cost-effectiveness and impact There was also interest in documenting lessons learned to date

The author later spoke with Kagondou about possible contributions to the WHO social mobilization by BASICS during the coming months In particular, Kagondou inquired about BASICS assistance in writing up case studies in DR Congo, Madagascar, Nigeria, Mozambique, and/or other countries where BASICS has been active in EPI communications She also asked about BASICS carrying out qualitative research to support disease surveillance—perhaps this could be done in Senegal, enlisting the technical support of BASICS EPI and communications advisors there The author clarified that BASICS was in a difficult position to commit to these activities, but would explore options upon returning to Washington

- ***Countries in difficult circumstances Angola and Democratic Republic (DR) of Congo***
The special plights of immunization and especially polio eradication in these two countries were the subject of an extra evening session. Angola was congratulated for succeeding in carrying out NIDs this year and achieving coverage of 91 percent in the first round and 104 percent in the second round. However, as several municipalities and districts could not be reached during each round, it was recognized that these data are not reliable and probably many children from DR Congo were vaccinated instead of Angolan children. DR Congo is thought to pose even greater problems than Angola and is to be the subject of increased attention by WHO/AFRO. Special strategies to negotiate “days of tranquility” were recommended and the possibility of WHO/AFRO appointing an EPI focal point for countries in conflict was proposed.

Other technical topics discussed during the meeting included regional certification of polio eradication, community-based disease surveillance, vitamin A and EPI, and the introduction of yellow fever and hepatitis vaccines. As was the case at the 1997 TFI meeting, neonatal tetanus was not discussed.

Estimates of 1999 budgetary requirements were presented by various WHO/AFRO staff during the ARICC meeting. Those requirements for polio eradication, cold chain rehabilitation, and selected areas of routine services strengthening are contained in Appendix F.

FOLLOW-UP ACTIONS

- 1 Send to Grace Kagundu articles from Uganda and Indonesia on behavioral aspects of injection safety (R. Fields)
- 2 Discuss with BASICS/Washington and Dakar staff possible assistance to WHO/AFRO in communications/social mobilization (Fields, Shump, Steinglass, Rasmuson, Drabo, Mutombo)
- 3 Remain in contact with Modibo Dicko, Grace Kagundu, and Margret Phiri regarding possible country-level injection safety activities (Fields)
- 4 Follow up with Doug Klaucke, Okwo Bele, Rachel Feilden, Mary Harvey, Robert Steinglass, and the SARA project regarding participation by Feilden in the next East African EPI managers’ meeting (Fields)
- 5 Send electronic version of injection safety committee report to Suomi Sakai (Fields)
- 6 Continue discussions with Tracey Goodman of WHO/GPV/Geneva regarding collaboration on vitamin A/EPI integration (Fields)

- 7 Discuss with South Africa EPI manager the details, including financial support from UNICEF/S Africa, of February consultation on neonatal tetanus (Steinglass)

APPENDIXES

APPENDIX A
LIST OF PARTICIPANTS

**6th MEETING OF THE TFI AND 5th MEETING OF THE ICC, 1-4 December 1998,
Harare, Zimbabwe**

List of Participants

Agencies/Organizations (TFI Members)

Organization	Name	Address	Telephone	Fax	E-mail
AMP	Da Silva Alfred	3 Avenue Pasteur BP 10 92430 Marnes-la Coquette France	33-1-47958030	33-1-47958035	aldasilva@compuserve.com
BASICS	Fields Rebecca	1600 Wilson Bld suite 300 Arlington, VA 22209 USA	1-703-312-6800	1-703-312-6900	rfields@basics.org rfields@basics.org
	Michel Othepa	PEV-LMTE, Kinshasa	002438803974		mothepa@maf.org
CDC/Atlanta	S Cochi	National Immunization Program Mailstop E-05 Atlanta GA 30333 U S A	1 404 639 8252	1 404 639 8573	SLC1@CDC GOV
	R Sutter	Same as Above	1 404 639 8762	1 404 639 8573	RWS4@CDC GOV
	A Marx	Same as above, AI RO/ICP/Abidjan	1 404 639 8252	1 404 639 8573	AHM9@CDC GOV
	P Strcbel	Same as above	1 404 639 8764	1 404 639 8573	PMS4@CDC GOV
	O Kew	National Center for Infectious diseases, MS G -10 Atlanta, 30333	404 639 3990	1 404 639 2648	OMK1@CDC GOV

DFID	C Sergeant	DFID East Africa P O Box 30465 Nairobi Kenya	717 609	719112	C-sergeant@dfid.gnet.gov.uk
	Γ Bebbington	Same as above	717609	719112	t-bebbington@dfid.gnet.gov.uk
EU	D Malle	Coordinator of the EU Technical Support Unit, 01 BP 11 30 Bobo- Dioulasso, Burkina Faso	226 97 06 71	226 97 04 81	fed.arivas@fasonet.bf
JICA	Naomi Toyoshi	Shinjuku Maynads Tower B1 D 6 th Floor 1-1 Yoyogi, 2 chome Shibuyaku, Tokyo, 151-8558 Japan	81 3 5352 5465	81 3 5352 5350	toyoshi@jica.go.jp
GOVERNMENT OF JAPAN	1 Yuko Yaguchi	Embassy of Japan, P O Box 2710 Harare	263-4-757861	263-4-757864	yukoy@africaonline.co.zw
GOVERNMENT OF JAPAN	2 Dr Erika Hagino	Embassy of Japan, P O Box 2710 Harare	263-4-757861	263-4-757864	
ROTARY INTERNATIONAL	Akeya Ofori	P O Box DS 2249 Dansoman, Accra, Ghana	233-21-312180	233-21-312219	eakeya@africaonline.com.gh
ROTARY INTERNATIONAL	Mankoubi Sandani Bawa	P O Box 888 Lome, Togo	228-210734	228-217832	
ROTARY INTERNATIONAL	Majiyagbe Jonathan B	4 human Rights Avenue P O Box 726 KANO	234-64-644171	234-64-647146	75452,217@compuserve.com
ROTARY INTERNATIONAL	Bizuneh, Shifarrow	P O Box 3455 Addis Abba Ethiopia	251-1-516102, 112890	251-1-513548	shif@telecom.net.et
ROTARY INTERNATIONAL	I Young-Kanyi	BP 4129 Yaounde Cameroon	237 31 73 78	237 31 73 78/ 237 21 8887	

ROTARY INTERNATIONAL	C Hansford	P O Box 33 Malawi Coordinating Centre Lilongwe 0850 South Africa	27 15 307 51 56/ 37 36	27 15 307 1683	
ROTARY INTERNATIONAL	W Sergeant				
ROTARY INTERNATIONAL	G Kaba	National PP CHAIRMAN BP 11513 Niamey, Niger	227 74 26 33 / 38	227 74 13 99	gkaba@ne peacecorps gov
ROTARY INTERNATIONAL	A Kasongo	National PP Chairman BP 8342, Kinshasa, DRC	243 8804618 8800317	243 8846548 8844210	
ROTARY INTERNATIONAL	S Okudzeto	Sam Okudzeto Associates Mobil House, Liberia Rd Box 5520 Accra, Ghana	233 21 668114 666377	233 21 668115	okudzeto@ghana.com
ROTARY INTERNATIONAL	A Serrano	P O Box 1416, Bedfordview South Africa	27 11 616 4595	27 11 615 4918	office hours 27 11 3263130 Mr Marais
ROTARY INTERNATIONAL	S Owori				
Task force for Child survival & Development	A Hinman	TFCS & Dev 750 Commerce Drive, Suite 400 Decatur, Georgia 30030 USA	404 687 5636	404 371 0415	ahinman@taskforce.org
TOTAL HEALTHCARE SOLUTIONS	Murray Michael Phillip	S B House, Great West Road Brentford TW89BD UK	44-181-9754806	44-181-9753175	mike murray@sb.com
University of Maryland School of Medicine	M Levine	Centre for Vaccine University of Maryland 685 W Baltimore, MD 21201 U S A		404 706 7588	mlevine@umppa1 AB umb.edu

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UNICEF	De Medeiros Narcisse	04 BP 443 Abidjan 04	225-208102	225-227607	ndemedeiros@unicef.org
	I Zucker	UNICEF/NY 3 UN Plaza Health Section, TA-24A NEW YORK, NY 10017 USA	212 824 6312	212 824 6460	jzucker@unicef.org
	S Sakar	633 Third Ave (24F) New York NY10017, U S A	1 212 824 6313	1 212 824 6460	ssakar@unicef.org
	J M Ndiaye	UNICEF/WCARO 04 BP 443 Abidjan 04	225 21 31 31 225 20 81 59		jmnndiaye@unicef.org
USAID	H Sukin	USAID, RRB 406, AFR/SD Washington, DC 20523	202 712 0952		hosukin@usaid.gov
	M Harvey	USAID AID/AFR/SD Room 4,06 Ronald Reagan Bldg 1300 Pennsylvania Ave N W WASHINGTON, DC 20523	202 712 5483		maharvey@usaid.gov
	E Ogden	USAID G/PHN/CS Room 3 07-06Z 1300 Pennsylvania Ave Washington DC, 20523-3700	202 712 5891	202 316 3702	eogden@usaid.gov
THE CORE GROUP	Victoria Graham	220 1st NE #270 Washington, DC 20002, U S A	202 608 1800	202 543 0121	vgraham@worldvision.org
CRHCS	M Phiri	CRHCS Box 1009, Arusha, Tanzania	255 57 8362	255 57 3292	crhcs@cybernet.co.tz

TEMPORARY ADVISORS	S Foster	International Health Roll School Public Health 1518 Clifton Rd 712 Atlanta GA 30333, USA	404 727 2446	404 727 4590	sfoster@sph.emory.edu
	Γ Nkrumah	Noguchi Institute for Medical Research University of Ghana Box 25 Legon Ghana	233 21 500 374	233 21 502182	noguchi@ncs.com.gh
	R Leke	Faculty of Medicine, University of Yaounde I, Cameroon	237 23 74 29	237 23 44 51	rose.leke@camnet.cm
COUNTRY REPRESENTATIVES	R Eggers	Dept of Health Private Bag X828 Pretoria 0001 South Africa	27 12 312 0111	2712 321 9882	eggerr@hltrsa.pwv.gov.za
	D Koffi	BP V47 Abidjan Cote d'Ivoire	221 22 05 33	221 22 05 40	DLPEVCI@AFRICAONLINE.CO.CI
	Γ Valente	Angola EPI Director Ministry of Health	02 44 91226	1 407 956 3882	pav.ang@ebonet.net
	B D Senegal	WHO Office 443 Herbert Maccauley Street Lagos Nigeria	234 1 5453662/3	234 1 5452179	admin@who-nigeria.org
	M Adamassu	Ministry of Health P O Box 70 371 Ethiopia	251 15 63 51		
	B Anya	Ministry of Health Director of Community Health Yaounde Cameroon	237 23 93 50/23 3384	237 22 44 19	

	A Awoska	National Programme on Immunization 3 rd floor, Federal Secretariat Room 335- 345 Maitama Abuja, Nigeria	234 9 523 5613 234 1 774 5923	234 1 688996	
	A E Shearley	Ministry of Health and Child Welfare P O Box CY1122 Causeway, Harare, Zimbabwe	263 4 790896	263 4 706249	
	Nyandu Basambombo	Ministry of Health PEV-LMTE Kinshasa, DRC	00 243 88 03976		nyandubasi@maf.org
	M Mashako	Coordination nationale des JNV RD Congo, WHO/RDC	00 243 8804612		
LABORATORY REPRESENTATIVES	Mr A Mukaratirwa	Dept of Medical Microbiology University of Zimbabwe Medical School, P O Box 178A Avondale Harare, Zimbabwe	263 4 791631 ext 150, 320	263 4 792245	srmoyo@health.net
	Dr Akoua Koffi	Institut Pasteur de Cote d'Ivoire BP 490 abidjan	225 45 33 92 / 46 45 95	225 45 76 23	polioci@globeaccess.net

WHO COUNTRY REPRESENTATIVES	Dr D Barakamfitye	P O Box 5160, Harare	263-4-728991-7	263-4-728998	
	Dr R Chatora WR/Kenya	P O Box 45335 Nairobi, Kenya	254 2 724818	254 2 720050	chatorawho@net2000ke.com
	Dr D Warning WR/Cameroon	B P 155 Yaounde, Cameroon	237 222920	237 23 02 96	who_yao@camnet.cm
	Dr K Tankari WR/Senegal	22 Bd, Djily Mbaye OMS Dakar B P 40 39 DakarSenegal	221 823 2769	221 823 32 55	omsdakar@telecomplus.sn
	Dr A B Njie WR/Uganda	WHO Country Office Plot 4 Nice Avenue Kampala, Uganda	256 41 344 038/044	256 41 344 059	njeh@who.inn.ul.com
	Dr A Moudi WR/D R Congo	WHO/D R C	1 407 956 37 82	1 407 956 37 92	oms-drc@maf.org
	Dr P Eriki WR/Angola	WHO-Luanda cp 3243 Luanda Angola	244 2 332398	244 2 3323 98 1 407 956 3882	whoang@ebonet.net
	E Njelesani WR/Nigeria	WHO/NIGERIA P O Box 2152 Lagos, Nigeria	234 1 5453661/3	234 1 5452 179	WHONIE@Compuserve.com

WHO/HQ	B Melgaard	GPV/EPI CH-1211 Geneva 27 Switzerland	41 22 791 3641	4122 791	melgaardb@who.ch
	B Aylward		"	"	aylwardb@who.ch
	F Goodman	Same as above	Same as above	41 22 791 3641	goodmant@who.ch
	A M Hena-restrepo	Same as above	Same as above	"	henaorestrepa@who.ch
	R Franco	Same as above		41 22 791 41 93	francor@whoafr.org
	R Van de Weerd	Rue aux laines 154 1000 Brussels, Belgium	32 25 38 36 07		vandeweerdtr@hotmail.com whoafr.org
WHO/AFRO	Dr E M Samba Regional Director	WHO Regional Office for Africa, P O Box BE773 Belvedere, Harare, Zimbabwe	703580, 702044, 706951	263 4 79 12 14	sambae@whoafr.org
	L Sambo DPMa	"			sambol@whoafr.org
	F Issembe				issembef@whoafr.org
	M Mathey-Boo				matheybooh@whoafr.org
	A Kabore		011 401 743	1 407 733 9009	kaborea@whoafr.org
	J M Okwo-Bele		011 402 068		okwob@whoafr.org
	M Dicko				dickom@whoafr.org
	W Ghartey				gharteyw@whoafr.org
	M Mailhot				mailhotm@whoafr.org
	G Kagondug				kagondug@whoafr.org
	M Ngoma				ngomam@whoafr.org
	O Oni				onio@whoafr.org

	M Otten				ottenm@whoafr.org
	K Shaba				shibak@whoafr.org
	O Tomori				tomorio@whoafr.org
	V Gaglioti				gagliotiv@whoafr.org
	R Cuddy	01 BP 24 34 Abidjan, Cote d'Ivoire	221 32 28 54		cuddyr@africaonline.co.ci
	O Babanyi	WHO/Ethiopia P O Box 3069 Addis Ababa	251 1 514031 514037	251 1 514674	babanyi@tcl.com.nct.et
	S Okiror	WHO-Nigeria 443 Herbert Macaulay St Yaba P O Box 2153, Lagos, Nigeria	234 1 77411717	234 1 5452179	okirors@who-nigeria.org
	D Klaucke	WHO/Kenya P O Box 45335, Nairobi Kenya	254 2 723069 254 2 724818	254 2 720050	klaucke@africaonline.co.ke
	D Nshimirimana	WHO/Cameroon Box 155 Yaounde, Cameroon	237 222 920	237 230 296 237 23 59 78	nshimid@camnet.cm
	L Tapsoba	01 BP 2494 Abidjan, Cameroon	25 322854	225 322854	leotaps@africaonline.co.ci
	R Biellik	WHO P O Box 5160 Harare Zimbabwe	263 4 728 991	263 4 728 998	biellik@healthnet.zw
	T Matare	AFRO/EPI	1 407 733 9332	1 407 733 9009	matarct@whoafr.org
	F Manyenyeni	WHO/EPI, Zimbabwe	728991	728998	
	L Kellou		703580		kelloul@whoafr.org
	L Pierre	WHO Kigali BP1324	250 76682/74239	250 74534	jpierre@umicct.org
	M Munyoro	Ministry of Health Box CY1122 Causeway Harare	263 4 790896	263 4 706249	

APPENDIX B
AGENDA OF TFI AND ARICC MEETINGS

**6th Meeting of the Task Force on Immunization in Africa
Harare, Zimbabwe, 1-4 December 1998**

Meeting Objectives

- To agree on the main strategies for improving the management and the delivery of EPI in the Member States and for expanding the benefits of immunization with the introduction of new vaccines
- To review progress made and remaining challenges regarding the achievement of the polio eradication goal in the African Region.
- To agree on the 1999 EPI and the 1999-2001 polio eradication priority actions to be conducted at country, inter-country and regional levels

Provisional Programme of Work

Tuesday, 1 December 1998

- 08 00 – 08 30 - Registration
- 08 30 – 09 00 - Welcome remarks
- F Nkrumah, TFI Chairman
 - E M Samba, WHO/AFRO Regional Director
- Introduction of participants (Chairman)
- Administrative announcements (W Ghartey, AFRO)

Overview of progress made

- 09 00 – 09 10 - Implementation of the 1997 TFI recommendations (A Kabore, AFRO)
- 09 10 – 09 30 - Overview of progress made and main issues for 1999 (Okwo-Bele, AFRO)
- 09 30 – 09 50 - Regional EPI review findings and proposed areas for future improvements (S Foster, Emory University)
- 09 50 – 10 30 - Discussions
- 10 30 – 11 00 - Coffee break

Improving EPI management and delivery of quality services

- 11 00 – 11 15 - Attaining and maintaining higher routine vaccination coverage in the African Region (M Ngoma, AFRO)
- 11 15 – 11 30 - Health sector reforms and their effects on technical programmes the case of EPI (B Melgaard, WHO/HQ)
- 11 30 – 11 45 - Implementation of the Vaccine Independence Initiative in West Africa (D Malle, EU/CATR Project)
- 11 45 – 13 00 - Discussions
- 13 00 – 14.30 - Lunch break

Safety of injections

- 14 30 – 14 45 - Safety of injections for immunizations What are the options in the African context? (M Dicko, AFRO)
- 14 45 – 15 00 - ~~Status of the ECSACON-WHO initiative on universal precautions on injection safety (M Phiri, ECSACON, Tanzania)~~ Safety of injections in Uganda
- 15 00 – 16 00 - Discussions (Lionel Pierre)

Propose
at/central
from Africa
Muzasa

16 00 – 16 30 - Coffee break

Cold chain and other logistics issues

16 30 – 16 45 - Plan for the rehabilitation of the EPI logistics in the Region (M Dicko/L Pierre, AFRO)
16 45 – 18 00 - Discussions

Wednesday, 2 December 1998

Polio Eradication Initiative

Progress with supplemental immunization

08 30 – 08 40 - Country perspectives further to the 3rd series of NIDs (S Onyango, EPI/Kenya)
08 40 – 08 50 - Improving the quality of NIDs in Central Africa (B Anya, EPI/Cameroon)
08 50 – 09 00 - Increased UNICEF support for NIDs (J Zucker, UNICEF/NY)
09 00 – 09 30 - Discussions

09 30 – 09 50 - Plan for conducting NIDs/mopping-up activities during the period 1999-2001
(L Tapsoba, AFRO)
09 50 – 10 00 - Reaching the PE goal global participants (B Melgaard, WHO/HQ)

10 00- 10 30 - Discussions
10 30 – 11 00 - Coffee break

AFP surveillance

11 00 – 11 10 - Expanding AFP surveillance in Nigeria (S Okiror, WHO/Nigeria)
11 10 – 11 20 - Reaching the surveillance standards in South Africa (R. Eggers, EPI/South Africa)
11 20 – 11 30 - Experiences with community-based surveillance activities (J Zucker, UNICEF)
11 30 – 12 00 - Discussions

12 00 – 12 15 - African Region Polio Lab Network status, priorities and plan of action
(O Tomori, AFRO)
12 15 – 12 30 - Summary of progress with AFP surveillance and major areas for future action
(M Otten, AFRO)
12 30 – 13 00 - Discussions

13 00 – 14.30 - Lunch break

14 30 – 14 45 - Discussions on Surveillance (con't)

14 45 – 15 00 - Report of the meeting of the Regional Certification Commission for Polio Eradication
(R. Leke)

Advocacy and social mobilisation

15 00 – 15 30 - Progress made in 1998 with advocacy and social mobilisation plan (G Kagondou/
R.Franco, AFRO)
15 30 – 16 00 - Discussions

16 00 – 16 30 - Coffee break

16 30 – 16 45 - Report of the meetings of the advisory group on social mobilisation
(E Manoncourt, UNICEF)
16 45 – 18 00 - Discussions

Thursday, 3 December 1998

Acceleration of measles mortality reduction and elimination

- 08 30 – 08 40 - Measles NIDs in Zimbabwe Issues with planning and AEFT's (A Shearley, EPI/Zimbabwe)
08 40 – 09 00 - Update on accelerated measles control activities implemented in 1998 and joint WHO/UNICEF support for implementing measles control activities in 1999-2000 (O Babaniyi/S Sakai)
09 00 – 10 30 - Discussions
10 30 – 11 00 - Coffee break

Other disease control initiatives

- 11 00 – 11 15 - Plan for expanding the control of YF in the Region (O Babaniyi, EPI/AFRO)
11 15 – 11 30 - Plan for expanding the introduction of HB Vaccine in the Region (O Oni, EPI/AFRO)
11 30 – 12 15 - Discussions

Vitamin A supplementation

- 12 15 – 12 30 - Vitamin A supplementation through immunization contacts and plan of action for 1999 (T Goodman)
12 30 – 13 00 - Discussions
13 00 – 18 00 - Social event

Special sessions

- 20 00 – 22 00
- Main issues with the EPI/PEI in Angola and the DRC Perspectives for intensified surveillance and immunization activities (presentations by Programme Managers followed by discussions)

Friday, 4 December 1998

- 08 30 – 13 00 *Closed Meeting of the Africa Regional Inter-Agency Co-ordination Committee (ARICC)*

Provisional Programme of Work

- 08 30 – 08 45 - Opening session
- Welcome remarks (J Majiyagbe, ARICC Chairman)
- Announcements (Secretariat)
08 45 – 09 15 - Review of the 1997 ARICC recommendations (Okwo-Bele, AFRO)
- Financial report – 1998 activities (M Mailhot)
- Discussions
09 15 – 10 30 - Three Year Action Plan for Polio Eradication
- Follow-up of the Washington, DC September Meeting (M Mailhot, AFRO)
- Discussions and statements by the partners

- 10 30 – 11 00 - Coffee break
- 11 00 – 12 00 - Financing of the EPI cold chain and logistics
- Replacement of the ageing cold chain equipment, further to the inventory done in the countries (M Dicko, AFRO)
- Discussions and statements by the partners
- 12 00 – 13 00 - 1999 action plan
- Review of the 1999 action plan for the strengthening of EPI (AFRO)
- Discussions on the existing funding gaps and commitments for support
- Closing of ARICC
-
- 13.00 – 14.30 Lunch break
- 14 30 – 16 30 *TFI meeting closing session*
- Review of the Meeting recommendations
- Closing remarks
- E.M Samba, Regional Director, AFRO
- F Nkrumah, TFI Chairman

APPENDIX C
INDICATORS PROPOSED FOR COUNTRY PROFILES

Summary indicators Eastern Epidemiologic block 1997

<i>Indicator</i>	<i>Country Burundi</i>	<i>Ethiopia</i>	<i>Eritrea</i>	<i>Kenya</i>	<i>Rwanda</i>	<i>Tanzania</i>	<i>Uganda</i>	<i>Zambia</i>
<i>POA available</i>	1999-2001	1998 for EPI/NID		1999 POA	1999-2001 draft	1998-1999	1998-1999	Nil current
<i>ICC formed</i>	Not for EPI	Monthly Meetings		Meet 2x per month	Once per month	ICC and EPI management	ICC ,EPI+ DC	Functional
<i>Govt funds</i>	Yes	Yes		12 %		6%	27% Operational VII	3%
<i>Purchase of vaccines</i>	-	-		Yes		-		
<i>Operational</i>	-	-		-		--		
<i>Donor funds</i>	-	-		-		-		
<i>Other</i>	-	-		-		-		
<i>BCG cov</i>	71%	87%		50 %		85%	88%	100%
<i>DPT3cov</i>	60%	67%		45 %		79%	61%	83%
<i>OPV3cov</i>	60%	54%		43%		79%	61%	81%
<i>Measles cov</i>	52%	-		38%		73%	63 %	93%
<i>HepB cov</i>	-	-		-		-	-	-
<i>YF cov</i>	N/A	N/A	N/A	Zero	N/A	N/A	N/A	N/A
<i>TT coverage</i>	-	12%		-				-
<i>F child bearing</i>						32%	9%	
<i>TT pregnant women</i>	-	31%				-		-
				39%			47%	
<i>Current EPI Policies</i>	Yes	None		Yes		Available	Available	Available
<i>Policies last reviewed</i>	Yes	Nil				-	-	Available
<i>Current EPI Manual</i>	Yes	Nil		Not available		Available	Available	Available
<i>Disrupted service(specify Level- national)</i>	Yes Unrest	Nil		Nurses strike Cold cham		Yes	Yes	1997
<i>AFP cases with stool collected Within 14 days of illness</i>	-			-		-	-	-
<i>Number of AFP with lab confirmation on</i>	-			-		-	-	-

<i>stool</i>								
<i>Non polio AFP rate per 100,000 <15</i>	-	0 12 %		0 17		0 20	0 5	0 15
<i>Measles cases (total)</i>	Upward	-		No outbreaks		Increase over 2yrs	33,257	2,446 decrease
<i>NNT cases (total)</i>	Upward	-		-		Declining	135	10 decrease
<i>Yellow fever cases(total)</i>	N/A	-		Zero		-	-	N/A
<i>% districts complete reports</i>	-			84% reporting		-	-	-
<i>% districts timely reports</i>	25%	60 %		Poor not Available		30%	4 4 %	-
<i>NIDS polio Coverage</i>	90 1%	90 %		78 8 % R1 82 0 % R2		97%	93%	91%
<i>Measles coverage</i>	-	-		-		73%	-	-
<i>Vit A 1</i>	-	-		-		-	-	64%
<i>Vit A 2</i>	-	-		-		-	-	-
<i>Other(specify)</i>	-	-		-		-	-	-

Data to be sent to AFRO as confirmation of data submitted during East African block meeting, November 1998

APPENDIX D

**CONCLUSIONS AND RECOMMENDATIONS OF
AD HOC INJECTION SAFETY COMMITTEE**

SAFE INJECTION FOR EVERY IMMUNIZATION IN AFRICA TASK FORCE FOR IMMUNIZATION IN AFRICA - 4 DECEMBER 1998

WHO Policies

- 1 Every immunization will be given with a sterile needle and syringe
- 2 Supplementary (campaign) vaccinations will utilize auto-destruct injection devices bundled with Safety Boxes

Public Confidence

Public confidence in immunization is paramount to the achievement of immunization goals. Assurance of immunization safety is an essential component of this confidence.

Current Status of Immunization Injection Safety

All African countries have a policy of a sterile needle and sterile syringe for each injection. While most immunization injections in Africa do comply with this policy, data presented to the Task Force for Immunization in Africa at its annual meeting in Harare December 1-5, 1998, documented that significant numbers of immunization injections do not meet the established standards of a sterile needle and a sterile syringe for each immunization. As much of these data were collected through national EPI reviews or rapid assessment sampling of actual practices, the data were deemed sufficient in identifying a significant health risk which merits immediate attention and action.

Current Status of Curative Service Injection Safety

Data available to the TFI show that the current injection practices at outpatient and inpatient services are less safe than those of immunization. While beyond the terms of reference of the TFI, the Task Force strongly believes that the issues and recommendations about immunization injections are equally relevant to all preventive and curative injections, public and private.

Health Risks Associated with Immunization

WHO identifies three groups at risk of immunization associated harm¹

- **Client to client** transmission from injections with contaminated equipment
- **Client to health care worker** cross infection due to needlestick injuries
- **Client to community transmission** through accidental needle sticks to or reuse of improperly disposed contaminated equipment (within or outside the formal medical system)

What are the Risks?

- Transmission of blood-borne pathogens including Hepatitis B, Hepatitis C, HIV, and malaria (Given the high rates of Hepatitis B (10-15 %) and HIV (1-15%) in the African region, zero tolerance for unsafe immunization injections is mandatory.)
- Iatrogenic infections due to unsterile equipment including abscesses, tetanus, and septicemia
- Impotent vaccine due to non-use of diluent provided by vaccine manufacturer or non-use of cold diluent

¹ Reducing the risk of unsafe injections in immunization programmes WHO 1994

Available Injection Technologies

Several injection technologies are in current use in Africa. Except for the ped-o-jet which is no longer recommended for safety reasons, technologies listed in the table below, when properly used, can provide safe injection. Injection safety requires political will and commitment, policy formulation and dissemination, development and distribution of standards and guidelines, hands on skill building (training), and systems of self, peer, and supervisory monitoring of compliance with standards. It also requires retrieval of used materials at the time of resupply. Elements required to ensure safe injection include:

- MOH directive mandating sterile needle and syringe for each injection along with standards of performance and guidelines (job aids) for each method
- Communication strategy on safe injection policy and practices for policy makers, health workers, and the community
- Staff knowledgeable of and committed to safe injection practices
- Skills in the correct use of safe injection technology
- Functioning equipment
- Adequate quantities of needles and syringes
- Monitoring systems of compliance with standards
- Supportive-supervision systems to identify and correct gaps between standards and performance

Technologies Available for Safe Injection				
Method	Equipment and Supplies	Operational Requirements	Barriers to Safe Injection	Risks R&D Issues
Sterilizables	Adequate needles and syringes Sterilizer Spare Parts Resupply needles, syringe, spares, TST spots	Every sterilization needs to be visually verified by TST spot System needs to be available for regular resupply	Compliance with Guidelines Pull resupply system	Failure to comply with guidelines Faulty equipment
Disposable	Adequate numbers Safety Boxes	Bundled disposables and Safety Boxes	100% use of Safety Boxes according to standards	Cost Reuse Incineration of Safety Boxes
Auto-destruct	Adequate numbers Safety Boxes	Bundled auto-destruct and Safety Boxes	100% use of safety boxes according to standards	Cost Incineration of Safety Boxes
Unject (TT)	Adequate numbers to meet all needs	Use according to Standards		Availability (2000) Cost Storage

Recommendations for WHO AFRO

- Issue of Injection Safety be included on agendas of EPI Managers' Meeting (1st Qtr 99)
- Following these meetings, the issue of injection safety, including these recommendations, be officially communicated through WHO Representatives to decision makers in Ministries of Health (April 99) The policy of 100% auto-destruct syringes for supplemental/campaign immunization should be included

Recommendations for Countries

- Ministries affirm national policy on safe injections and communicate it together with standards and guidelines to all (public and private) providers of immunization
- Utilize regional and country communication working groups to develop communication strategies targeting 1) senior decision makers including Ministries of Health and Finance, 2) health workers at all levels, and 3) communities the epidemiologic rationale for and methods of safe injection
- MOH emphasize individual, unit, and supervisory responsibilities for safe immunization
- In countries that do not have current data on safety of injection practices (within 3 years), carry out a rapid assessment for injection safety (available from Inter-country/Country Logisticians or WHO AFR Logisticians)
- Use available data to develop injection safety plan including forecasting, budgeting, supply, training and disposal for emergency implementation to maximize safety of currently available safe injection technologies
- Develop and maintain system of monitoring injection and disposal practices capable of identifying and closing gaps between standards and practices (especially critical in the area of disposal of used needles and syringes, even those burned in safety boxes)
- Encourage countries to increase use of auto-destruct and other non-reuseable technologies to assess feasibility, disposal, and cost WHO AFR will provide countries a methodology to compare sterilizable and auto-destruct alternatives using own data
- Countries in African region establish a date, e.g., January 1, 2002, for introduction of a total auto-destruct policy for immunization

Recommendations for Partners

- Commend the progress achieved to date on the development of non-reuseables
- Through ICCs at country level, encourage/support assessments of current injection practices and the development of safe injection policies, standards, and guidelines
- Given the unacceptable risk of unsafe injection 1) assist countries in developing strategies and plans for financing, supply, use, and disposal, 2) continue search for low-cost auto-destruct injection devices, and 3) expand UNICEF trials on safe incineration
- Partner support for vaccine procurement, e.g. Vaccine Independence Initiative, include the supply of equipment and supplies essential for safe injection
- Partners support current WHO/UNICEF/Red Cross strategy for bundling auto-destruct syringes and safety boxes for supplemental/campaign immunization
- Promote technology transfer to established producers of syringe and needles in Africa to provide sources of auto-destruct syringes in Africa
- Continue communication with manufacturers on the health benefits achievable through safe low-cost injection technologies and encourage development of other auto-destruct, e.g., BCG, Uniject technologies, e.g., DPT, DPT Hepatitis B

APPENDIX E

**PLAN FOR CONDUCTING SUPPLEMENTAL POLIO IMMUNIZATION,
1999-2001**

(Taken from presentation by Dr Leonard Tapsoba)

Plan for Conducting NIDs/SNIDs and Mopping Up Activities

1) Usual NIDs/SNIDs

NIDs

- 1999 and 2000 All West and Central blocks and four big countries
- 1999 Burundi, Eritrea, Kenya, Rwanda, Uganda, Malawi, Madagascar, Mozambique

SNIDs

- 1999 Namibia, Tanzania, Zambia, Algeria, Mauritania
- 2000 Eastern block (except Burundi, Eritrea) and Mauritania

2) Extra Rounds

NIDs (2 extra rounds)

- 1999 and 2000 Angola, Chad, Guinea Bissau, Liberia, Nigeria, Sierra Leone

SNIDs

- 1999 Nigeria (20 states) March/April 1999
- 1999 and 2000 DR Congo (90%)

Mop-Up

- 1999 Benin, Burkina Faso, Cameroon, CAR, Cote d'Ivoire, Ghana, Togo
- 2000 Angola, CAR, Ethiopia, Nigeria (20 states), and 1-3 provinces whenever Wild virus is detected

For year 2001, activities will be determined largely by progress during 1999-2000. At this point, however, they are expected to include

Usual NIDs/SNIDs

- NIDs Four big countries
- SNIDs All West Africa (50%)
Central Africa Cameroon, CAR, Chad (30%)
Ethiopia (30%)

Extra Rounds

- SNIDs DR Congo (90%)
- Mop-up Angola, DR Congo, Ethiopia, Nigeria

RESOURCE REQUIREMENTS FOR
SUPPLEMENTAL POLIO IMMUNIZATION

	1999	2000	2001
VACCINE			
Extra NIDs	\$5,569,826	\$3,504,660	\$1,927,293
Mopping Up	\$1,413,108	\$3,625,699	\$4,749,866
OPS COSTS			
Extra NIDs	\$13,463,000	\$12,760,000	\$6,836,000
Mopping Up	\$7,329,000	\$19,127,000	\$25,505,000
TOTAL			
Vaccine	\$ 6,983,000	\$ 7,130,000	\$ 6,677,000
Ops Costs	\$20,792,000	\$31,887,000	\$32,341,000
GRAND TOTAL	\$27,775,000	\$39,017,000	\$39,018,000

APPENDIX F

**WHO/AFRO PROPOSED 1999 BUDGETS FOR
POLIO ERADICATION, COLD CHAIN/LOGISTICS, AND
SELECTED ASPECTS OF ROUTINE IMMUNIZATION**

HWCC
Melinda

Resource Requirements for Polio Eradication Activities in 1999

	Funds Needed US\$	Funds Commi US\$	Funding Source	Shortfall US\$
DPV for Usual NIDs and Extra Rounds	\$26,357,000	\$26,357,000	CDC, Japan, vaccine manufacturers	\$0
Usual NIDs Op Costs for the Countries	\$38,538,000	\$24,802,315	CIDA, DFID, Rotary, USAID, UNICEF	\$13,735,685
Extra Rounds Op Costs for the Countries	\$20,792,000	\$0		\$20,792,000
Surveillance Op Costs for the Countries	\$8,395,000	\$8,395,000	CIDA, DFID, Rotary, USAID	\$0
Laboratory Activities	\$810,000	\$277,288	AAWH	\$532,712
Certification Activities	\$102,000	\$0		\$102,000
Personnel including duty travel and support	\$9,067,000	\$4,686,000	CDC, CIDA, DFID, Rotary, USAID	\$4,381,000
Regional Office/Inter-Country Activities	\$650,000	\$650,000	Rotary, USAID	\$0
TOTAL	\$104,711,000	\$65,167,603		\$39,543,397

38

H.M.
12/1/98
Mary Ngoma

Requirements for supporting activities in routine EPI at Regional and intercountry levels in 1999

In order to cost the requirements for support to routine immunisation accurately, country plans should rightly reflect district level requirements. With the advent of Health Sector Reform, many countries are working to ensure that districts are conducting microplanning for health services. It is therefore premature to expect countries to have accurate plans reflecting bottom up plans for EPI, unless the countries are advanced with decentralisation and district capacity building. Countries currently have different levels of planning skills and will require time, possibly another year or two, to consolidate these skills.

The budget presented for routine EPI and cold chain and logistics reflects regional and intercountry activities only. These activities span salaries, vaccine supply and quality, logistics, programme management needs in planning and monitoring EPI for the year 1999.

Logistics have been designated as AFRO's priority in 1999. The plan attempts to address logistic priorities that will strengthen all activities subsequently.

Cold chain rehabilitation requirements extend over five years, with the budget addressing needs for 13 countries in the first year.

Salaries take into account cold chain and logistics, vaccine supply and quality officers at Regional, intercountry and country level who are or will be supported by WHO during 1999, in order to strengthen logistics vaccine quality in 1999. A budget estimate is outlined.

PROGRAM MANAGEMENT, LOGISTICS & COLD CHAIN BUDGET 1999

BUDGET ITEMS	COST		AMOUNT AVAILABLE (US\$)	SHORTFALL (US\$)
	(US\$)	PERCENT		
1 ACTIVITIES	2,355,000	36.9	636,813	1,718,187
1.1 Country Level	1,580,000	24.7	386,813	
Support to EPI reviews and surveys	50,000			
Support to EPI policy formulation	50,000			
Support planning and monitoring at country level and training at Program Manager meetings	120,000			
Support phased implementation of elements of 0-10-20 in select countries	750,000			
Provide technical support in planning and IEC for the introduction of HBV in 7 select countries	50,000			
Support training in logistics management, inventories, equipment maintenance, and safety of injections	560,000			
1.2 Inter-country Level	190,000	3.0		
Anglophone/francophone courses in program management	40,000			
Workshops on logistics management and use of new technologies	150,000			
1.3 Regional Level	585,000	9.2		
Regional training need assessment and consultant travel costs for 3 months	25,000			
Regional working group on routine EPI, travel documentation	70,000			
Support to countries in strengthening vaccine control functions	270,000		250,000	
Special logistics support to large countries and those not covered by inter-country logisticians	120,000			
Regional capacity building in logistics, and review meetings of national and AFRO logisticians	100,000			
2 STAFF & TRAVEL	3,580,000	56.1	0	3,580,000
Regional staff (Cold chain & Logistics, VSQ, Program Management)	450,000			
EPI epidemiologists for select countries in West and Central Africa and Big 4 countries	1,350,000			
VSQ Consultants	120,000			
Inter-country logisticians (5)	700,000			
Country logisticians (Angola, Ethiopia, DRC, Nigeria)	560,000			
WHO hired "National" (and provincial) logisticians (20)	400,000			
3 OTHER COSTS	450,000	7.0	0	450,000
Materials, equipment & communication	100,000			
Vehicles for country & national logisticians	350,000			
5 GRAND TOTAL	6,385,000	100.0	636,813	5,748,187

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Mozambique

12/4/18
ARCC

**FUNDING REQUIREMENT
FOR COLD CHAIN REHABILITATION
(Five Year Plans)**

Countries	Date of inventory	Need for cold chain	Need for transport	Total needs
Kenya	oct 97	\$3,604,716	\$1,075,000	\$4,679,716
Malawi	oct 97	\$2,220,227	\$1,509,200	\$3,729,427
Mozambique	oct 97	\$2,346,621	\$500,000	\$2,846,621
Uganda	oct 97	\$5,895,850	\$120,000	\$6,015,850
Zambia	oct 97	\$2,437,321	\$240,000	\$2,677,321
Zimbabwe	oct 97	\$2,109,335	\$3,346,897	\$5,456,232
Benin	oct 97	\$2,097,046	\$3,096,000	\$5,193,046
Burkina Faso	oct 97	\$7,009,920	\$5,568,667	\$12,578,587
Niger	oct 97	\$1,667,383	\$3,862,600	\$5,529,983
Madagascar*	avr 98	\$2,686,179	\$1,737,315	\$4,423,494
Mauritania	oct 97	\$1,227,177	\$564,400	\$1,791,577
Guinee Bissau	janv 98	\$964,799	\$797,040	\$1,761,839
Liberia	may 98	\$653,757	\$167,977	\$821,734
Total		\$34,920,331	\$22,585,096	\$57,505,427
Mean per country		2,686,179	1,737,315	4,423,494

* rough estimation

- for 5 years, 13 countries

AGE OF COLD CHAIN EQUIPMENT IN AFR COUNTRIES

Countries	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	Age>10	5<Age<10	Age<5
Kenya	639	202	321	243	132	63	59	250	7			1426	4491	4210
Malawi	47	14	11	27	22	62	52	38	50	53	87			
Mozambique	0	77	77	77	77	77	73	73	73	73	73			
Uganda	189	266	171	244	107	141	124	141	99	253	197	1933		
Zambia	0	165	165	165	165	165	82	82	82	82	82			
Zimbabwe	55	14	11	27	23	61	50	36	50	52	86			
Benin	30	119	140	73	24	23	13	14	15	30	5			
Burkina Faso	79	16	32	36	14	75	79	65	91	80	45			
Niger	115	40	40	40	40	40	85	85	85	85	85			
Madagascar	215	70	88	71	27	42	37	50	134	108	452	1294		
Mauritania	7	6	6	6	5	5	14	13	13	13	13			
Guinee Bissau	51	7	4	13	8	7	4	7	23	3	6			
Total	1426	996	1067	1023	644	762	672	854	721	832	1131			

