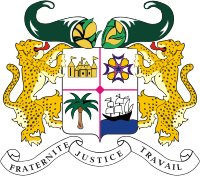
**MINISTRY OF HEALTH**



**REPUBLIC OF BENIN**

**National Agency for Vaccination and Primary Healthcare**

**(Agence Nationale pour la Vaccination et les Soins de Santé Primaires- ANV-SSP)**

**```````````````**

**Measles rubella vaccine**

**introduction plan**

**to replace the MCV vaccine**

##### January 2017

##### *TABLES OF CONTENTS*

*ACRONYMS ................................................................................................................................3*

*LIST OF FIGURES ........................................................................................................................4* *Analytical summary ...................................................................................................................6*

1. *General points on Benin .......................................................................................................9*
2. *Healthcare sector overview ................................................................................................11*
   1. Organisation of the healthcare system ........................................................................11
   2. Epidemiological data ....................................................................................................13
   3. Situation analysis for the Expanded Programme on Immunisation (EPI) .....................13
      1. Institutional and management framework ...........................................................13
      2. Services offered .....................................................................................................14
      3. Quality of vaccines and cold chain Situation .........................................................16
      4. Communication .....................................................................................................19
      5. Data management .................................................................................................19
      6. Human resources ...................................................................................................20
      7. Funding ..................................................................................................................20

2.4. EPI Performance ...........................................................................................................20

* + 1. Vaccination coverage ............................................................................................20
    2. Monitoring of vaccine-preventable diseases .........................................................22

1. *Introducing the rubella vaccine in the routine EPI ..............................................................25*
   1. Background and justification for introducing the measles-rubella (MR) vaccine ..…….25
   2. Objectives .....................................................................................................................27

3.2.1. General objective ..................................................................................................27

* 1. 2. Specific objectives ................................................................................................27
  2. Information on the vaccine and vaccination calendar.............................................30

*3.2.4. Means of introduction ...................................................................................................30*

1. *Strategies and fields of action ............................................................................................31*
   1. Vaccination strategies ..................................................................................................31
   2. Monitoring of Adverse event following immunisation (AEFI).......................................33
   3. Strengthening of capacity .............................................................................................34

4.5. Review of management tools and other EPI documents .............................................35

[MR VACCINE INTRODUCTION PLAN IN THE EPI Page 3 3](#_Toc475466113)

[4.5. Logistics 35](#_Toc475466114)

[4.5.1. Needs, Procurement and Distribution of the vaccine 35](#_Toc475466115)

[4.5.1.1. Requirements for vaccines and consumable supplies from 2017 to 2020 35](#_Toc475466116)

[4.5.1.2. Vaccine procurement and distribution 37](#_Toc475466117)

[4.5.2. Vaccines management and storage capacity 38](#_Toc475466118)

[4.5.2.1. Measles and Rubella Vaccine Procurement, 38](#_Toc475466119)

[injection and safety material 38](#_Toc475466120)

[4.5.2.2. Vaccine storage capacity 39](#_Toc475466121)

[4.5.2.3. Freezing plan for cold accumulators- before and during 40](#_Toc475466122)

[the introduction 40](#_Toc475466123)

[4.5.2.4. Vaccine distribution, monitoring and safety plan 40](#_Toc475466124)

[4.5.2.5. Cooler, vaccine container and accumulator needs 41](#_Toc475466125)

[4.5.2.7. Monitoring of the vaccine preservation temperature 42](#_Toc475466126)

[4.5.2.8. Monitoring of vaccine loss rates 42](#_Toc475466127)

[4.5.2.10. Injections safety 42](#_Toc475466128)

[4.5.2.11. Distribution plan for the injection material 43](#_Toc475466129)

[4.5.2.12. Use, handling and elimination of injection material 45](#_Toc475466130)

[4.6. Information, Education and Communication (IEC) 46](#_Toc475466131)

[V. Role of CNCV-Bénin and the Inter-Agency Coordination Committee (ICC) 46](#_Toc475466132)

[VI. EPI financial perpetuation 47](#_Toc475466133)

[VII. Main stages of the MR vaccine’s introduction 47](#_Toc475466134)

# MR VACCINE INTRODUCTION PLAN IN THE EPI Page 3

**LIST OF TABLES**

Table I: Socio-demographic indicators .........................................................................................9

Table II: National Healthcare system in Benin ...........................................................................12

Table III: Distribution of vaccines used in the Benin EPI according to year of introduction ..…..15

Table IV: Monitoring performance for cases of measles in Benin from 2005 to 2015 ..…………..23

Table V : Risks and challenges in introducing the combined measles and rubella vaccine .......29

Table VI: Vaccination calendar for infants in Benin ...................................................................31

Table VII: Dosage, sites and means of administration of infant vaccines in Benin ....................31

Table VIII : Estimated need for MR vaccines and consumable supplies in Benin from 2018 to 2020 ..…………………………………......................................................................................................36

Table IX: Estimated need for MR vaccines and consumable supplies in Benin for rural areas

mass 2017 ..........................................................................................................................37

Table X: Storage capacity of central and intermediary facilities ................................................39

Table XI: Distribution of number of MR doses per department as routine for 2018 .................41

Table XII: Distribution of injection equipment per department in 2018 ....................................43

Table XIII: Distribution of the number of MR vaccine doses and consumable supplies per department for mass vaccination in 2017..........................................................................44

Table XIV: Distribution of the number of MR vaccine doses and consumable supplies per department for mass vaccination in 2020 .........................................................................44

Table XV: Incinerator points per department in 2016 ...............................................................45

**LIST OF FIGURES**

Figure 1: Administrative Map of Benin ......................................................................................11

Figure 2: Development of vaccine coverage from 1990 to 2015 in Benin .................................20

Figure 3: EPI performance indicators in children in Benin’s 85 Departments

in 2014 *(n= 17 789)* ............................................................................................................21

Figure 4: Suspected measles cases and MCV coverage in Benin from 1990 to 2016 …..………....23

Figure 5 : Positive cases of rubella in Benin from 2010 to 2016 ..…………………………………………...23

Figure 6: Vaccine replenishment circuit .....................................................................................38

**ACRONYMS**

|  |  |
| --- | --- |
| ***BCG*** | : Bacille de Calmette et Guérin (immunisation against tuberculosis) |
| ***ICC*** | : Inter-Agency Coordination Committee for EPI |
| ***CNHU-HKM*** | : Hubert Kutuku Maga National Teaching Hospital (Centre National Hospitalier Universitaire Hubert Kutuku Maga) |
| ***ANV-SSP*** | : National Agency for Vaccination and Primary Healthcare (Agence Nationale pour la vaccination et les soins de santé primaires) |
| ***DTP*** | : Diphtheria Tetanus Pertussis |
| ***GAVI*** | : Global Alliance for Vaccine and Immunization |
| ***Hep B*** | : Viral Hepatitis B |
| ***Hib*** | : Haemophilus Influenzae Type B |
| ***IEC*** | : Information, Education and Communication |
| ***CF*** | : Cerebral Fluid |
| ***AEFI*** | : Adverse Event Following Immunisation (AEFI) |
| ***WHO/AFRO*** | : World Health Organization for Africa |
| ***EPI*** | : Expanded Programme on Immunisation |
| ***AFP*** | : Acute flaccid paralysis |
| ***MPA*** | : Minimum Activity Package |
| ***MR*** | : Measles-Rubella |
| ***TI*** | : Trans Isolate |
| ***YF*** | : Yellow Fever Vaccine |
| ***MCV*** | : Anti-Measles Vaccine |
| ***HIV/AIDS*** | : Human Immuno-Deficiency Syndrome/ Acquired Immune Deficiency Syndrome |
| ***IPV*** | : Inactivated Poliomyelitis Vaccine |
| ***OPV*** | : Oral Poliomyelitis Vaccine |

**Analytical summary**

Benin, a country in West Africa, has an estimated population of 11,096,879 habitants[[1]](#footnote-1) as at 2016. Children younger than one year old are estimated to number 395,549, i.e. 4% of the total population, with survivors numbering 369047. The national healthcare system is organised as a pyramid-style structure with three levels: the central (or national) level, the regional (or intermediate) level and the operational (or peripheral) level. There are 855 healthcare centers offering the Minimum Package of Activities; these include preventive, curative and promotional actions, including vaccination.

Infant mortality in Benin remains high, at 68.1% Children’s epidemiological profile is characterised by a predominance of endemo-epidemic conditions including: malaria, diarrhea and other gastro-intestinal conditions, acute respiratory infections, and anemia. Diseases which can be prevented by vaccination are still being recorded. 255 suspected cases of measles were registered in 2015 (34 of which were confirmed) and 34 cases of rubella were recorded.

The EPI, which began in Benin in 1982, aims to reduce morbidity and mortality in connection with target diseases which can be avoided through vaccination. The selected antigens in the programme are administered to children aged 0-11 months, and to pregnant women.

In the context of the initiative for independent immunisation, Benin has been purchasing all traditional vaccines (BCG, OPV, VAT, DTP-HepB-Hib, MCV, YF) since 1996 and contributes to the acquisition of new vaccines and under-utilised vaccines with co-funding from GAVI. Based on the development in EPI vaccine funding from 2012 to 2015, Benin remains strongly dependent on GAVI subsidies (approximately 90%) for the provision of under-utilised vaccines, or new vaccines. Currently, through the EPI, ten (10) target diseases can be countered. These are: tuberculosis, maternal and neonatal tetanus, infections owing to pneumococcus, measles, yellow fever, poliomyelitis, haemophilus influenzae infections, hepatitis B, mumps and diphtheria.

Rubella is a viral illness which is generally benign. However, if a pregnant woman develops the illness in the course of the first trimester of pregnancy, in particular, the risk of it being passed on to the foetus is very high. Rubella infection may bring about a series of malformations and disabilities: blindness, deafness and cardiac problems. These are referred to under the umbrella term of congenital rubella syndrome. In addition, this infection can bring about stillbirth or miscarriage.

In April 2012, the “Measles Initiative” group launched a ***Global Plan for the elimination of Measles and Rubella*** 2012-2020. The WHO regional office then, in the course of its 61st session, adopted a 2012-2020 ***Regional Strategic Plan for the elimination of Measles and Rubella***. The WHO briefing document on vaccination against rubella recommends that countries make use of the measles platform to introduce the rubella-containing vaccine (RCV) in their expanded programme for immunisation in a combined form, either as an anti-measles and anti-rubella vaccine (MR) or an anti-measles, anti-mumps and anti-rubella vaccine (MMR).

Benin thereby plans to introduce, within the EPI, the Rubella vaccine in its combined MR form. This introduction of the MR vaccine will therefore not change the vaccination calendar. It will be administered to children aged 9 months. The vaccination of the target group will be implemented as a fixed strategy and as an advanced strategy. These strategies will both by complemented by other ad hoc approaches, such as catch-up vaccinations (special vaccination sessions intended for target individuals requiring recalls), the active search for individuals out of touch, sweep operations, etc.).

This introductory plan will take into account logistical considerations (vaccination requirements, storage capacity at each level, the processes of supply and elimination of waste), the training and supervision of staff. Information, education and communication, to support the introduction of this vaccine, is an important component and has been subject to a communication plan.

This plan was developed based upon the information contained within the following documents:

* Full Multi-Year Plan (Plan Pluri Annuel complet- PPAC 2015-1018)
* PCV13 post introduction assessment in 2012
* External EPI 2014 review
* Logistical assessment of the cold chain, carried out in 2012
* Review of the AFP and measles monitoring data

With a view to contributing to the measles elimination objectives, the national vaccination programme, (EPI) will develop priority problem-solving strategies observed during post-introduction assessments of the new vaccines. The main implementation strategies have been advocated for the successful introduction of the vaccine.

Consequently, Benin is requesting support from GAVI amounting to $ 726 647 for 1 year. 354 874 $ USD of this amount will cover the purchase cost for the MR vaccine during the first year (2018) and 371 773 $ USD will cover the operational costs for the introductions processes. In order to implement the 2017 campaign, Benin is requesting financial support from GAVI amounting to 3 349 103 $ USD, covering the purchase cost for the MR vaccine and vaccination consumable supplies, in addition to operational costs.

**I. General points on Benin**

Benin is a country in West Africa that stretches between Niger in the

North, and the Atlantic Ocean in the South. It is delimited to the northwest by Burkina Faso, to the west by Togo and to the east by Nigeria. Its surface area[[2]](#footnote-2) extends over 114.763 km².

The relief consists of crystalline plains and plateaux in the southern region of the country, that gradually rise northwards, reaching altitudes of 641m (the Atacora Range). From north to south, three climatic zones can be distinguished:

* The dry tropical climate in the north with a dry season and a rainy season.
* The Guineo-Sudanese type climate at the centre characterised by a semi-humid tropical climate;
* The humid tropical climate to the south with two rainy seasons (from April to June and from September to October) and two dry seasons from July to August and from November to March.

The population of Benin was estimated at 11 096 879 inhabitants[[3]](#footnote-3) in 2016; of which

51.2% is female. Children aged less than one year are estimated at 395 549, i.e. [[4]](#footnote-4)% of the total population, and survivors are estimated at 369 047. Women of reproductive age comprise 24% of the population (2 670 942).

The table below presents the main socio-demographic indicators:

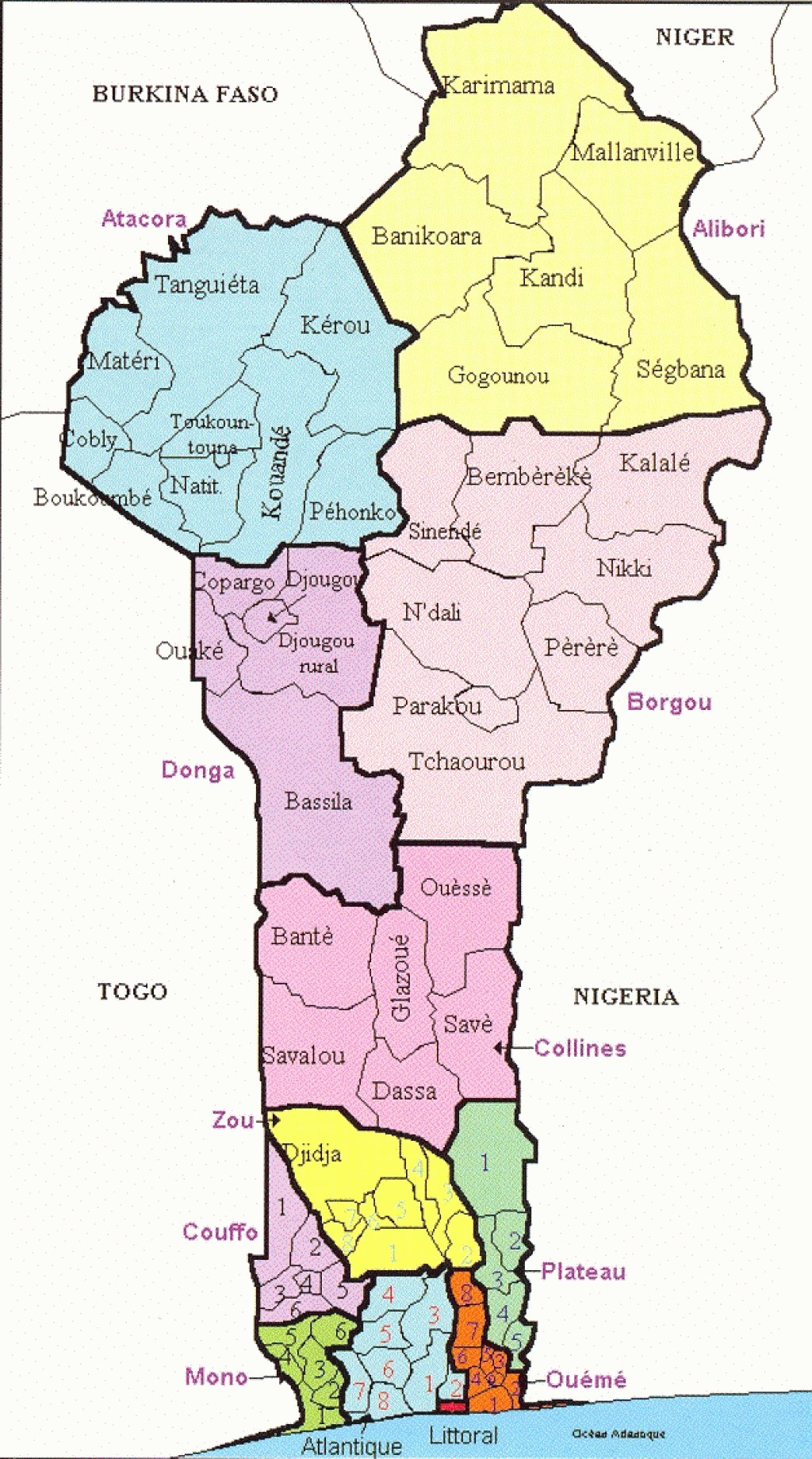
**Table I: Socio-demographic indicators**

|  |  |
| --- | --- |
| **Indicators** | **Value** |
| Gross Birth Rate (GBR) | 36,4‰4 |
| Gross Death Rate (GDR) | 8.5‰ |
| Infant death rate (IDR) | 68.1‰ |
| Infant-juvenile death rate (IDR) | 41‰ |

|  |  |
| --- | --- |
| Maternal mortality rate (MMR) | 335.5 deaths for 100.000 live births |
| Life expectancy at birth | 63.84 years |
| Life expectancy at birth for men | 59 years[[5]](#footnote-5) |
| Life expectancy at birth for women | 61.59 years |
| Composite fertility index (CFI) | 4.8 children per women |
| Growth rate | 3.5% |

***Sources: RGPH-4, 2013, EDS4, 2012-2013*** *(for life expectancy at birth)*

Benin is subdivided into 12 departments comprising Atakora, Donga, Borgou, Albori, Zou, Collines, Mono, Couffo, Atlantic, Littoral, Ouémé and Plateau. It comprises 77 municipalities, 546 arrondissements and 5,290 villages or city areas[[6]](#footnote-6).



**Figure 1: Administrative map of Benin**

In 2015, Benin ranked 140th out of 198 countries[[7]](#footnote-7) and the GDP per capita was US$ 708.98, or CFAF 354,500[[8]](#footnote-8).

State subsidies for the health sector have increased from 71.757 billion in 2013 to 69.582 billion in 2016. However, the budget for 2017 provides for a subsidy of US$ 81 billion for the health sector.

**II. Healthcare sector overview**

###### 2.1. Organisation of the healthcare system

The national healthcare system is organised into a pyramid-style structure with three levels, as indicated in the table below:

**Table II: National Healthcare system in Benin**

|  |  |  |
| --- | --- | --- |
| **Levels** | **Structures** | **Hospital and socio-sanitary institutions** |
| Central or national | Ministry of Health | * National Hospital and Teaching Hospital Centre   (CNHU-HKM)   * National centre of Pneumo-phtisiology * National centre of Psychiatry * National centre of Gerontology |
| Intermediary or  Departmental | Departmental  Healthcare  Directorate  (DHD) | * Lagune Mother and Child Hospital   (Hôpital de la Mère et de l’Enfant Lagune-HOMEL)   * Departmental Hospital Centre (CHD- Centre Hospitalier Départemental) * Information, Future studies, Counselling and Consultative centre (IFLCC)(CIPEC) * -Anti-Leprosy Centre (Centre de Traitement Anti Lèpre (CTAL)- Buruli ulcer treatment centre (Allada, Lallo and Pobè) * Pneumo-phtisiology centre, Akron |
| Peripheral | Health District  (Area Office) | * Area Hospital (AH) * Healthcare center (HC) * Private healthcare training   - Centre for detection and treatment of  Tuberculosis (CDT)  -Village Healthcare Unit (VHU) |

**Source:** MS/DPP/SSD

In addition to public structures, Benin has a large number of private facilities offering both modern and traditional health care.

The health zone represents the

operational unit for planning, management and operation of the health system. Benin has 34 health zones. There are 855 healthcare centers offering the Minimum Package of Activities; these include preventive, curative and promotional actions, including vaccination.

In 2015, Benin had 1,617 doctors, 5,079 nurses and 1,451 midwives in the public sector, a total of 8,147 qualified staff. The ratio of qualified staff to inhabitants is 8 per 10,000 inhabitants (WHO standards 25 per 10,000 inhabitants). However, this estimate does not take into account qualified staff working in the private sector.

For the 2009-2018 decade, Benin has developed a national health development plan (NHDP) with a focus on five priority areas, which are:

* Prevention of and fight against illness and improvement of healthcare
* Valuing Human Resources
* Building the partnership in the sector and promoting ethics and medical responsibility
* Improving the sector’s funding mechanism

Strengthening sector management

###### 2.2. Epidemiological data

Benin’s epidemiological profile is characterised by a predominance of endemo-epidemic conditions including: malaria, diarrhea and other gastro-intestinal conditions, acute respiratory infections, and anemia.

Diseases which can be prevented by vaccination are still being recorded.

###### 2.3. Situation analysis for the Expanded Programme on Immunisation (EPI)

2.3.1. Institutional and management framework

At the Ministerial level, management of the EPI is implemented by the National Agency for Vaccination and Primary Healthcare (ANV-SSP) by Ministerial Decree No. 2011-413 of 28 May 2011. Its mission is to implement national health policy in the areas of immunisation and primary health care. At the level of the departments and municipalities, the Agency relies on several persons including the heads of departmental services, chief medical officers, EPI managers, heads of units and their collaborators. To coordinate and implement these activities in addition to the Agency’s technical directorates, technical committees have been set up. These are the Inter-Agency Coordination Committee (ICC) , the National Experts’ Committee for the eradication of

Poliomyelitis (Comité National des Experts pour l’éradication de la Poliomyélite (CNEP), the National Certification Committee (Comité National de Certification (CNC), the National Consultative Committee for Vaccines and Vaccination (Comité National Consultatif pour les Vaccins et la Vaccination (CNCV-Bénin))

and the AEFI (MAPI) Management Committee.

Furthermore, the ANV-SScollaborates with all technical directorates within the Ministry of Health. The programme does not have any national regulatory authorities (NRA). For queries on this subject, the EPI addresses the National Directorate of Pharmacy and Medicines (DPMED) through its National Committee for the Supply of Health Products (CNAPS).

2.3.2. Services offered

The EPI, which began in Benin in 1982, aims to reduce morbidity and mortality in connection with target diseases which can be avoided through vaccination. Initially, the EPI focused on six diseases. Given the epidemiological context and availability, Benin has introduced new vaccines into the EPI progressively. Four new antigens have been introduced. Currently, the EPI can be used to fight ten (10) target diseases.

The selected antigens in the programme are administered to children aged 0-11 months, and to pregnant women. The following table presents the vaccines used in the EPI in Benin.

**Table III: Distribution of vaccines used in the Benin EPI according to year of introduction**

|  |  |  |
| --- | --- | --- |
| **Number of** | **Vaccine** | **Year of introduction** |
| **1** | BCG | 1982 |
| **2** | Polio | 1982 |
| **3** | DTP | 1982 |
| **4** | MCV | 1982 |
| **5** | VAT | 1982 |
| **6** | YF | 2002 |
| **7** | Hepatitis B | 2002 |
| **8** | Hib (pentavalent) | 2005 |
| **9** | PCV-13 | 2011 |
| **10** | IPV | 2015 |

Immunisation services are offered in 855 HCs throughout the country, indicating that access to immunisation services is satisfactory, as evidenced by the 98% BCG coverage. On the other hand, continuity raises some problems because the drop-out rate between the first and third dose of pentavalent was 9.4% in 2014 and the drop-out rate between BCG and MCV is very high (19%)[[9]](#footnote-9).

It is recommended that immunisation be conducted daily in all units. However, in reality, daily vaccination is performed in 40% of HCs and all antigens are offered at each immunisation session in 35% of HCs.

Vaccination of target groups is implemented as a fixed strategy and as an advanced strategy. These strategies are both complemented by other ad hoc approaches, such as catch-up vaccinations (special vaccination sessions intended for target individuals requiring recalls), the active search for individuals out of touch, sweep operations, etc. Moreover, Benin plans to implement, within the EPI, vaccines against Rubella and Rotavirus vaccines within its routine immunisation programme.

2.3.3. Quality of vaccines and cold chain situation

2.3.3.1. Supply and quality of vaccines

The State of Benin and its partners contribute to the purchase of traditional vaccines and the joint funding of new vaccines (existence of a budget line, etc.). In the context of the initiative for independent immunisation, Benin has been purchasing all traditional vaccines (BCG, OPV, VAT, DTP-HepB-Hib, MCV, YF) since 1996 and contributes to the acquisition of new vaccines and under-utilised vaccines with co-funding from GAVI. Based on the development in EPI vaccine funding from 2012 to 2015, Benin remains strongly dependent on GAVI subsidies (approximately 90%) for the provision of under-utilised vaccines, or new vaccines.

Strengthening the supply chain at all levels, in particular by increasing CDF equipment coverage in HCs, the reliability of equipment, maintaining rolling stock and CDF equipment in good working order at all levels to ensure a steady supply of vaccines and other inputs.

With respect to the vaccine against measles and rubella (MR), the current CYMP will end in 2018 and will not allow the request for support to go beyond this year, the country will, throughout 2018, develop another CYMP, an introductory report for MR vaccine and estimate the MR vaccine requirements for the remaining four years to submit to Gavi.

2.3.3.2. Cold chain situation

The MR vaccine will be introduced to replace the MCV vaccine. The MR vaccine has an analogous presentation to the MCV vaccine: it takes up the same storage volume as the

MCV vaccine. Therefore, as Benin has not had a storage capacity deficit for the MCV vaccine at the central and operational levels, the volume to be taken up by the MR vaccine is already available.

An analysis of forecasts for storage capacity requirements (equipment of the cold chain coupled with physical inventory of cold chain equipment) by level produced the following results:

The cold chain across the country comprises:

At the central level:

For the total net positive current capacity of the cold chain, this amounts to 54 000 liters whereas the required capacity is 28 034 liters for 2018. There is therefore no additional need for equipment required at this level.

At the intermediate level

The storage capacity of the central and intermediary facilities are laid out as follows:

**Table 7.1: Capacity and costs (for positive storage)**

**Main warehouse**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  | **2013** | **2014** | **2015** | **2016** | **2017** | **2018** |
| **A** | Net storage capacity required amounts to  CdF (litres) | *Capacity required* | 22 064  litre | 21 192 litres | 18 880 litres | 21 013 litres | 22 287 litres | 28 034 litres |
| **B** | Existing net total positive capacity for cold chain | *Current net capacity* | 54 000  litre | 54 000 litres | 54 000 litres | 54 000 litres | 54 000 litres | 54 000 litres |
| **C** | Additional net capacity installed | *Expected additional capacity* | 0 litres | 0 litres | 0 litres | 0 litres | 0 litres | 0 litres |
| **D** | Existing net total positive capacity | *Total capacity*  *made available* | 54 000  litre | 54 000 litres | 54 000 litres | 54 000 litres | 54 000 litres | 54 000 litres |
| **E** | Difference (where applicable) | *A-D* | - 31 936  litre | - 32 808 litres | 35 120 litres | 32 987 litres | - 31 713 litres | - 25 966 litres |

The central warehouse offers sufficient capacity to introduce the MR vaccine.

**Table 6.1: Capacity and costs (for positive storage)**

**Warehouse**

**Intermediaries in 2017**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Formulae** | **Atacora** | **Atlantic** | **Borgou** | **Mono** | **Ouémé** | **Zou** |
| **A** | Annual total volume of vaccines in positive storage | *Figure obtained by multiplying the*  *total vaccine doses by the volume per dose* | 3 057 litres | 4 826 litres | 4 836 litres | 3 108 litres | 4 309 litres | 3 645 litres |
| **B** | Existing net total positive capacity for cold chain | *#* | 5 000 litres | 6 000 litres | 5 500 litres | 634 litres | 591 litres | 5 300 litres |
| **C** | Estimated minimum number  of annual shipments required for actual cold chain capacity | *A/B* | 0.61 | 0.80 | 0.88 | 4.90 | 7.29 | 0.69 |
| **D** | Annual number of shipments | *Based on the national vaccine distribution plan* | 4 | 4 | 4 | 6 | 6 | 4 |
| **E** | Difference (where applicable) | *((A\*(1/D+Reserve/12) - B)* | **-**  **3726.2868** | **3 989 litres** | **3 485 litres** | **143 litres** | **486 litres** | **3 781 litres** |

At the level of the departments (districts), no warehouse has a deficit for a quarterly supply. The majority of municipalities have sufficient capacity to maintain the full vaccine requirements of their health areas and to freeze accumulators.

The supply and storage chain of vaccines and vaccine consumables is modeled on the health pyramid and comprises three levels: the central level (Ministry), the intermediate level (department) and the peripheral level. The central level and four of the six departmental repositories are equipped with cold rooms. The other facilities use refrigerators and freezers for the storage of vaccines. The vaccine supply system is well defined and complied with throughout the country (ordering period and storage level compliance). Inventory management of vaccines and consumables is computerised (SMT tool) up to intermediate level. However, the bases are not updated whenever products are moved. Syringes used for vaccination and healthcare are destroyed by incineration. In terms of logistics, efforts remain to be made in terms of equipment maintenance, the development of a cold chain and rolling stock depreciation plan and the development of standard operating procedures (SOPs) for logistics.

2.3.4. Communication

Communication supporting the EPI employs the following main strategies:

* advocacy,
* social mobilisation,
* communication for development (C4D).

The external EPI 2014 review revealed several shortcomings in the implementation of EPI development communication activities. Among these weaknesses are:

* + Lack of communication plan for the routine EPI at all levels;
  + lack of financial means to fund EPI communication activities (through lack of a perennial contract with the media for routine vaccination);
  + a lacking involvement of leaders in EP activities;
  + a lacking involvement of NGOs in raising awareness on EPI;

To counter these shortcomings, a routine vaccine communication plan is being drawn up with the financial and technical support of UNICEF.

2.3.5. Data management

EPI data is collected at all vaccination units using SNIGS media, and is sent to the Agency at a specific frequency. There are still problems relating to promptness and data quality.

This is why Benin is planning to draw up a plan to improve the quality of data for February 2017.

2.3.6. Human resources

At the Ministerial level, the EPI has its own staff for the ANV-SNP. At intermediary and peripheral level, EPI activities are integrated into the MPA and rely on the human resources available.

2.3.7. Funding

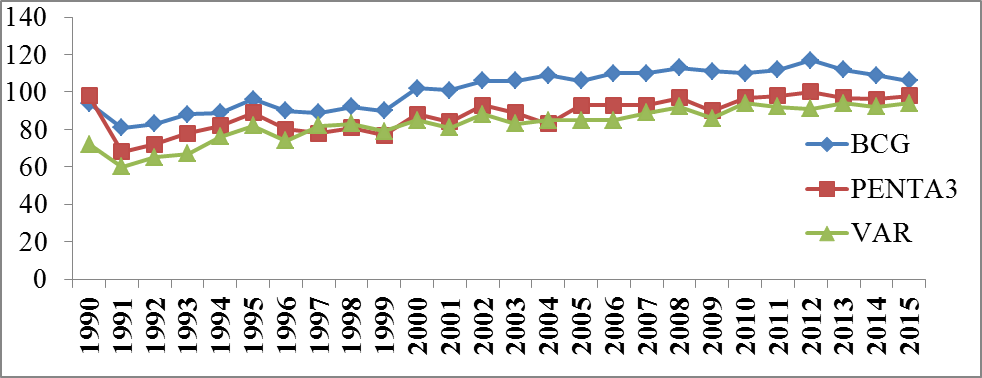
In the context of the initiative for independent immunisation, Benin has been purchasing all traditional vaccines (BCG, OPV, VAT, DTP-HepB-Hib, MCV, YF) since 1996 and contributes to the acquisition of new vaccines and under-utilised vaccines with co-funding from GAVI. Based on the development in EPI vaccine funding from 2012 to 2015, Benin remains strongly dependent on GAVI subsidies (approximately 90%) for the provision of under-utilised vaccines, or new vaccines.

For 2015, the total cost of routine EPI and additional immunisation activities, chain cold and logistics amounted to 3,745,884,619 CFA francs, including 1,776,922,000 CFA francs financed by GAVI, 914,111,000 francs CFA by other partners and 1,054,851,619 by the Government of Benin.

###### 2.4. EPI Performance

2.4.1. Vaccination coverage

The evolution of antigen-based administrative vaccination coverage is presented in the graph below:



**Source: ANV-SSP**

**Figure 2: Development of vaccination coverage from 1990 to 2015 in Benin**

Whatever the antigen in question, vaccination coverage has remained relatively stable over the past ten years.

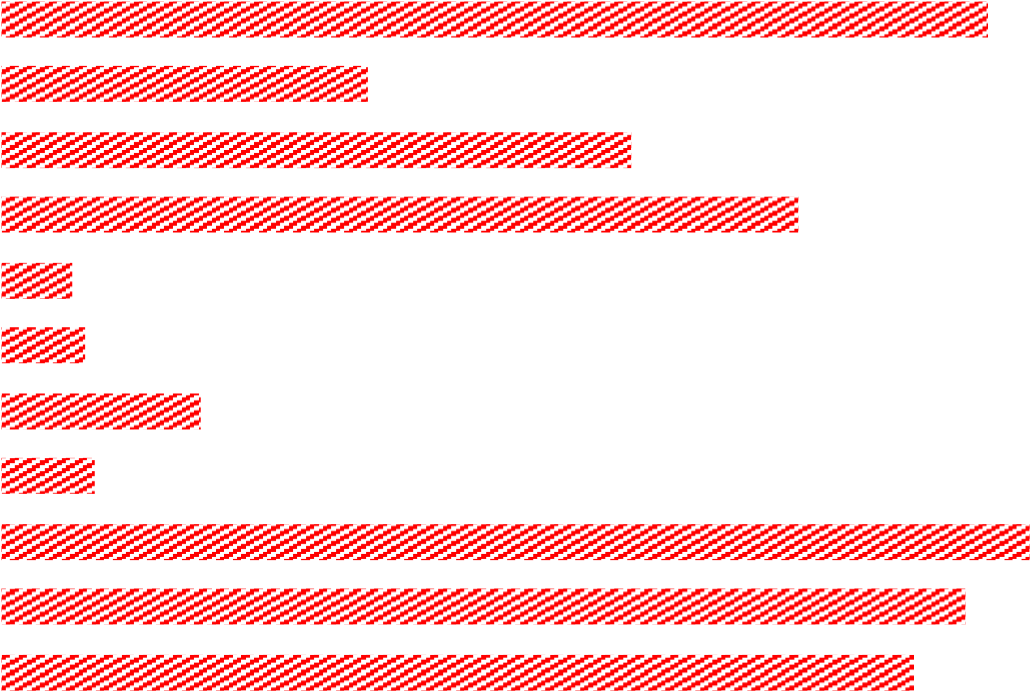
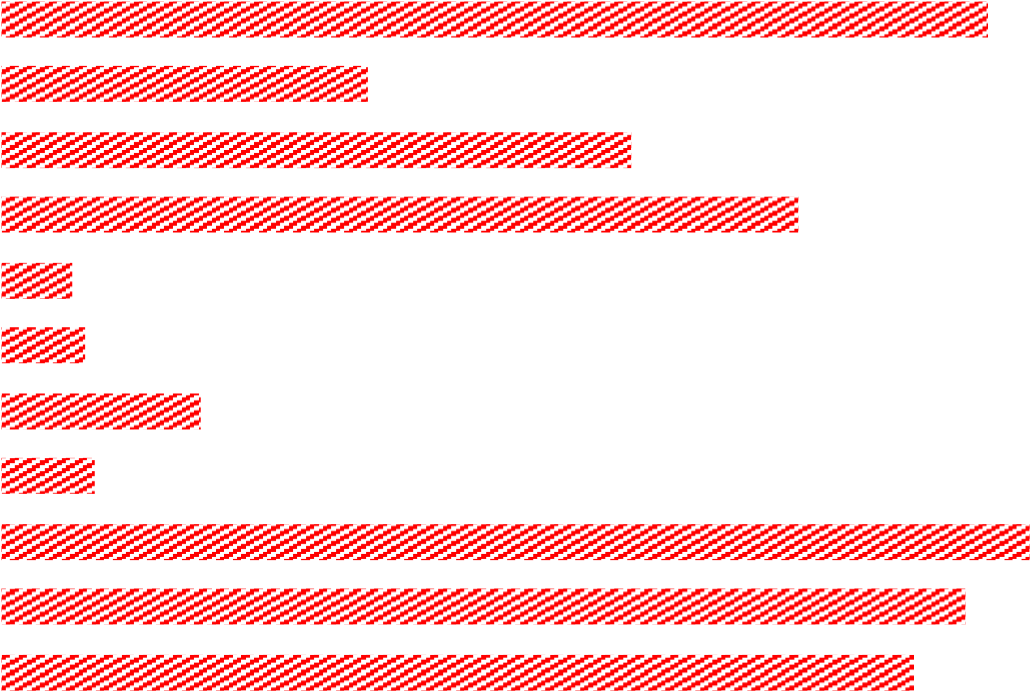
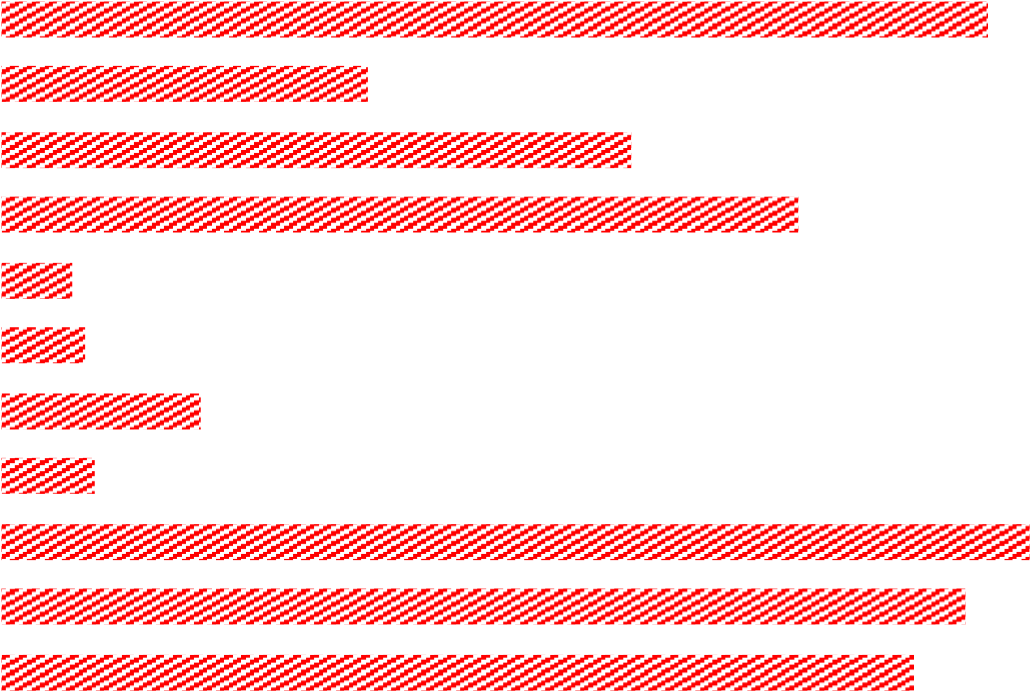
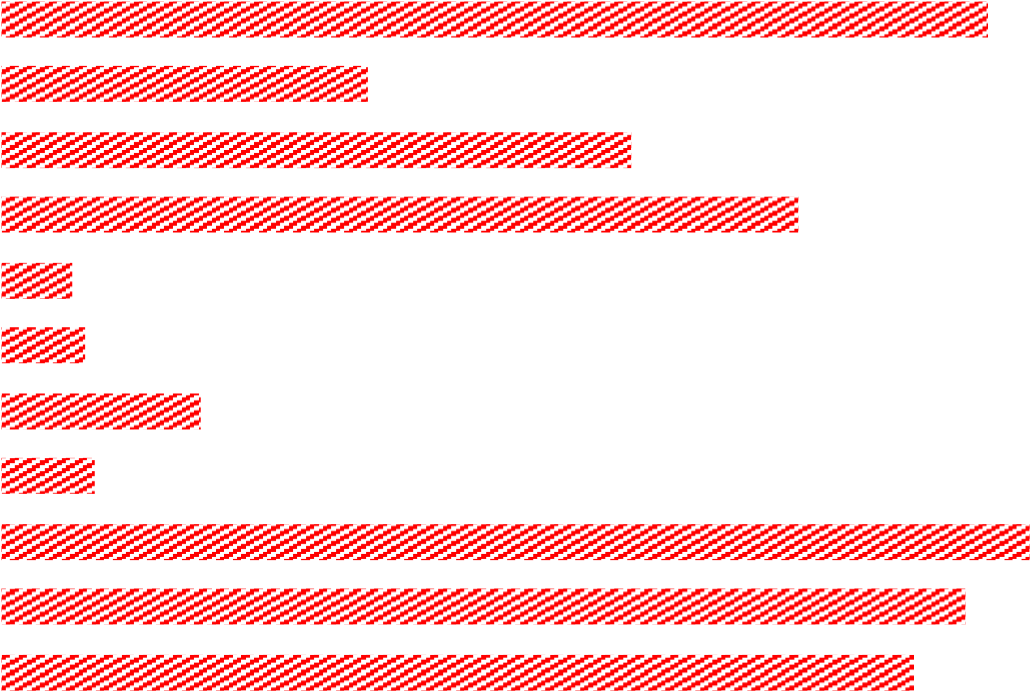
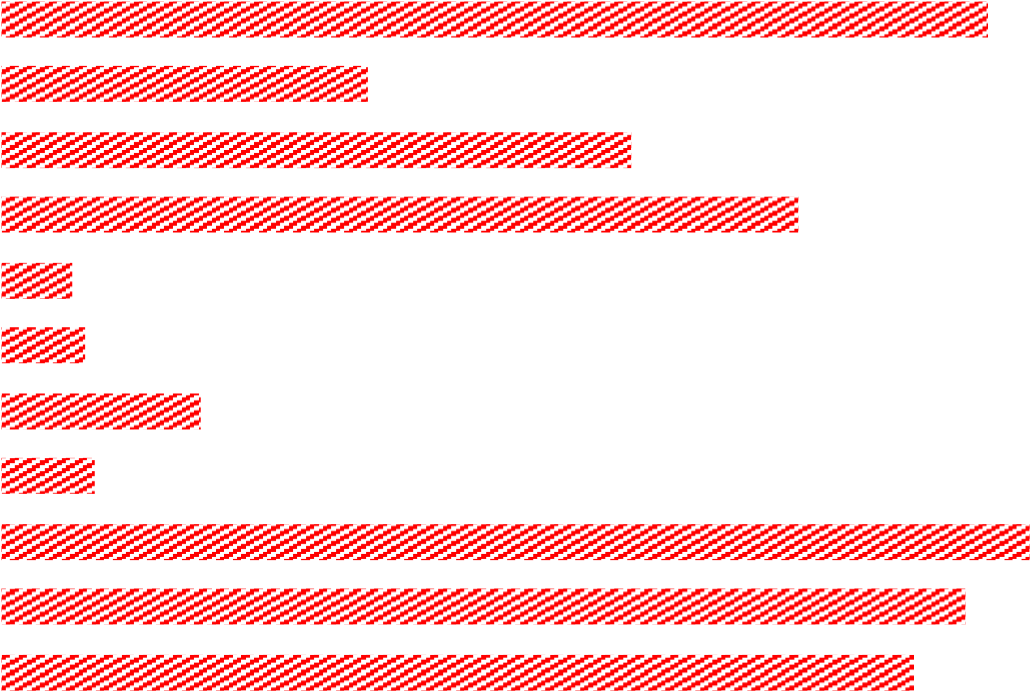
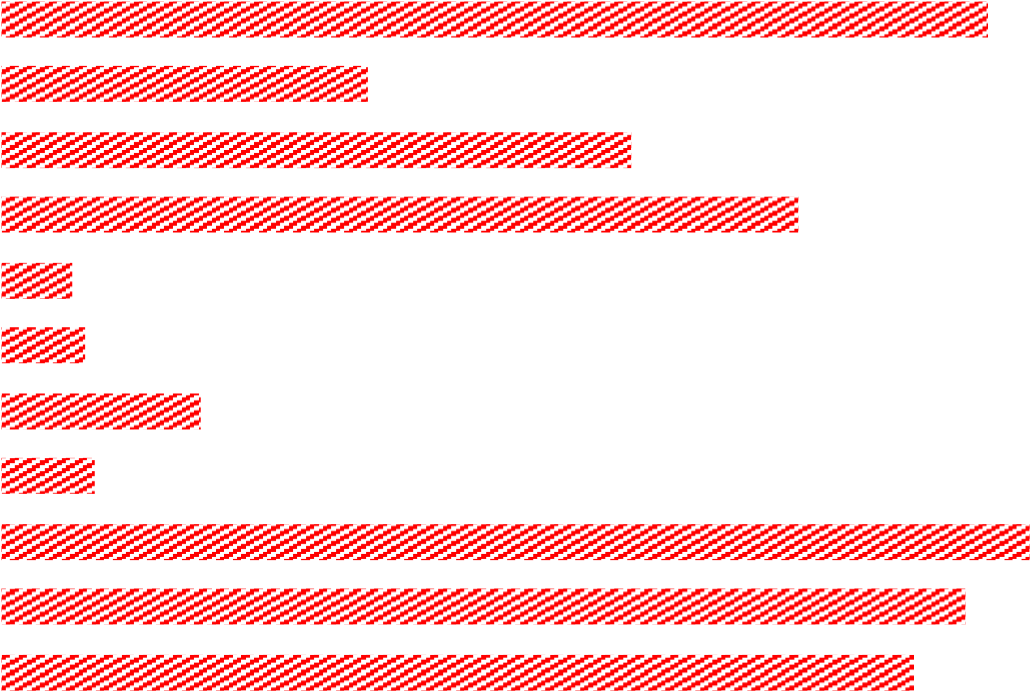
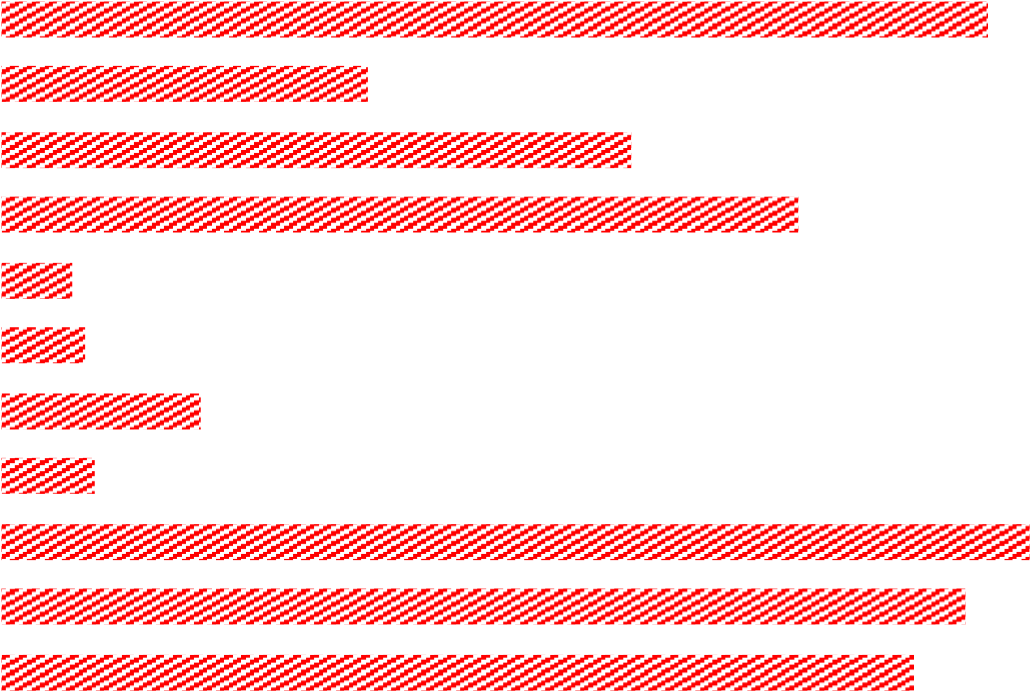
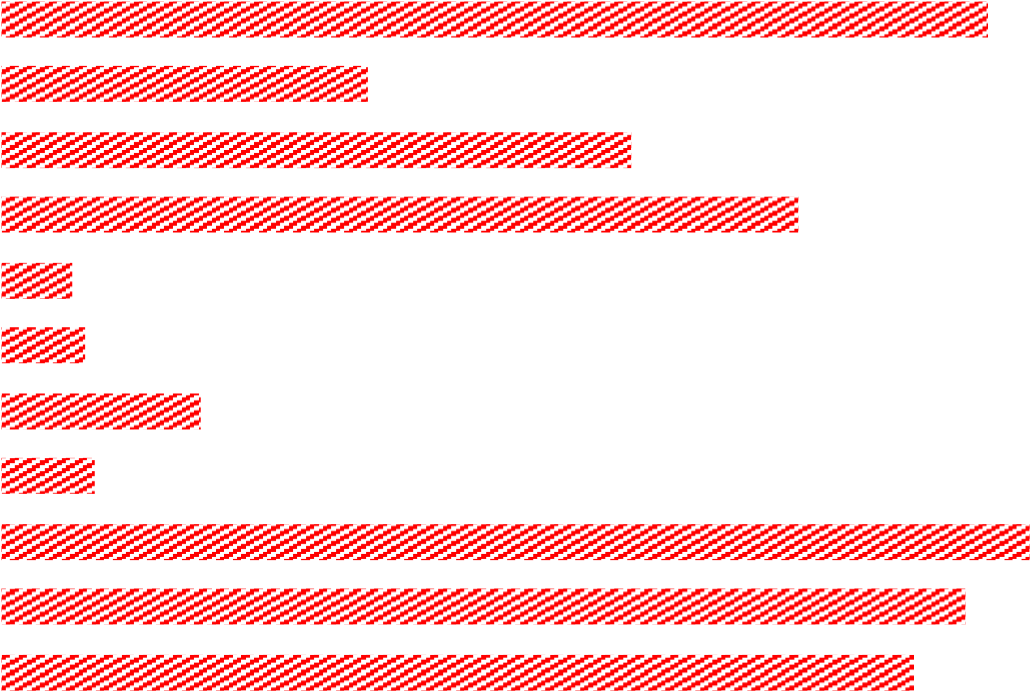
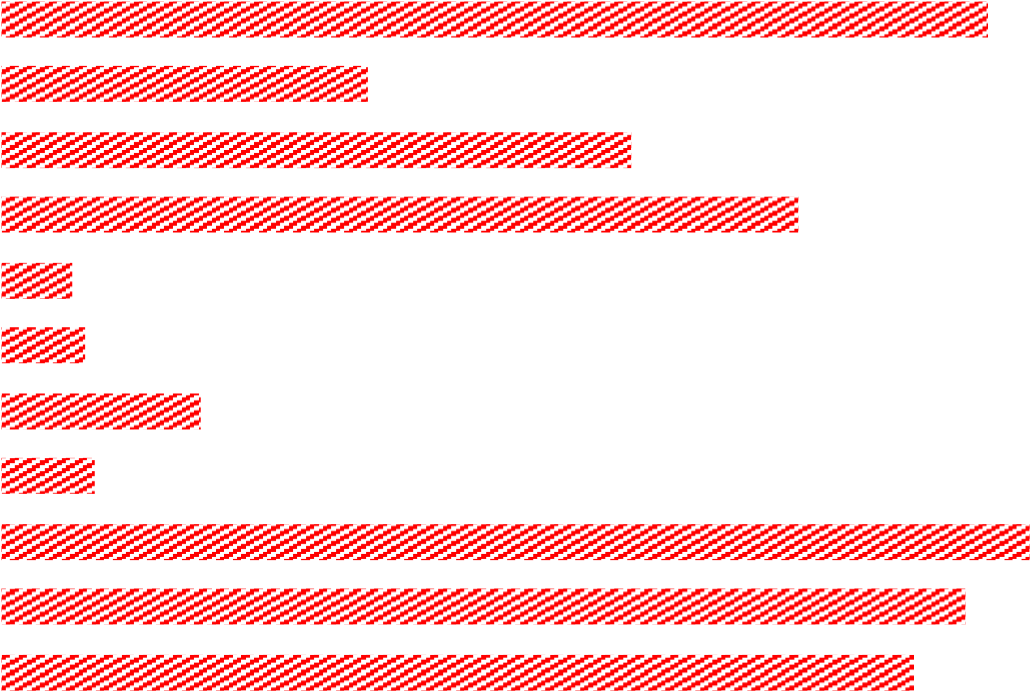
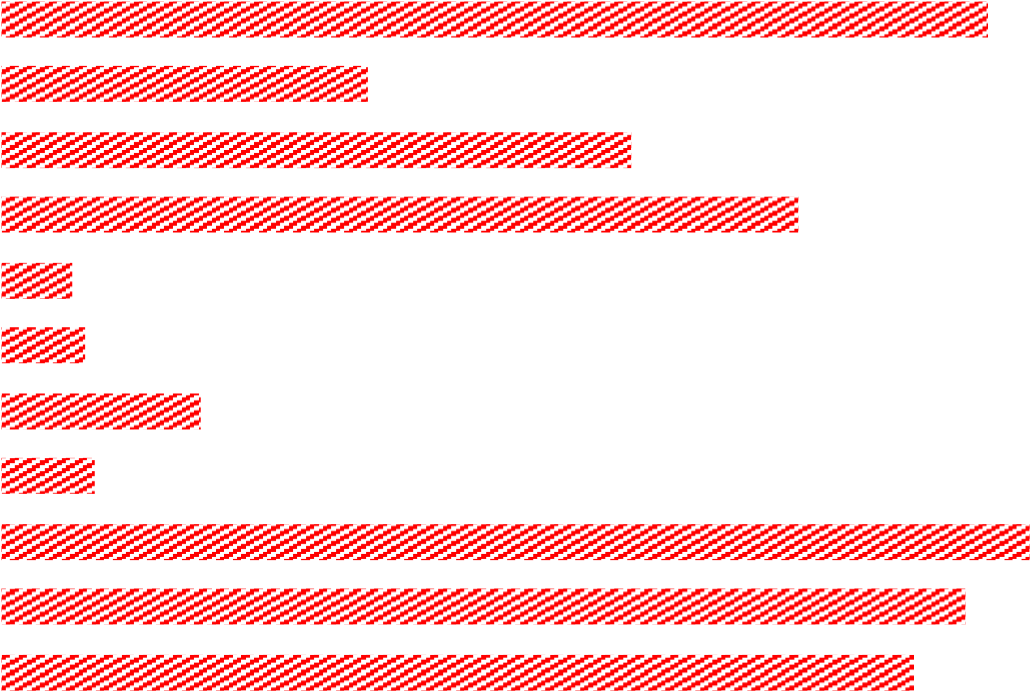
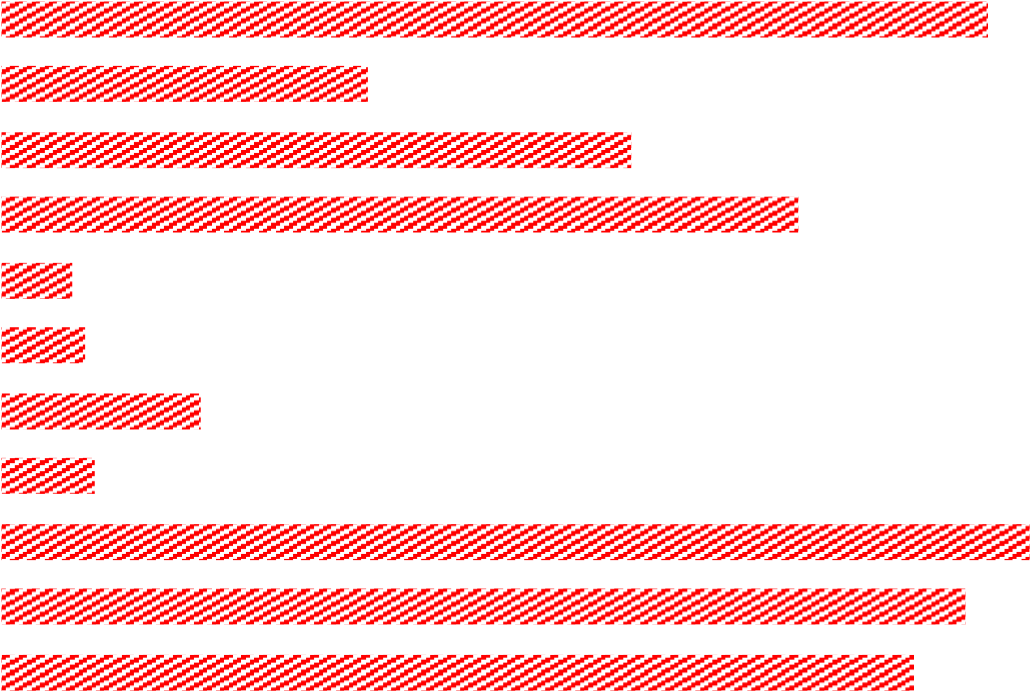
Contrary to the good performance levels broadcast according to administrative data, UNICEF ​​estimates place DTP-Hib-HepB3 coverage at less than 85% (75% in 2014 and 79% in 2015).

The external EPI 2014 review revealed a BCG coverage of 98% (scarring) and showed that 76% of children were fully vaccinated.

(booklet + medical history).

However, the survey also revealed efforts must be made for:

* the safe keeping of vaccination documents by parents,
* compliance with the vaccination schedule (35% of valid ECV).



**87**

**92**

**98**

**9**

**19**

**8**

**7**

**76**

**60**

**35**

**94**

**0**

**20**

**40**

**60**

**80**

**100**

**Holding of Card**

**BCG scar**

**Access to EPI: BCG**

**Penta 1/3 drop-out rate**

**BCG/VAR drop-out rate**

**Invalid Penta1**

**Invalid VAR**

**ECV (card + history)**

**ECV (card)**

**ECV at one year (valid)**

**Capacity to be achieved in under 1 year**

**%**

Source : 2014 EPI review

**Figure 3: EPI performance indicators in children in Benin’s 85 municipalities in 2014 *(n= 17 789)***

2.4.2. Monitoring of vaccine-preventable diseases

The established monitoring system takes into account all levels of the healthcare pyramid. Like most countries in the subregion, Benin has put in place an integrated disease surveillance and response system in all healthcare training programmers. This system allows for the collection of data pertaining to monitored diseases and other health events (AEFI).

In the context of surveillance of vaccine-preventable diseases, special attention has been given to the surveillance of AFP and measles cases. Performance indicators for these two conditions have developed within satisfactory limits. For polio (AFP surveillance), between 2005 and 2015, the rate of non-polio AFP fluctuated between 1.9 and 4.3 per 100,000 children under the age of 15 years. AFP with stool samples collected within 14 days ranged from 81% to 99% for the same period.

For a period of eleven years (2005 to 2015), indicators for measles hereinbelow evolved as follows:

* the rate of non-measles eruption per 100,000 inhabitants varied from 0.5 to 3 (this indicator fell within standards (> = 2 cases per 100,000 inhabitants) for just four years out of 11.
* Proportion of cases notified and collected from 28% to 98%. 80% standards at least. This standard has been reached for just three years out of the total 11.
* The proportion of municipalities which reported with a blood sample grew from 44% to 92% (standard: 80% at least). This standard was reached for five years out of the 11-year period.

**Table IV: Monitoring performance for cases of measles in Benin from 2005 to 2015**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Year** | **Population** | **Suspected Cases**  **s** | **Measles cases**  **confirmed**  **(IgM+ and**  **Epidemiological link)** | **Compatibl**  **e** | **Rejected** | **Non-measles outbreak**  **rate for**  **100000 inhabs**  **(2/100000)** | **Specimen collected** | **Proportion of cases**  **reported and**  **collected**  **80%** | **municipality**  **having reported with**  **blood specimens per year** | **Proportion of municipalities having reported with**  **blood specimens per year (80%)** |
| 2016 | 10315244 | 315 | 70 | 20 | 223 | 2.2 | 293 | 93% | 61 | 79.2% |
| 2015 | 10315244 | 255 | 34 | 21 | 200 | 1.9 | 251 | 98.4% | 52 | 67.5% |
| 2014 | 9988068 | 908 | 716 | 52 | 140 | 1.4 | 557 | 61.3% | 66 | 85.7% |
| 2013 | 9671592 | 1005 | 642 | 124 | 230 | 2.4 | 611 | 60.8% | 71 | 92.2% |
| 2012 | 9364619 | 547 | 231 | 69 | 247 | 2.6 | 438 | 80.1% | 63 | 81.8% |
| 2011 | 9067076 | 609 | 389 | 40 | 180 | 2.0 | 509 | 83.6% | 58 | 75.3% |
| 2010 | 8778648 | 368 | 221 | 25 | 122 | 1.4 | 214 | 58.2% | 51 | 66.2% |
| 2009 | 8497828 | 1445 | 1003 | 357 | 85 | 1.0 | 405 | 28.0% | 63 | 81.8% |
| 2008 | 8224644 | 1117 | 712 | 13 | 248 | 3.0 | 466 | 41.7% | 67 | 87.0% |
| 2007 | 7958813 | 498 | 336 | 18 | 144 | 1.8 | 262 | 52.6% | 57 | 74.0% |
| 2006 | 7839914 | 284 | 184 | 4 | 95 | 1.2 | 167 | 58.8% | 46 | 59.7% |
| 2005 | 7447454 | 208 | 169 | 1 | 38 | 0.5 | 104 | 50.0% | 34 | 44.2% |

Benin experienced its peak time in 2009, with 1445 cases of suspected measles, 1003 of which were confirmed and 357 were compatible

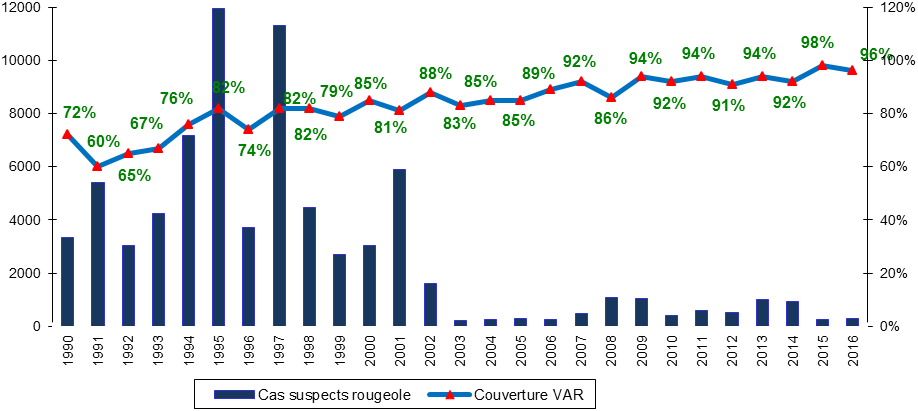
1.1.1 Measles

The accelerated fight against measles in Benin is characterised by these major stages: catch-up campaigns, follow-up campaigns and monitoring based on the cases.

The catch-up campaigns took place in 2001 in the departments of Atacora/Donga and Zou/Collines, and then in 2003 in Benin’s eight (8) other departments. The follow-up campaigns were carried out in December 2005, in November 2008, in September 2011, across the whole territory then in November 2014 (in 10 departments) and in January 2015 in Atacora/Donga (which did not run this campaign in November 2014 owing to the hemorrhagic Lassa-virus epidemic in the Tanguieta municipality).

As well as these various campaigns, the monitoring based on the cases has been implemented in all the country’s health units since 2001, with the laboratory’s support, through the systematic confirmation of all suspected cases of measles. Phases such as the EPI routine reinforcement and the correct handling of cases of measles are ensured through the daily activity of the healthcare centers.

At a regional level, the fight against measles has enabled the reduction goal to reach at least 90% of the morbidity set for the African region. Benin also reached this objective for the period extending from 2002 to 2007. However, since 2008, epidemic centres being multiple in a number of departments and municipalities, there was an increase in the number of cases recorded and a low reduction level of cases ensued as compared to the 2001 period, with a rate of measles cases confirmation which was often very high (around 70% of suspect cases for a 10% target). The following graph summarises the development of suspected measles cases and the measles vaccination coverage in Benin from 1990 to 2016.



**Figure 4:** Suspected cases of measles and LMV coverage in Benin from 1990 to 2016

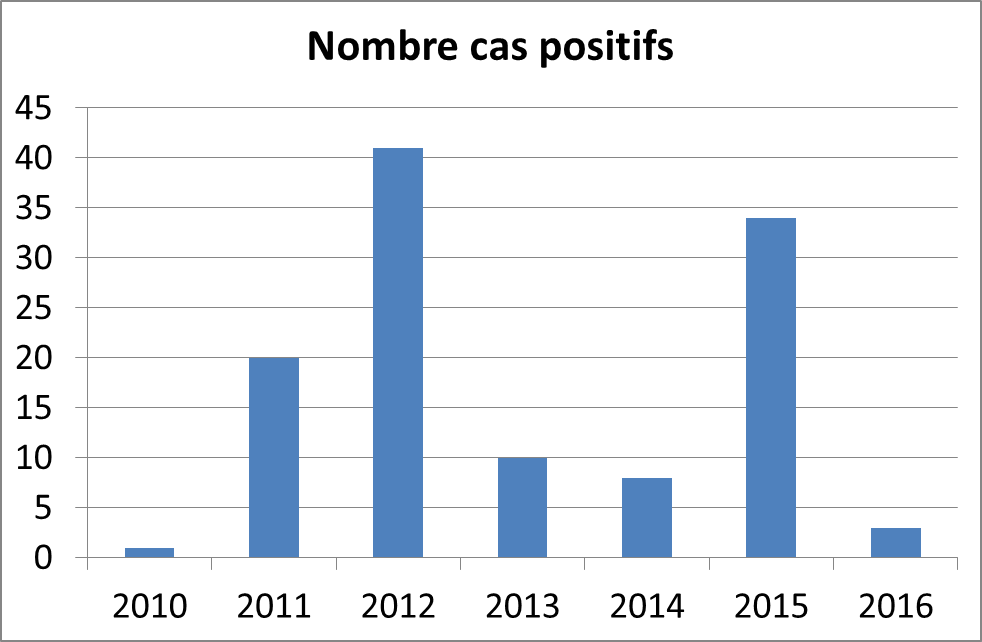
1.1.2 Rubella

The country has not yet established monitoring of congenital measles syndrome. Conversely, in the context of routine measles monitoring activities, the monitoring of measles cases is carried out. All the cases which tested negative for measles are tested for rubella. An analysis of rubella monitoring data is presented in the table below:

**Table V** : Rubella surveillance data from 2010 to 2015

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Year** | **Number of reported cases** | **Number of cases**  **tested** | **Number of positive cases** | **% positive**  **cases** |
| 2016 | 223 | 183 | 3 | 1.6% |
| 2015 | 255 | 205 | 34 | 16.6% |
| 2014 | 922 | 61 | 8 | 13.1% |
| 2013 | 1008 | 343 | 10 | 2.9% |
| 2012 | 535 | 292 | 41 | 14.0% |
| 2011 | 604 | 114 | 20 | 17.5% |
| 2010 | 393 | 67 | 1 | 1.5% |
| Total | 3940 | 1265 | 117 | 9.25% |

This analysis allows us to note than 9.25% of suspected measles cases tested are positive. This proportion varies from 1.5% to 17.5% across the 2010 to 2016 period.



**Figure 5 :** Positive cases of rubella in Benin from 2010 to 2016

**III. Introducing the rubella vaccine in routine EPI**

###### 3.1. Background and justification for introducing the measles-rubella (MR) vaccine

Rubella is a viral illness which is generally benign. However, if a pregnant woman develops the illness in the course of the first trimester of pregnancy, in particular, the risk of it being passed on to the foetus is very high. Rubella infection may bring about a series of malformations and disabilities: blindness, deafness and cardiac problems. These are referred to under the umbrella term of congenital rubella syndrome. In addition, this infection can bring about stillbirth or miscarriage.

An ad hoc survey carried out in Cotonou with 413 pregnant women showed IgG in 82%, underlining the risk of infection in women with the rubella virus across the population of Benin[[10]](#footnote-10).

Biological testing has shown the circulation risk for the rubella virus across the population of children targeted by measles vaccination. In 2015, non-measles eruptive illnesses simulating rubella had a variable frequency from one department to another with extremes ranging from 3 per 100 000 inhabitants (Atlantic) to 0.9 per 100 000 inhabitants (Borgou)[[11]](#footnote-11).

In April 2012, the “Measles Initiative” group launched a ***Global Plan for the elimination of Measles and Rubella*** 2012-2020. The WHO regional office then, in the course of its 61st session, adopted a 2012-2020 ***Regional Strategic Plan for the elimination of Measles and Rubella***. The WHO briefing document on vaccination against rubella recommends that countries make use of the measles platform to introduce the rubella-containing vaccine (RCV) in their expanded programme for immunisation in a combined form, either as an anti-measles and anti-rubella vaccine (MR) or an anti-measles, anti-mumps and anti-rubella vaccine (MMR).

Thus Benin, as with some African countries fulfilling the conditions to receive support from GAVI, undertook during the internal regional review carried out in Kampala, Uganda from 18 to 19 July 2016, to eliminate rubella by introducing the rubella-containing vaccine in the routine EPI through the combined anti-measles anti-rubella format. This decision was included in the cMYP when it was updated.

Unlike with the anti-measles vaccine, for which the seroconversion rates are lower when the vaccine is administered to children younger than 12 months (making 2 anti-measles vaccines necessary), almost all children (over 95%) effect seroconversion after a single-dose anti-measles vaccine, even when aged 9 months.

###### 3.2. Objectives

3.2.1. General objective

To contribute to the reduction of mortality linked to measles and rubella

###### 3.2. 2. Specific objectives

* To introduce, into the EPI, a bivalent vaccine combining an anti-measles vaccine and an anti-rubella vaccine (MR Vaccine)
* To ensure the permanent availability of the MR vaccine and inputs in the healthcare units,
* To vaccinate at least 92% of the annual target of children aged at least one at the national level with a dose of combined anti-measles and anti-rubella vaccine from February 2018;
* To ensure the monitoring and the care for AEFI cases;
* To destroy 100% of waste generated by vaccination against measles and rubella according to the national guidelines in vigor.

3.2.3. Expected impact of the vaccine

The expected impact of the introduction of this new vaccine is a substantial decrease in morbidity and infant mortality linked with measles, as well as a decrease in congenital measles syndrome.

The combined vaccine against measles and rubella will be introduced within the routine EPI at the national level, and will be administered both in urban and in rural areas to all children, irrespective of gender and social situation. Special strategies will be implemented to reach difficult-to-access populations, in addition to the fixed, advanced and mobile strategies. The vaccine introduction support activities will contribute to the reinforcement of the vaccination and general healthcare system through staff training, reinforcement of the cold chain, the improvement of waste management as well as the strengthening of community participation.

3.2.4. Main difficulties and risks related to the introduction of the new vaccine, and country’s capacity to resolve them

The main difficulties which may have an impact upon introduction are delays in social mobilisation and the non-availability of additional financial resources.

A communication plan will be drawn up in the context of the anti-measles and anti-rubella combined vaccine’s introduction and will take into account this vaccine’s specificities as well as its levels of acceptance among communities, in order to plan appropriate strategies in the event of potential rumors.

As concerns resource mobilisation, a case will be made to the State and to its local partners. The country’s adhesion process to the Vaccination Independence Initiative (VII) constitutes an opportunity to guarantee the State’s share in co-funding the vaccine.

3.2.5. Main risks, potential challenges and proposed solutions to overcome them

The main challenges which the country may face in the context of the introduction of the anti-measles and anti-rubella combined vaccine are summarised in the table below:

**Table V :** Risks and challenges in introducing the combined measles and rubella vaccine

|  |  |  |
| --- | --- | --- |
| **Fields** | **Potential risks/challenges** | **Solutions proposed to avoid the risk** |
| Programme-based | Capacity to store and keep the vaccines in good condition at all levels | * Reinforcement of storage and preservation capacity, * Staff training |
| Upkeeping the vaccine administration calendar | * Training and supervision of service providers * Establishment and broadcasting of guidelines at all levels |
| Community mobilisation for the vaccine to be adopted and accepted | Management of rumors, reticence and refusal | * Crisis communication training * Awareness-raising among parents |
| Funding | Mobilisation of additional costs relating to introduction | Case made to the State and to partners |

###### 3.3. Information on the vaccine and vaccination calendar

***3.3.1. Choice of vaccine***

Following the CNCV’s recommendations, the Ministry of Health, in coordination with the technical partners, has decided to introduce the measles and rubella vaccine in 2018 as a routine vaccination.

In Benin, the bivalent vaccine combining rubella and measles antigens was selected. This is a 10-dose, combined, freeze-dried vaccine. The anti-measles vaccine will be administered through a MR vaccine, with the vaccine’s first dose containing the measles valency.

The rubella-containing vaccine must not be administered to individuals with a history of anaphylactic reaction to neomycine, gelatine or other ingredients contained in the vaccine. Antil-rubella vaccines must not be administered to persons affected by serious immunodeficiency disorder. The administration of the vaccine can cause side effects in sensitive adult females (25% have presented with anthralgia and 12% have presented with full arthritis). These reactions generally arise 7 to 21 days after vaccination and their duration extends from a few days to 2 weeks. In children, joint-related symptoms tend to be rare (0-3%).

***3.3.2. Means of introduction***

Drawing lessons from previous experiences of the introduction of new vaccines, including PCV13 in 2011 and IPV in 2015, Benin has chosen national introduction across the country.

***3.2.4.*** ***Vaccination calendar***

The introduction of the MR vaccine will not change the vaccination calendar. It will be administered to children aged 9 months. Both antigens are combined in a single presentation. It is a freeze-dried vaccine presented in a 10-dose container.

Page

**Table VI: Vaccination schedule for infants in Benin**

|  |  |  |
| --- | --- | --- |
| **VACCINES** | | **AGE at administration** |
| BCG | OPV 0 | At birth |
| OPV 1 | Penta 1 (DTC-HepB-Hib1), PCV 13\_1 | At the sixth week |
| OPV 2 | Penta2 (DTC-HepB-Hib2), PCV 13\_2 | At the tenth week |
| OPV 3 | Penta 3 (DTC-HepB-Hib3), PCV13\_3 VPI | At the fourteenth week |
| **MR** | YF | At nine months |

The table below shows the doses, sites and administration

means for antigens on the vaccination schedule in force in Benin.

**Table VII:** **Doses, sites and means of administration for infant vaccines in Benin**

|  |  |  |  |
| --- | --- | --- | --- |
| **ANTIGENS** | **DOSES** | **SITES** | **MEANS OF ADMINISTRATION** |
| BCG | 0.05ml | External surface 1/3 upper left forearm | Intra dermal |
| OPV | Two drops | Mouth | Oral |
| Pentavalent  (DTC-HepB- Hib) | 0.5ml | Deltoid left arm | Deep intramuscular injection |
| IPV | 0.5ml | Anterior surface right thigh | Deep intramuscular injection |
| PCV13 | 0.5ml | Anterior surface left thigh | Deep intramuscular injection |
| **MR** | **0.5ml** | **Right arm** | **Subcutaneous** |
| YF | 0.5ml | Right thigh | Subcutaneous |

**IV. Strategies and fields of action**

###### 4.1. Vaccinations strategies

The WHO’s vaccine introduction guide recommends six strategies:

* Additional vaccination campaigns covering a broad range of ages
* The introduction of the vaccine containing the rubella valency in the systematic vaccination calendar for children aged 9 to 11 months
* Coordinating the monitoring of rubella and the monitoring of measles
* Additional vaccination follow-up activities with the related MR vaccine to maintain a high coverage rate (>95%)
* Fulfilment of immune deficits among the older population (subject aged more than 15 years, vaccination of women of child-bearing age in the context of systematic vaccination and vaccination of healthcare staff).
* Congenital rubella syndrome (CRS) monitoring

In accordance with the guide and with CNCV recommendations, Benin will implement the introduction of the vaccine containing the rubella valency by adopting four of these strategies, which are:

***Initial stage***: (i) Additional vaccination campaign for children aged 9 months to over 14 years followed by (ii) the introduction of the vaccine containing the rubella valency into the systematic vaccination calendar for children aged 9 to 11 months.

***Later stage***: (iii) supplementary vaccination follow-up activities with the related MR vaccine to maintain the high coverage rate (>95%) and (iv) Monitoring of congenital rubella syndrome (CRS).

* ***Catch up measles and rubella vaccination campaign***

This campaign is scheduled for November 2017. It targets children aged 9 months to over 14 years. It will take place over ten days across the entire national territory through fixed and advanced strategies. The implementation of this mass vaccination will be described in its action plan drawn up for this purpose.

* ***Introducing the measles and rubella into the routine EPI***

Following the catch up campaign, the MR vaccine will be integrated into systematic vaccination for children aged 9 months. The vaccination service will be rendered based upon usual vaccination strategies- i.e. fixed and advanced strategies.

* + The fixed strategy covers targets living in locations within a 5-Km radius of a vaccination point. This strategy will be used in both rural and urban areas.
  + The advanced strategy covers targets living in locations within a 5-Km to 15-Km radius around a vaccination point. The vaccination teams travel by motorbike.

In the course of micro-planning involving the community, appropriate strategies will be identified and implemented according to the specific characteristics of the populations and locations concerned, to take into account the aims of the 2011-2020 global plan for vaccination and vaccines 2011-2020.

The introduction of the combined Measles and Rubella vaccine is integrated within the global framework of input already effected to fight against diseases in children:

* Vaccination against pneumococcal infections and measles,
* The promotion of breastfeeding by mothers and hand washing,
* Vitamin A supplements,
* Disinfestation
* The promotion of essential family practices (EFP).

* + ***Additional vaccination follow-up activities with the related MR vaccine***

campaign Periodically, every 3 years, a mass measles and rubella vaccination campaign with the MR vaccine will be organised across the entire national territory in order to reduce the rate of vulnerable individuals and to maintain good immunity levels across the population.

* + ***Congenital rubella syndrome (CRS) monitoring***

In order to assess the impact of vaccination against rubella, the monitoring of congenital rubella syndrome will be established in Benin at the level of look-out sites which will have been selected for this purpose.

###### 4.2. Monitoring of Adverse Event Following Immunisation (AEFI)

The effective monitoring of the AEFI requires staff to be trained, monitoring and the researching of AEFI as well as systematic reporting.

Surveillance of AEFI is not yet systematic at the healthcare units level. Data transmission is the same as that of diseases with epidemic potential.

A policy/guidelines on conduct in the event of AEFI is available, but health workers are not always trained in these measures. A national committee of AEFI experts was established during the organisation of the meningitis A campaign (MenAfrivac) and continues to coordinate the case management of AEFI. Benin elaborated, thanks to the technical support and financial backing of the WHO, the monitoring manual of AEFI which has been approved and will be disseminated for implementation in 2017. Likewise, a new permanent AEFI experts committee will also be set up to manage reported cases.

The efficiency of AEFI monitoring will entail the training of service providers, the sharing of guidelines and various background materials, the integration of the AEFI supervision into other supervisory activities and the community’s involvement through relays.

According to the external EPI 2014 review, cases of AEFI were observed during the last six months in 15% of HCs. Registration of AEFI cases was regular in only 20% of cases.

###### 4.3. Capacity building

The training of healthcare professionals (vaccination staff) is a key stage in the introduction of new vaccines. It must be meticulously planned for and must be complete prior to the introduction of the MR vaccine. EPI guides and training material on measles which exist in Benin and in the regional office will be adapted for the purposes of staff training. Appropriate material will be produced to brief staff on the specific characteristics of the MR vaccine, as concerns the storage and the administration of the vaccine. Trainers will ensure that samples of the MR vaccine and other demonstration materials are available when running training, in order to familiarise staff with the use of this vaccine.

###### 4.4. Training supervision

In order to ensure the correct implementation of the MR vaccine, the frequency of supervisions on key player sites should be increased during the first three months following introduction, then once every three months according to the usual supervision schedule. To this end, the necessary funding will be made available.

The supervision process will include the following aspects: vaccination coverage, vaccination techniques, a reduction in loss rates, the safety of injections, and the monitoring of AEFI.

The monitoring of vaccination activities will take place as usual in the course of monthly meetings at municipal level, emphasising the analysis of the vaccination coverage for the various antigens, data on AEFI and the management of vaccine waste.

The revised specifications taking into account the MR vaccine will be used as a guide for the training and supervision of activities.

###### 4.5. Review of management tools and other EPI documents

The introduction of the MR vaccine will require a review of the EPI management tools/ supporting materials.

## 4.5. Logistics

### 4.5.1. Needs, Procurement and Distribution of the vaccine

#### 4.5.1.1. Requirements for vaccines and consumable supplies from 2017 to 2020

* ***For routine vaccination***

The needs were calculated thanks to the logistical planning tool using the following parameters:

* Average growth rate of 3.2% of the population for previous year.
* Each target will receive one MR dose; this is a freeze-dried vaccine in a 10-dose container to be re-assembled and to be used at least 6 hours after being opened.
* Loss rate: 25% for the vaccine and 10% for consumable supplies. Benin used the target population method to estimate vaccine and consumable supplies requirements.

Formula = TargetP x vcR x doseN x lossF

Targetpop = target population

VcR = vaccination coverage (objective)

doseN = number of doses lossF = loss factor

For the MR vaccine’s first year of introduction (2018) a back-up stock must be provided.

Taking into account vaccine needs for this year, the safety stock to be assembled must represent 25% of the requirement, i.e. 568 627 doses x 25% = 142 157 doses. Thus the total MR doses requirement in 2017 is 710 784 doses (568 627 + 142 157).

The MR and consumable supplies requirements are summarised in the table below:

**Table VIII :** Estimated need for MR vaccines and consumable supplies in Benin from 2018 to 2020

|  |  |  |  |
| --- | --- | --- | --- |
| **Vaccines and consumable supplies** | **2018** | **2019** | **2020** |
| **Target Population** | 506 963 | 525 822 | 545 383 |
| **MR (doses)** | 710 784 | 830 470 | 861 364 |
| **AB 0.5 ml Syringe** | 781 862 | 91 3517 | 947 501 |
| **SD 5 ml Syringe** | 78 186 | 91 352 | 94 750 |
| **Sharps boxes** | 9 461 | 11 054 | 11 465 |

* ***For the vaccination catch up campaign***

Benin used the target population method to estimate vaccine and consumable supplies requirements.

The needs were calculated thanks to the logistical planning tool using the following parameters:

* Average growth rate of 3.2% of the population for previous year.
* Each target will receive one MR dose; this is a freeze-dried vaccine in a 10-dose container to be re-assembled and to be used at least 6 hours after being opened.
* Loss rate: 10% for the vaccine and 10% for consumable supplies

Taking into account the vaccine requirement for this year, the total need for MR doses to implement the 2017 campaign is 5 719 237 doses.

**Table IX:** Estimated need for MR vaccines and consumable supplies in Benin for the 2017 mass campaign

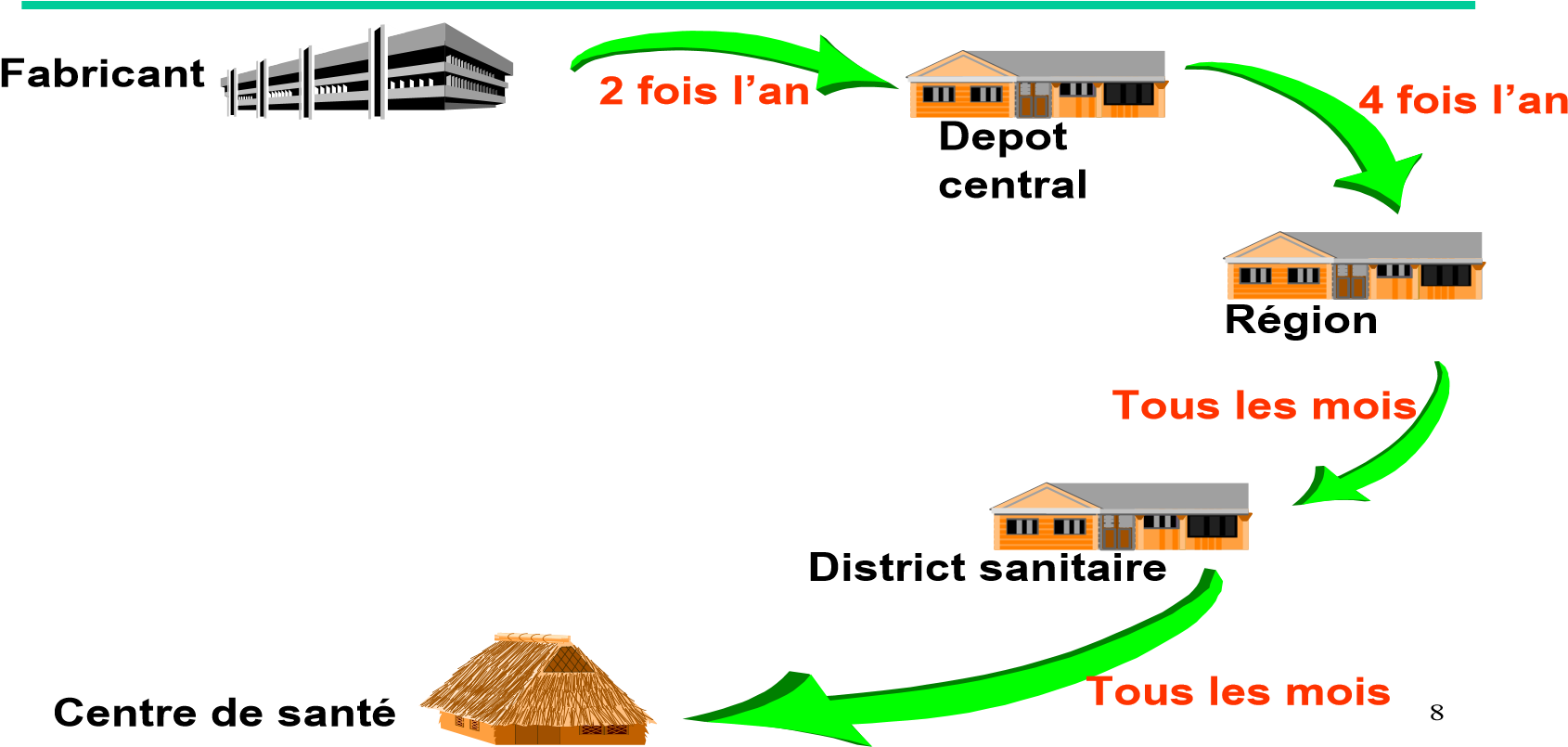
|  |  |
| --- | --- |
| **Vaccines and consumable supplies** | **2017** |
| **Target Population** | **5 152 466** |
| **MR (doses)** | **5 719 237** |
| **AB 0.5 ml Syringe** | **5 719 237** |
| **SD 5 ml Syringe** | **571 924** |
| **Sharps boxes** | **62 912** |

#### 4.5.1.2. Vaccine procurement and distribution

Yearly vaccine requirements have been estimated by the government with the technical support of UNICEF, which schedules orders according to its regular procurement mechanisms. Once delivered, the vaccines will be stored in the central cold room and distributed quarterly out to the departments. This mechanisms presents certain benefits, including the good quality of vaccines at the point of purchase, affordable prices thanks to the UNICEF order system, and brief delivery timeframes. UNICEF provides a remarkable contribution to the vaccines’ distribution and preservation mechanism.

The replenishment of vaccines from healthcare areas to healthcare centres has been planned for. The intermediary levels calculate their own needs based upon national guidelines and process requests at the level of the national level which supplies them. The replenishment schedule is monthly at the peripheral level and quarterly at the intermediary level. The central level is replenished on a bi-annual basis.

At the level of GAVI support, MR procurement as well as procurement of the injection material and sharps boxes must go through UNICEF procurement channels.



**Figure 6:** **Vaccine replenishment circuit**

### 4.5.2. Vaccines management and storage capacity

#### 4.5.2.1. Measles and Rubella Vaccine Procurement,

#### injection and safety material

The results of the vaccine management assessment at the point of the EPI external review, carried out in October 2014, show an overall score of 5 out of 5 points for the availability of vaccines at all levels of the healthcare pyramid.

As for the estimation of vaccine and materials needs, this is highly satisfactory at the central and intermediary levels, notably thanks to the use of the digitised stock management registry (SMT) at both levels. An annual projection of vaccine and injection materials needs is available. An adjustment of needs is made for each order.

At the operational level, the management of vaccines and consumable supplies is not digitised in any municipal storage facility. Stock is inventoried through a stock sheet, which is not, however, updated with each movement of stock. In most municipal storage facilities, thinner stock is not registered.

All storage facilities use the target population method to assess the need for consumable vaccines, but the calculation components are not always based upon factual data. The vaccine management score is 63%.

Notices are made available to healthcare centre agents, in order to help them make accurate estimates of the number of vaccines.

The logistical requirements of each Healthcare Centre have been estimated according to the target population (3.2%), the coverage rate set at **92%** for 2018 and a loss rate estimated at **25%** (loss factor **1.33**) by the EPI managers at each level of the pyramid. Each municipality is supplied in accordance with the micro-planning data.

#### 4.5.2.2. Vaccine storage capacity

The cold chain across the country comprises:

Storage capacity of central and intermediary facilities are presented as follows

**Table X: Storage capacity of central and intermediary facilities**

|  |  |  |
| --- | --- | --- |
| **Name of storage facility** | **from +2 °C to +8 °C** | **from -25 °C to -15 °C** |
| Cotonou/MS National | 27 000 litres | 6 700 litres |
| Atacora/Donga | 5 000 litres | 5 000litres |
| Borgou/Alibori | 13 428 litres | 5 000 litres |
| Zou/Collines | 5 000 litres | 5 000 litres |
| Mono/Couffo | 634 litres | 604 litres |
| Ouémé/Plateau | 12 400 litres | 943 litres |
| Atlantic/Littoral | 5 000 litres | 5 000 litres |

In total, for **2018**, **710 784** doses of measles and rubella Vaccine will be ordered. The cold room capacities at national level are sufficient for storage awaiting distribution towards departments.

Based upon the available storage capacities in the department seats and considering the other routine vaccines, it emerges that all departments have sufficient storage capacity (this is not an additional vaccine volume, the MR will take up the same space as the LMV).

The majority of municipalities have sufficient capacity to maintain the full vaccine requirements of their health areas and to freeze accumulators.

#### 4.5.2.3. Freezing plan for cold accumulators- before and during

#### the introduction

The routine EPI benefits from a cold accumulator freezing system. For the purposes of this introduction, the freezing of accumulators will adhere to the principles established.

In order for this task to be fulfilled, the maintenance follow-up for the functioning of the cold chain material remains an absolute necessity.

A 0.3 L accumulators inventory is requested at all levels in order to palliate shortcomings to allow for a sufficient stock to be available.

#### 4.5.2.4. Vaccine distribution, monitoring and safety plan

###### At department level

The storage facilities will receive the vaccines from the central level at a delivery frequency of 6 per year.

The follow-up and the monitoring of vaccine and consumable supply stocks are essential for the vaccination service quality. This is established through the digitised database called SMT. The quality of this follow up relies on a good system for the recording of input movements.

The recording process entails not only essential information on the exited inputs (quantities, batch, expiry date...), but specific details of beneficiaries/recipients (localisation, etc.).

###### At the peripheral level

The peripheral level comprises 85 EPI municipalities and 763 healthcare centres. Each municipal storage facility is equipped with multiple refrigerators and freezers while the healthcare centres generally only have one combined refrigerator and freezer unit. The municipalities (last distribution level) collect the vaccines from the department storage facilities and from the single regional storage facility/relay at least once a month (i.e. 12 collections per year). The healthcare centres (service dispensing point), in turn, collect vaccines from municipalities with the same frequency, i.e. 12 times a year. However, certain healthcare points, for a variety of reasons, are supplied either twice a month, either every 45 days.

The follow-up and the monitoring of vaccine and consumable supply stocks are essential for the vaccination service quality. This is carried out using stock sheets. As well as the departmental level, the quality of this follow-up rests on a good system to record the input movements. The recording process entails not only essential information on the exited inputs (quantities, batch, expiry date...), but specific details of beneficiaries/recipients (localisation, etc.).

Training is to be carried out to update healthcare staff, including newly recruited staff.

The vaccines are distributed as follows:

**Table XI: Distribution of number of MR doses per department as routine for 2018**

|  |  |
| --- | --- |
| **Departments** | **Doses** |
| ATACORA-DONGA | 98 332 |
| BORGOU-ALIBORI | 144 479 |
| ATLANTIC-LITTORAL | 1 395 556 |
| MONO-COUFFO | 88 256 |
| OUEME-PLATEAU | 120 913 |
| ZOU-COLLINES | 119 247 |
| **BENIN** | **710 784** |

The implementation of the vaccine and of the injection material is ensured according to the procedural flow from the national level down to the department level, by means of a refrigeration truck at least fifteen (15) days prior to the start of the introduction. The departments supply the municipalities which arrive via their means of transport eight days prior to the start of activity; to be supplied, the Healthcare Centers will travel to the municipalities three days prior to the launch.

#### 4.5.2.5. Cooler, vaccine container and accumulator needs

The healthcare units have the necessary coolers and vaccine holders necessary to effect the MR introduction. The coolers and vaccine holders which are out of order will systematically be replaced using the existing stock.

Measures will be taken at the municipal level to supply healthcare centres which do not have sufficient supplies.

#### 4.5.2.7. Monitoring of the vaccine preservation temperature

According to the results of the external 2014 EPI review, instruments for the continuous recording of temperature are available at each municipal facility. This constitutes a significant improvement, however, handlers do not always know how to use these correctly. However, at the point of the recent supply (in October 2016) of all HCs in new automatic recorders with support from UNICEF, healthcare personnel was briefed on the use of this equipment. Upcoming supervisions will allow for user competency and use of this tool to be followed up on.

#### 4.5.2.8. Monitoring of vaccine loss rates

The monitoring of vaccine loss rates is essential for the management of vaccines within the programme. Data on the loss of unopened containers are almost non-existent across all municipal facilities. The loss rate objectives are displayed in the departmental facilities and in the Healthcare Centres. In most cases, the stocks allocated for distribution are not counted as separated from the municipal healthcare centre stock. There is no recording of loss rates for unopened containers. Data on existing losses cover vaccination activity also offered by the healthcare centre. When the rates are calculated, they are not used to monitor the efficiency of the vaccine management.

Training healthcare areas’ EPI managers to use the DVD-MT tool will allow for the effective use of this tool for improved management and monitoring of EPI indicators, such are loss rates, as well as usage rates, availability rates and rates relating to vaccination coverage, among others.

#### 4.5.2.10. Injections safety

The safety of injections is one of the essential factors in ensuring the quality of vaccination services. The Benin EPI national policy declaration reasserts the fundamental need to guarantee the safety of injections through the use of sterile injection material and the safe destruction of the waste generated. Three key points are required to ensure the safety of injections:

* the use of sterile injection material
* adherence to risk-free injection practices  the safe destruction of waste.

The injection material for the vaccination activities is mostly made up of self-blocking syringes to administer injectable antigens, dilution syringes, sharps boxes to collect use syringes and cotton pads. The correct use of the injection material entails the availability of the material at all vaccination points, procurement in keeping with the vaccines, good vaccination practices, and the appropriate elimination of the injection material used.

#### 4.5.2.11. Distribution plan for the injection material

The analysis for the results of the external 2014 EPI review shows that **70%** of the workers involved in vaccination are trained on injection safety. Self-blocking syringes and sharps boxes are available at all levels of the healthcare pyramid.

The injection material is distributed as follows:

**Table XII: Distribution of injection equipment per department in 2018**

|  |  |  |  |
| --- | --- | --- | --- |
| **Departments** | **AB 0.5ml syringe** | **SD 5ml syringe** | **Sharps box** |
| ATACORA-DONGA | 108165 | 10816 | 1310 |
| BORGOU-ALIBORI | 158927 | 15893 | 1923 |
| ATLANTIC-LITTORAL | 153511 | 15351 | 1857 |
| MONO-COUFFO | 97083 | 9708 | 1175 |
| OUEME-PLATEAU | 133002 | 13299 | 1610 |
| ZOU-COLLINES | 131173 | 13117 | 1588 |
| **BENIN** | **781 862** | **78 186** | **9 461** |

In the context of the mass vaccination catch up campaign, vaccination and consumable supply needs are set out in the below tables:

**Table XIII: Distribution of the number of MR vaccine doses and consumable supplies per department for mass vaccination in 2017**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Departments** | **Total population 2017** | **Population aged 9 months to**  **14 years (30%)** | **Doses** | **AB 0.5ml syringe** | **SD 5ml syringe** | **Sharps box** |
| ATACORA | **886 188** | **425 016** | **471768** | **471768** | **47177** | **5189** |
| DONGA | **623 254** | **254 461** | **282452** | **282452** | **28245** | **3107** |
| ALIBORI | **995 434** | **494 831** | **549262** | **549262** | **54926** | **6042** |
| BORGOU | **1 393 379** | **672 722** | **746721** | **746721** | **74672** | **8214** |
| ATLANTIC | **1 604 500** | **703 252** | **780610** | **780610** | **78061** | **8587** |
| LITORAL | **779 182** | **249 495** | **276939** | **276939** | **27694** | **3046** |
| MONO | **570 598** | **257 796** | **286154** | **286154** | **28615** | **3148** |
| COUFFO | **855 281** | **430 292** | **477624** | **477624** | **47762** | **5254** |
| OUEME | **1 262 739** | **522 395** | **579858** | **579858** | **57986** | **6378** |
| PLATEAU | **714 186** | **318 527** | **353565** | **353565** | **35356** | **3889** |
| ZOU | **977 208** | **439 352** | **487681** | **487681** | **48768** | **5364** |
| COLLINES | **823 321** | **384 327** | **426603** | **426603** | **42660** | **4693** |
| **BENIN** | **11 485 270** | **5 142 503** | **5 911 307** | **6 502 243** | **650 244** | **76 680** |

**Table XIV: Distribution of the number of MR vaccine doses and consumable supplies per department for mass vaccination in 2020**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Departments** | **total population 2020** | **pop 9 to 59 months (14%)** | **Doses** | **Syringe**  **AB 0.5ml** | **SD 5ml syringe** | **Sharps box** |
| AtacoraDonga | 1654227 | 231592 | 292 616 | 244 214 | 29 262 | 2735 |
| Borgou-Alibori | 2617946 | 366512 | 463 088 | 386 487 | 46 309 | 4328 |
| Atlantic-  Littoral | 2612324 | 365725 | 462 094 | 385 657 | 46 209 | 4319 |
| Mono-Couffo | 1562648 | 218771 | 276 417 | 230 694 | 27 642 | 2583 |
| Oueme-  Plateau | 2166550 | 303317 | 383 241 | 319 848 | 38 324 | 3582 |
| Zou-Collines | 1973235 | 276253 | 349 046 | 291 309 | 34 905 | 3262 |
| **BENIN** | **12 586 929** | **1 762 170** | 2 226 502 | 1 858 208 | **222 650** | **20 809** |

#### 4.5.2.12. Use, handling and elimination of injection material

The review’s results on the use of the injection material show that self-blocking syringes and the practice of not recapping needles is observed in 96% of healthcare centres. In addition, during the vaccination sessions, the thinners were used at the correct temperature (between +2 and +8°c), the injections were prepared on a clean surface. However, it was noted that the reconstituted vaccine container was sometimes placed on the cold accumulator.

Staff’s awareness will be raised as to good practice in management vaccine during supervisions and training.

In several training sessions observed in the course of the review, it was noted that there were no soiled needles and syringes in the courtyard, no needles and syringes around the waste elimination site, and that waste was eliminated through incineration.

Numerous types of incinerators were noted in the field. Efforts have been made for the construction of incinerators in the healthcare centres to refurbish those not in working order. Meanwhile, the healthcare centres which to not have incinerators relay the sharps boxes to the municipalities for incineration. The same principles will be observed for all activities within the context of this introduction.

The below table presents the location of functional incinerators per department.

**Table XV: Incinerator points per department in 2016**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **DEPARTMENT** | **DHAB** | | **MONFORT** | | **FUNCTIONAL TOTAL** |
| **F** | **NF** | **F** | **NF** |
| Atacora/Donga | 2 | 0 | 17 | 37 | 19 |
| Atlantic/Littoral | 5 | 18 | 32 | 22 | 37 |
| Borgou/Alibori | 6 | 26 | 74 | 46 | 80 |
| Mono/Couffo | 0 | 7 | 58 | 23 | 58 |
| Ouémé/Plateau | 0 | 8 | 27 | 32 | 27 |
| Zou/Collines | 0 | 0 | 68 | 8 | 68 |
| **Total** | **13** | **59** | **276** | **168** | **289** |

**Source:** ANV-SSP 2016 Inventory, F= Functional; NF= Non-Functional

## 4.6. Information, Education and Communication (IEC)

The experience gathered following the introduction of new vaccines (pentavalent, PCV-13, VPI) showed the importance of communication in the MR introduction implementation process. Likewise, the strategies used in the context of the introduction of these vaccines will be leveraged and strengthened. This aspect of the EPI is crucial to retain parents’ interest, especially in a country like Benin where there is increasing evidence of reluctance following repeated vaccination campaigns. It is in this context that the global vaccine action plan (GVAP) adopted by the World Health Assembly in 2012, and the strategic global plan for the fight against measles and rubella

(2012-2020), published by the partners of the Initiative against measles and rubella (in 2012), defined stages to be reached progressively in order to eliminate rubella and congenital rubella syndrome by 2020.

For this reason, specific emphasis will be placed on interpersonal communication, which is a key strategy in reducing drop-out rates, especially since communication has been recognised by several assessments as a weak link in the EPI in Benin. Advocacy will be conducted with decision-makers and opinion leaders, health staff, and the general public, including parents, to secure their support and their involvement. Policy makers, EPI staff at all levels, medical staff at educational institutions, hospital staff, and even the national media, will need to be properly informed about MR.

# Role of CNCV-Bénin and the Inter-Agency Coordination Committee (ICC)

The National Consultative Committee for Vaccination and vaccines of Benin (CNCV-Benin) elaborated and submitted, to the Ministry of Health, in September 2016, its supported position on the introduction of the measles and rubella vaccine within the routine EPI. Experts have underlined the usefulness of replacing the measles vaccine by the Measles/Rubella vaccine, and have recommended the following measures:

To strengthen the epidemiological monitoring system for measles, by integrating the system for rubella and CRS, in order to gather useful information to monitor both these conditions.

To encourage the laboratories to systematically research the rubella IgCs in all samples taken from children affected by non-measles eruptive illnesses.

To introduce the MR vaccine into the systematic vaccination schedule for children immediately after an MR vaccination campaign covering a broad age spectrum.

The ICC-EPI’s role is, non-exhaustively, to support the establishment of EPI policy aims, to support the preparation of strategic plans, yearly EPI plans and the approval of certain submission documents (an introduction plan for new vaccines, data quality improvement plan...). The ICC’s role is also to mobilise necessary resources for the implementation of programme action plans, to regularly assess progress in the execution of the programmes, and to ensure the optimisation of the use of resources mobilised.

These ICC attributes now constitute a driving force for EPI Benin and will accompany/support the country in the introduction of the MR vaccine.

The ICC authorised the ANV-SSP, on 16 January 2017, to submit a request for the introduction of new vaccines, and approved this MR introduction plan, and will ensure its success.

# EPI financial perpetuation

Benin is firmly committed to funding vaccine costs (purchase of traditional vaccines and joint funding of new vaccines). Advocacy must continue in order for this effort to be maintained.

# Main stages of the MR vaccine’s introduction

The MR vaccine introduction process involves the following main stages:

* The planning of introductory activities (mass campaign, systematic vaccination, etc)
* The organisation and coordination process (ICC technical committee meetings and ICC meetings)
* Developing the communication plan
* The reinforcement of the capacity of the cold chain
* The reinforcement of laboratory network capacities
* The updating of monitoring guidelines on AEFI
* The production and dissemination of notices on EPI maintenance and the monitoring of temperatures
* Reviewing tools on AEFI monitoring
* Equipment maintenance
* Staff training
* Logistical organisation (establishment of vaccines and consumable supplies)
* The implementation of communication and advocacy activities
* The running of the measles and rubella vaccination campaign
* The introduction launch
* Supervision and monitoring
* Post-introduction assessment (12 months following introduction)
* Impact assessment

**Table XVI: SCHEDULE OF ACTIVITIES FOR THE MASS CAMPAIGN WITH MR**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Activities** | **2017** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **2018** | | | | | | | |
| **JANUARY** | | | | **FEBRUARY** | | | | **MARCH** | | | | **APRIL** | | | | **MAY** | | | | **JUNE** | | | | **JULY** | | | | **AUGUST** | | | | **SEPTEMBER** | | | | **OCTOBER** | | | **NOVEMBER** | | | | **DECEMBER** | | | | **JANUARY** | | | | **FEBRUARY** | | | |
| W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3    W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 |
| Action plan drafting |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Establishment of a National Organisational Committee for the campaign at the central level |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Preparatory meeting |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Meetings with the  Committee for  Campaign  Leadership |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Campaign Technical Committee Meetings |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Logistical plan: vaccines, inputs, waste management |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Consultants Recruitment |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Communication Plan |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Activities** | **2017** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **2018** | | | | | | |
| **JANUARY** | | | | **FEBRUARY** | | | | **MARCH** | | | | **APRIL** | | | | **MAY** | | | | **JUNE** | | | | **JULY** | | | | **AUGUST** | | | | **SEPTEMBER** | | | | **OCTOBER** | | | **NOVEMBER** | | | | | **DECEMBER** | | | | **JANUARY** | | | **FEBRUARY** | | | |
| W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3    W4 | W1 | W2 | | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3    W4 | W1 | | W2    W3 | W4 |
| Micro-planning |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  | |  |  |
| **Mobilisation of financial resources** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Submit requests to partners |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  | |  |  |
| Make partner funds available to the ANV |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  | |  |  |
| Make partner funds available to the DDSs |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  | |  |  |
| Make partner funds available to the ANV and DDSs |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  | |  |  |
| **Logistics** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Receive the consumable supplies (SAB, SD, BS) at the central level |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  | |  |  |
| Implement the  consumable supplies at the DDS level |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  | |  |  |

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| **Activities** | **2017** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **2018** | | | | | | | |
| **JANUARY** | | | | **FEBRUARY** | | | | **MARCH** | | | | **APRIL** | | | | **MAY** | | | | **JUNE** | | | | **JULY** | | | | **AUGUST** | | | | **SEPTEMBER** | | | | **OCTOBER** | | | | **NOVEMBER** | | | | **DECEMBER** | | | | **JANUARY** | | | | **FEBRUARY** | | | |
| W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W2  W1 | | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 |
| Implement the  consumable supplies at the Municipal level |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Receive the vaccines at the central  level |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Implement the vaccines at the DDS level |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Implement the vaccines at the municipal level |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Implement the vaccines at the HC level |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Reproduce all tools  (cards, sheets,  Modules,...) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Implement the tools at the DDS level |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Implement the  tools at the Municipal level |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Ensure tasks |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| **Activities** | **2017** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **2018** | | | | | | |
| **JANUARY** | | | | **FEBRUARY** | | | | **MARCH** | | | | **APRIL** | | | | **MAY** | | | | **JUNE** | | | | **JULY** | | | | **AUGUST** | | | | **SEPTEMBER** | | | | **OCTOBER** | | | **NOVEMBER** | | | | | **DECEMBER** | | | | **JANUARY** | | | **FEBRUARY** | | | |
| W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3    W4 | W1 | W2 | | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3    W4 | W1 | | W2    W3 | W4 |
| CC maintenance |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  | |  |  |
| Ensure the production and supply of frozen accumulators at all levels |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  | |  |  |
| Inventory mobile equipment  (motorbikes, vehicles), assess needs, if possible complete |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  | |  |  |
| Ensure the maintenance and the repair of motorbikes and vehicles for supervision |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  | |  |  |
| **Planning** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Finalise micro plans, taking into account  specifics |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  | |  |  |
| Proceed with the consolidation of the committee’s micro plans |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  | |  |  |

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| **Activities** | **2017** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **2018** | | | | | | | |
| **JANUARY** | | | | **FEBRUARY** | | | | **MARCH** | | | | **APRIL** | | | | **MAY** | | | | **JUNE** | | | | **JULY** | | | | **AUGUST** | | | | **SEPTEMBER** | | | | **OCTOBER** | | | **NOVEMBER** | | | | | **DECEMBER** | | | | **JANUARY** | | | **FEBRUARY** | | | | |
| W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3    W4 | W1 | W2 | | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3    W4 | W1 | W2    W3 | | W4 | |
| technical |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  | |  | |
| Campaign running |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  | |  | |
| **Communication/ Social mobilisation** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  | |
| Approve tools  for communication |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  | |  | |
| Produce mobilisation support materials (banner, tee-shirts, baseball caps, badges, notices, commercials) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  | |  | |
| Organise a briefing for journalists and radio hosts in all departments regarding the CAR |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  | |  | |
| Broadcast mass communication messages (Radio,  TV, SMS) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  | |
| Proceed with the campaign’s official launch |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  | |  | |

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| **Activities** | **2017** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **2018** | | | | | | | |
| **JANUARY** | | | | **FEBRUARY** | | | | **MARCH** | | | | **APRIL** | | | | **MAY** | | | | **JUNE** | | | | **JULY** | | | | **AUGUST** | | | | **SEPTEMBER** | | | | **OCTOBER** | | | **NOVEMBER** | | | | **DECEMBER** | | | | **JANUARY** | | | | **FEBRUARY** | | | |
| W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3    W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 |
| Carry out advocacy with the religious authorities at the national level for them to be involved in informing religious community members |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Carry out advocacy at the national level with schoolchildren’s parents’ associations to mobilise parents around the CAR |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Carry out advocacy with authorities and establish GSM networks  to send out messages, and the HAAC (Media authority) as well as other media directors |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| **Activities** | **2017** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **2018** | | | | | | | |
| **JANUARY** | | | | **FEBRUARY** | | | | **MARCH** | | | | **APRIL** | | | | **MAY** | | | | **JUNE** | | | | **JULY** | | | | **AUGUST** | | | | **SEPTEMBER** | | | | **OCTOBER** | | | **NOVEMBER** | | | | **DECEMBER** | | | | **JANUARY** | | | | **FEBRUARY** | | | |
| W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3    W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 |
| Organise awareness-raising for  parents on the measles campaign through children via information from the chiefs of the 85  school divisions and the heads of private and public establishments, as well as child-minders |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Organise sessions to inform students and teachers  in classrooms on the  CAMR in some large establishments in the department |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Organise information sessions with the parents’ Association |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| **Activities** | **2017** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **2018** | | | | | | | |
| **JANUARY** | | | | **FEBRUARY** | | | | **MARCH** | | | | **APRIL** | | | | **MAY** | | | | **JUNE** | | | | **JULY** | | | | **AUGUST** | | | | **SEPTEMBER** | | | | **OCTOBER** | | | **NOVEMBER** | | | | **DECEMBER** | | | | **JANUARY** | | | | **FEBRUARY** | | | |
| W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3    W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 |
| of students in public  establishments as well as  private establishments and with students |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Organise an orientation workshop for individuals involved in communication on the CAR |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Supervise communication activities run by community division chiefs (Management of Communication division chiefs in all 6 departments  (10days x 6 pers) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Provide support to  specific municipalities  for the implementation of people-led activities |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| **Activities** | **2017** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **2018** | | | | | | | |
| **JANUARY** | | | | **FEBRUARY** | | | | **MARCH** | | | | **APRIL** | | | | **MAY** | | | | **JUNE** | | | | **JULY** | | | | **AUGUST** | | | | **SEPTEMBER** | | | | **OCTOBER** | | | **NOVEMBER** | | | | **DECEMBER** | | | | **JANUARY** | | | | **FEBRUARY** | | | |
| W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3    W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 |
| resources (CRAMS, CPS) to support the organisation and the implementation of activities in specific municipalities with  low  LMV performance |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Organise an information day with local community representatives, religious and traditional leaders, under the leadership of the prefect, in each department |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Organise the briefing of town criers and village chiefs in the context of the CAR |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Disseminate messages through town criers |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| **Activities** | **2017** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **2018** | | | | | | | |
| **JANUARY** | | | | **FEBRUARY** | | | | **MARCH** | | | | **APRIL** | | | | **MAY** | | | | **JUNE** | | | | **JULY** | | | | **AUGUST** | | | | **SEPTEMBER** | | | | **OCTOBER** | | | **NOVEMBER** | | | | **DECEMBER** | | | | **JANUARY** | | | | **FEBRUARY** | | | |
| W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3    W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 |
| Organise information sessions with internal market managers, and women’s associations for the  mobilisation of  association  members, trading mothers and  users of markets [within] the  CAR. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Disseminate information in households through the relaying of  communities and members of  COGECs (municipal management committees) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Broadcast messages about the campaign in large markets and organise a special deployment of loudspeaker users |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| **Activities** | **2017** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **2018** | | | | | | |
| **JANUARY** | | | | **FEBRUARY** | | | | **MARCH** | | | | **APRIL** | | | | **MAY** | | | | **JUNE** | | | | **JULY** | | | | **AUGUST** | | | | **SEPTEMBER** | | | | **OCTOBER** | | | **NOVEMBER** | | | | | **DECEMBER** | | | | **JANUARY** | | | **FEBRUARY** | | | |
| W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3    W4 | W1 | W2 | | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3    W4 | W1 | | W2    W3 | W4 |
| in large markets depending on journeys made by the teams |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  | |  |  |
| Dissemination of messages during church and mosque ceremonies from the first Friday and the first Sunday in November |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  | |  |  |
| Organise the debriefing workshop with involved individuals at the end of the  MRAC campaign |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  | |  |  |
| **Training** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Carry out training for trainers  in healthcare areas and  Municipalities |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  | |  |  |
| Carry out training for vaccinators |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |
| Ensure supervision of  Trainings |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |

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| **Activities** | **2017** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **2018** | | | | | | |
| **JANUARY** | | | | **FEBRUARY** | | | | **MARCH** | | | | **APRIL** | | | | **MAY** | | | | **JUNE** | | | | **JULY** | | | | **AUGUST** | | | | **SEPTEMBER** | | | | **OCTOBER** | | | **NOVEMBER** | | | | | **DECEMBER** | | | | **JANUARY** | | | **FEBRUARY** | | | |
| W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3    W4 | W1 | W2 | | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3    W4 | W1 | | W2    W3 | W4 |
| **Follow up/Assessment** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Deploy national supervisors |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  | |  |  |
| Deploy departmental supervisors |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  | |  |  |
| Deploy municipal supervisors |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |
| Deploy  Consultants |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  | |  |  |
| Carry out rapid surveys as convenient during the campaign |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  | |  |  |
| Hold daily meetings to debrief supervisors |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  | |  |  |
| **AEFI Monitoring** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Identify one AEFI focus point per level |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  | |  |  |
| Identify structures to effect the management of serious AEFI per level |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  | |  |  |

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| **Activities** | **2017** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **2018** | | | | | | |
| **JANUARY** | | | | **FEBRUARY** | | | | **MARCH** | | | | **APRIL** | | | | **MAY** | | | | **JUNE** | | | | **JULY** | | | | **AUGUST** | | | | **SEPTEMBER** | | | | **OCTOBER** | | | **NOVEMBER** | | | | **DECEMBER** | | | | **JANUARY** | | | **FEBRUARY** | | | |
| W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3    W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3    W4 | W1 | | W2    W3 | W4 |
| Manage serious AEFI cases |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |
| **Campaign Assessment** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| RDT establishment of the post-campaign assessment |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |
| Recruit the independent structure appointed to conduct the assessment |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |
| Training trainers and surveyors |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |
| Training surveyors |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |
| data gathering |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |
| Process and analyse campaign assessment data |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |
| Draw up the campaign assessment report |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |
| Return results of the |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| **Activities** | **2017** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **2018** | | | | | | |
| **JANUARY** | | | | **FEBRUARY** | | | | **MARCH** | | | | **APRIL** | | | | **MAY** | | | | **JUNE** | | | | **JULY** | | | | **AUGUST** | | | | **SEPTEMBER** | | | | **OCTOBER** | | | **NOVEMBER** | | | | | **DECEMBER** | | | | **JANUARY** | | | **FEBRUARY** | | | |
| W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3    W4 | W1 | W2 | | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3    W4 | W1 | | W2    W3 | W4 |
| the assessment |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Coordination** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Establish the RDTs of the measles campaign for the coordination cells per level |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  | |  |  |
| Ensure that the  municipal microplans  include basic items (team circuits, specifics, etc), otherwise provide instructions for  this to be taken into account |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  | |  |  |
| Hold coordination Committee Meetings at least once a week every Monday |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |
| Hold sub-committee Meetings  Techniques  (Logistics,  Communication |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |

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| **Activities** | **2017** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **2018** | | | | | | | |
| **JANUARY** | | | | **FEBRUARY** | | | | **MARCH** | | | | **APRIL** | | | | **MAY** | | | | **JUNE** | | | | **JULY** | | | | **AUGUST** | | | | **SEPTEMBER** | | | | **OCTOBER** | | | **NOVEMBER** | | | | **DECEMBER** | | | | **JANUARY** | | | | **FEBRUARY** | | | |
| W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3    W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 |
| and AEFI management) at least once a week every  Friday |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Organise ICC meetings  on the follow-up on the  campaign |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Hold daily summary meetings at all levels |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Run overview meetings for the campaign at all levels |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Produce a letter  thanking all partners |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Publish a retrospective daily information bulletin at the central level |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Process, analyse and submit daily data for |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | ² |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| **Activities** | **2017** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **2018** | | | | | | |
| **JANUARY** | | | | **FEBRUARY** | | | | **MARCH** | | | | **APRIL** | | | | **MAY** | | | | **JUNE** | | | | **JULY** | | | | **AUGUST** | | | | **SEPTEMBER** | | | | **OCTOBER** | | | **NOVEMBER** | | | | **DECEMBER** | | | | **JANUARY** | | | **FEBRUARY** | | | |
| W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3    W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3    W4 | W1 | | W2    W3 | W4 |
| HZ towards the departments |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |
| Process, analyse and submit the daily DDS data towards the central level |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |
| Process, analyse  and share the  daily data from the central level with the partners |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |
| **Activities**  **Trans-border** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Direct correspondence to authorities in Togo and Burkina on synchronisation |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |
| Organise trans-border planning meetings and  harmonisation meetings between the DDS and |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |

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| **Activities** | **2017** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **2018** | | | | | | | |
| **JANUARY** | | | | **FEBRUARY** | | | | **MARCH** | | | | **APRIL** | | | | **MAY** | | | | **JUNE** | | | | **JULY** | | | | **AUGUST** | | | | **SEPTEMBER** | | | | **OCTOBER** | | | | **NOVEMBER** | | | | **DECEMBER** | | | | **JANUARY** | | | | **FEBRUARY** | | | |
| W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W2  W1 | | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 |
| Trans-border ZS |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Broadcast message along borders |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Implement the campaign along the borders |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Hold meetings for feedback and assessment of trans-border activities |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**Table XVII.** SCHEDULE FOR MR INTRODUCTION ACTIVITIES IN ROUTINE VACCINATION

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Activities** | **Month of the measles rubella vaccine introduction plan** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| **2017** | | | | | | | | | | | | **2018** | | | | | | | | | | | | **2019** | | | | | | | |  | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| Developing the plan for the introduction  and application  to GAVI : |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Submit the plan  for the introduction and application to GAVI |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Mobilise the financing guaranteed by GAVI and partners |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Draw up the procedures necessary for implementation |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Review and broadcast technical and guidance documents on the measles-rubella vaccine |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Draw up a communication plan |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Adapt communication support materials |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Organise advocacy and awareness-raising meetings with all individuals involved |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Ensure media coverage of the introduction of the measles-rubella vaccine |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| **Activities** | **Month of the measles rubella vaccine introduction plan** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **2017** | | | | | | | | | | | | **2018** | | | | | | | | | | | | **2019** | | | | | | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| Organise an information and awareness raising meeting for written press and broadcast journalists |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Organise the official launch of the measles-rubella vaccine introduction at the national scale |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Organise routine vaccination incorporating the measles rubella vaccine |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Confirm the storage space necessary in the cold rooms at the healthcare centre level |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Receive and store vaccines and consumable supplies |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Mobilise additional financial resources at the local level |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Allocate financial resources to the departments and healthcare areas to introduce the measles-rubella vaccine |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| **Activities** | **Month of the measles rubella vaccine introduction plan** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **2017** | | | | | | | | | | | | **2018** | | | | | | | | | | | | **2019** | | | | | | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| Organise trainings for the EPI managers and healthcare providers at all levels |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Supply DDS, municipalities and  healthcare centers in vaccines and consumable supplies |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Organise the follow up and management of AEFI cases within the introduction of the measles-rubella vaccine |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Ensure waste management |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Organise a post-introduction assessment for the measles-rubella vaccine |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Organise pre-introductory supervision visits in the municipalities and healthcare centres (state of stock-taking) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Establish surveillance of congenital rubella syndrome in look-out sites |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Activities** | **Month of the measles rubella vaccine introduction plan** | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | | |  | | | |
| **2017** | | | | | | | | | | | | **2018** | | | | | | | | | | | |  | | | |  | **2019** | | |  | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| Organise supervision visits in the municipalities and healthcare centres (stock-taking) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Collect, analyse and disseminate, on a monthly basis, data on the measles-rubella vaccine |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Submit a financial report to GAVI |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Submit a phase report to GAVI |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**Table XIX.** SCHEDULE OF ACTIVITIES TO ELIMINATE MEASLES AND RUBELLA FROM 2017 TO 2021

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **ACTIVITES** | **2017** | | | | **2018** | | |  |  | **2019** | |  |  | **2020** | |  |  | **2021** | |  |
| **T1** | **T2** | **T3** | **T4** | **T1** | **T2** | **T3** | **T4** | **T1** | **T2** | **T3** | **T4** | **T1** | **T2** | **T3** | **T4** | **T1** | **T2** | **T3** | **T4** |
| **I** | **Mobilisation of partners and coordination of involvement** | | | | | | | |  | |  | |  |  |  | |  |  |  | |  |
|  | Organise regular follow-up meetings on the implementation of activities |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Hold quarterly ICC meetings to deliberate on NCO proposals  for the fight against measles |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **II** | **Advocacy for resource mobilisation** | | | | | | | |  | |  | |  |  |  | |  |  |  | |  |
|  | Carry out advocacy communications with on-site companies to mobilise resources (GSM, SOBEBRA, FIFA, ADORO, etc.) to contribute to resource mobilisation |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **III.** | **Make the vaccine available** | | | | | | | |  | |  | |  |  |  | |  |  |  | |  |
|  | Purchase the vaccine for routine vaccination |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Purchase the vaccine for the mass campaigns |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **IV** | **Introduce the Measles/Rubella vaccine in the routine EPI** | | | | | | | |  | |  | |  |  |  | |  |  |  | |  |
|  | Draw up submissions to GAVI |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Draw up the introductory plan for the MR vaccine |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Implement the activities planned within the introduction plan for the MR vaccine |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Carry out the assessment to follow the introduction of the MR vaccine |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **V** | **Ensure the monitoring of Congenital rubella syndrome (CRS)** | | | | | | | |  | |  | |  |  |  | |  |  |  | |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **ACTIVITES** | | **2017** | | | | **2018** | | | | **2019** | | | | **2020** | | | | **2021** | | | |
| **T1** | **T2** | **T3** | **T4** | **T1** | **T2** | **T3** | **T4** | **T1** | **T2** | **T3** | **T4** | **T1** | **T2** | **T3** | **T4** | **T1** | **T2** | **T3** | **T4** |
|  | Organise a reflective meeting on the implementation of look-out sites to monitor rubella |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Establish a protocol to monitor CRS |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Establish training tools and reporting support materials |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Train all involved individuals on the monitoring of CRS |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Ensure that the collection and transportation of samples for biological testing are adequate |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Keep CRS monitoring database up-to-date |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Audit monitoring results and data quality |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Liaise with laboratory activity to ensure the cross-referencing of biological and epidemiological data |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Share results of the CRS monitoring process with healthcare personnel, healthcare establishments and related public health authorities |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **VI.** | **Capacity building** | | | | | | | | | | | | | | | | | | | | |
|  | Train 150 new agents on monitoring and EPI |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Organise two training supervisory sessions at the national level for ESC managers |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **ACTIVITES** | | **2017** | | | | **2018** | | | | **2019** | | | | **2020** | | | | **2021** | | | |
| **T1** | **T2** | **T3** | **T4** | **T1** | **T2** | **T3** | **T4** | **T1** | **T2** | **T3** | **T4** | **T1** | **T2** | **T3** | **T4** | **T1** | **T2** | **T3** | **T4** |
|  | Organise awareness raising meetings for practitioners to detect and report on cases |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **VII** | **Improve upon the quality of monitoring** | | | | | | | | | | | | | | | | | | | | |
|  | Establish/Update the list of priority sites for active monitoring |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Run quarterly active research trips in priority sites |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Display, in all surgeries and public and private healthcare structures, action to be taken in the event of any suspected case of measles and in the case of a suspected measles epidemic. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Investigate measles and rubella  epidemics |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Ensure the transportation of samples for suspected cases to the designated national Laboratory |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Print case reporting forms |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Ensure the laboratory’s supply of small materials and consumable supplies |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Organise two meetings to follow up on performance indicators |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Organise monthly meetings to approve surveillance data |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Source technical material for the laboratory |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **ACTIVITES** | | **2017** | | | | **2018** | | | |  | **2019** | |  |  | **2020** | |  |  | **2021** | |  |
| **T1** | **T2** | **T3** | **T4** | **T1** | **T2** | **T3** | **T4** | **T1** | **T2** | **T3** | **T4** | **T1** | **T2** | **T3** | **T4** | **T1** | **T2** | **T3** | **T4** |
|  | Source IT equipment for data management (department-level epidemiological monitoring centers and areas) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Retrospective information bulletins |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **VIII :** | **Improvement of vaccination coverage** | | | | | | | | | |  | |  |  |  | |  |  |  | |  |
|  | Implementation of ACD |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Monthly analysis of performance at each level identifying low-coverage areas |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Regular catch-up sessions (at the end of each quarter) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Hosting of special vaccination days (African Vaccination Week, Children’s health days, etc) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **IX** | **Improvement of data quality and vaccination follow up** | | | | | | | | | |  | |  |  |  | |  |  |  | |  |
|  | Assess the quality of data using the DQS tool twice a year in each area. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Carry out vaccination coverage surveys at national level every 3 to 5 years |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **X** | **Second opportunity for vaccination against measles/rubella (campaign)** | | | | | | | | | |  | |  |  |  | |  |  |  | |  |
|  | Vaccines |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Need for risk-free injections |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Means of eliminating injection material |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Vaccination safety (monitoring AEFI, injection safety, etc) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **ACTIVITES** | | **2017** | | | | **2018** | | | | **2019** | | | | **2020** | | |  |  | **2021** | |  |
| **T1** | **T2** | **T3** | **T4** | **T1** | **T2** | **T3** | **T4** | **T1** | **T2** | **T3** | **T4** | **T1** | **T2** | **T3** | **T4** | **T1** | **T2** | **T3** | **T4** |
|  | Transport |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Scheduling and training |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Social mobilisation |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Personnel |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Assessment of the process immediately after the campaign |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **XI** | **Second opportunity for vaccination against measles/rubella (introduce a second MR dose in the routine)** | | | | | | | | | | | | | | | |  |  |  | |  |
|  | Introduce a second VAR dose into the routine |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Prepare for submission to GAVI |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Contribute to funding the purchasing of the vaccine and injection materials) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **XII** | **Assessment follow up on the elimination of measles strategy** | | | | | | | | | | | | | | | |  |  |  | |  |
|  | Conduct operational research on measles elimination strategies |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **XIII** | **Supplementary vaccination campaigns** | | | | | | | | | | | | | | | |  |  |  | |  |
|  | Run mass campaigns against measles and rubella |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**Table XX :** **BUDGET FOR MASS CAMPAIGN WITH MR VACCINE IN 2017**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  | **Government support** | **Support from partners\*** | | **Existing funding from**  **GAVI** | **GAVI VIS**  **requested** |
|  | **Cost category** | **TOTAL COST** | **Amount** | **Name** | **Amount** | **Amount** | **Amount requested** |
| **USD** | **USD** | **USD** | **USD** | **USD** |
| **1** | **Programme management and coordination** | 18 000 | 0 |  | 0 | 0 | 18 000 |
| **2** | **Planning and preparation** | 132 563 | 0 |  | 0 | 0 | 132 563 |
| **3** | **Social mobilisation, CEI, and supporting arguments** | 131 182 | 0 |  | 0 | 0 | 131 182 |
| **4** | **Other training and meetings** | 76 030 | 0 |  | 0 | 0 | 76 030 |
| **5** | **Document production** | 35 804 | 0 |  | 0 | 0 | 35 804 |
| **6** | **Human resources and incentives** | 202 026 | 0 |  | 0 | 0 | 202 026 |
| **7** | **Cold chain equipment repair** | - | 0 |  | 0 | 0 | - |
| **8** | **Transport for implementation and supervision** | 78 144 | 0 |  | 0 | 0 | 78 144 |
| **9** | **Immunisation session supplies** | 5 850 796 | 0 |  | 0 | 0 | 1 992 452 |
| **10** | **Waste management** | 501 691 | 0 |  | 0 | 0 | 501 691 |
| **11** | **Monitoring and follow up/ Rota monitoring and AEFI** | 45 214 | 0 |  | 0 | 0 | 45 214 |
| **12** | **Assessment** | 89 286 | 0 |  | 0 | 0 | 89 286 |
| **13** | **Technical assistance** | 32 143 | 0 |  | 0 | 0 | 32 143 |
| **14** | **Data management** | 1 607 | 0 |  | 0 | 0 | 1 607 |
| **15** | **Other (please specify)** | 12 962 | 0 |  | 0 | 0 | 12 962 |
|  | **Total** | **7 207 446** | **0** |  | **0** | 0 | **3 349 103** |

NB: the gap between overall costs and GAVI funding will be covered by the government and the other partners.

**VIII. BUDGET FOR THE INTRODUCTION OF THE MR VACCINE INTO ROUTING VACCINATION IN 2018**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  | **Government support** | **Support from partners\*** | | **Existing funding from Gavi** | **GAVI VIS**  **requested** |
|  | **Cost category** | **TOTAL COST** | **Amount** | **Name** | **Amount** | **Amount** | **Amount requested** |
| **USD** | **USD** | **USD** | **USD** | **USD** |
| **1** | **Programme management and coordination** | 79 464 | 62 016 |  | 0 | 0 | 17 448 |
| **2** | **Planning and preparation** | 4 040 | 0 |  | 0 | 0 | 4 040 |
| **3** | **Social mobilisation, CEI, and supporting arguments** | 65 446 | 0 |  | 20 741 | 0 | 44 705 |
| **4** | **Other training and meetings** | 86 291 | 0 |  | 0 | 0 | 86 291 |
| **5** | **Document production** | 11 305 | 0 |  | 0 | 0 | 11 305 |
| **6** | **Human resources and incentives** | 0 | 0 |  | 0 | 0 | 0 |
| **7** | **Cold chain equipment repair** | 0 | 0 |  | 0 | 0 | 0 |
| **8** | **Transport for implementation and supervision** | 28 266 | 28 266 |  | 0 | 0 | 0 |
| **9** | **Immunisation session supplies** | 0 | 0 |  | 0 | 0 | 0 |
| **10** | **Waste management** | 91 758 | 0 |  | 0 | 0 | 91 758 |
| **11** | **Monitoring and follow up/ Rota monitoring and AEFI** | 82 829 | 0 |  | 73 901 | 0 | 0 |
| **12** | **Assessment** | 56 445 | 0 |  | 0 | 0 | 56 445 |
| **13** | **Technical assistance** | 0 | 0 |  | 0 | 0 | 0 |
| **14** | **Data management** | 0 | 0 |  | 0 | 0 | 0 |
| **15** | **Other (please specify)** | 0 | 0 |  | 0 | 0 | 0 |
|  | **Total** | **50 5845** | **90 282** |  | **94 642** | 0 | **311 992** |

1. Population projection based upon RGPH-4, INSAE, 2014 data. [↑](#footnote-ref-1)
2. National Geographical Institute, 1998 estimate. [↑](#footnote-ref-2)
3. Population projection based upon RGPH-4, INSAE, 2014 data. [↑](#footnote-ref-3)
4. **RGPH-4, 2013** [↑](#footnote-ref-4)
5. EDS4, 2012-2013 [↑](#footnote-ref-5)
6. Law on the creation, organisation, attribution and functioning of administrative and local units in the Republic of Benin [↑](#footnote-ref-6)
7. Income classification by country, International Monetary Fund, Nominal GDP by country 2014 [↑](#footnote-ref-7)
8. http // www.journaldunet.com [↑](#footnote-ref-8)
9. External EPI 2014 review. [↑](#footnote-ref-9)
10. **Tohon M. U. Houngbadji S. S**. Seroprevalence of antibodies in a population of pregnant women in Cotonou. 2004. [↑](#footnote-ref-10)
11. **WHO,** PFA-integrated monitoring quarterly report, measles, TNT, yellow fever. 2015 [↑](#footnote-ref-11)