Gavi 2020 multi-stakeholder dialogue in Sudan: immunisation planning in light of COVID-19

Introduction

2020 has been marked by the unprecedented crisis caused by COVID-19. Though the longer-term trajectory of the pandemic remains uncertain, evidence shows that immunisation services in Gavi-supported countries have been disrupted. Millions of people are expected to miss out on immunisation, likely leading to a resurgence of VPDs, further exacerbating existing inequities and putting the most marginalised and poorest communities at greater risk. Gavi-supported countries have already had the opportunity to re-allocate or re-programme[1] existing HSS and TCA support to respond to immediate needs presented by the COVID-19 pandemic. The Gavi Alliance is fully committed to assisting countries to restore immunisation services that have been scaled-back, brought off-track or otherwise affected during the pandemic response.

As an alliance, multi-stakeholder engagement remains key to Gavi's portfolio management approach. It is particularly critical in 2020 as a forum for engagement on how the Gavi Alliance partners and other stakeholders can support countries as they deal with the different phases of the COVID-19 pandemic and seek to maintain and restore primary health care, including immunisation services that have been disrupted. Civil society organisations (CSOs), in particular, will have a vital role to play in engaging communities to rebuild trust and demand, deliver services where there are gaps in government provision and in overcoming gender-related barriers.

Recognising the difficult operating environment and the rapidly evolving landscape currently faced by countries, and to ensure that Gavi's continuing support to the EPI programme is aligned with realities, countries are not requested to conduct a traditional Joint Appraisal in 2020. However, countries are encouraged to sustain the multi-stakeholder dialogue. This dialogue should review the immunisation programme performance in 2019, the impact of the COVID-19 pandemic on immunisation, discuss the needs for maintaining and restoring immunisation services in the context of primary health care, plan for short-term catch-up activities and, where needed, create a roadmap for further re-allocation/planning within the country's recovery plan.

The 2020 multi-stakeholder dialogue exercise

This 2020 multi-stakeholder dialogue exercise will be tailored to the country context, taking into account current constraints in terms of travel, meetings, and workload. The process will involve preparatory work on data for the review, potentially multiple exchanges with at least one event for live discussion (likely a virtual meeting), concluding with the finalisation of a report and relevant additional documents (e.g., workplan and budget for short-term response/recovery activities, roadmap for further planning). The process should be inclusive and transparent, with meaningful engagement of partners and civil society.

The 2020 multi-stakeholder dialogue report is structured as follows

- Section 1: Country situation: overview of performance of vaccine support, HSS grant implementation, PEF-TCA and other Gavi support, up to end of 2019/early 2020; pre-COVID-19.
- Section 2: Update on impact of COVID-19 immunisation service delivery and immunisation coverage (in 2020) and status of the implementation of the COVID-19 recovery plan (if relevant).
- Section 3: Discussion on priorities, immediate catch-up needs, related action plan, estimated budget and technical assistance needs. Roadmap for further analysis and re-allocation/planning in the context of the country health sector recovery plan.

Much of the information contained in sections 1 and 2 on the country immunisation programme and Gavi support is pre-filled by Gavi from existing documents and completed by the country. These form the basis for the multi-stakeholder dialogue. Section 3 focuses on a concise overview of Gavi's

[1] This document refers generally to the reallocation of Gavi support. Changes might also be categorized as reprogramming which is used for more significant modifications and may require to be reviewed by the Independent Review Committee.

potential contribution to maintaining and restoring essential services, with focus on immunisation, and short-term catch-up needs and further planning. It is to be tailored to the country context.

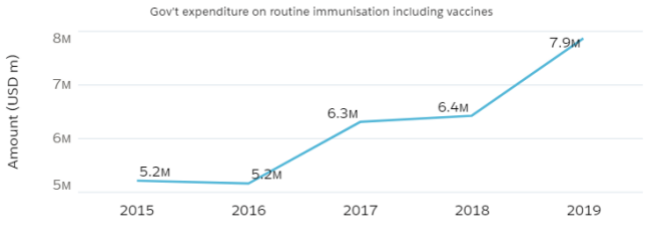
1. Sudan Country situation pre-COVID-19, based on information received by Gavi

Contextual Information

PEF Tier: Tier 3	Fragility Status: Fragile	2. Preparatory transition

Indicator Name	Year	Source	Value
GNI per capita	2019	World Bank	590
Health Centres per 100k population	2013	WHO - GHO	3.7
Nurses/Midwives per 1000 population	2017	WHO - GHO	7
Population	2020	UNPD	43,849,269
Surviving Infants	2020	UNPD	1,327,273
Under-5 mortality (per 1000)	2018	UNICEF	60

Health financing (and trends)



1.1. Overview of performance of vaccine support (end of 2019/early 2020; pre-COVID-19)

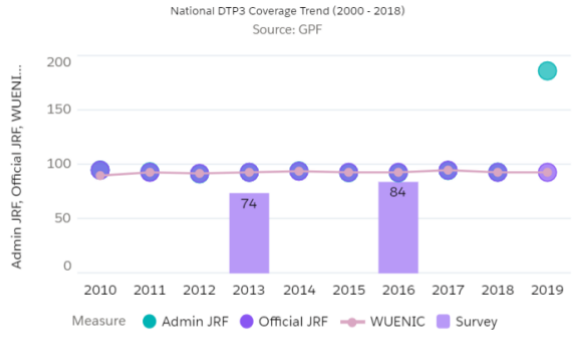
Vaccine	Introduction Date	2017 Coverage (%)	2018 Coverage (%)	2019 Target
PENTA	01-2007	95	93	94
ROTA	07-2011	95	94	94
PNEUMO	08-2013	95	93	94
IPV	05-2015	-	84	94
MENA	07-2016	82	84.1	94

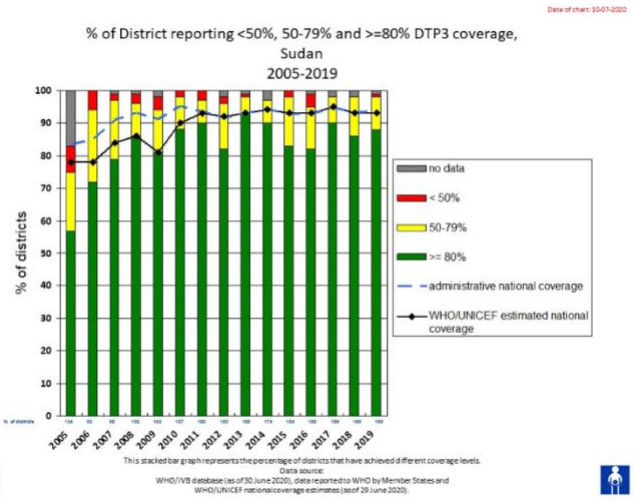
Vaccine Name	Type	Sub-Type	Status	CP Date ↑	Phase
YF	Routine	-	Approved	2020-07-30	NA
IPV	Campaign	Catch-up	Approved	2020-09-15	NA
MR	Campaign	Catch-up	Forecasted	2021-12-31	NA
MR	Routine	1st D	Forecasted	2022-12-31	NA
HPV	Routine	-	Forecasted	2028-11-30	NA
HPV	Campaign	MAC	Forecasted	2028-11-30	NA

Performance against Alliance KPIs

Indicator	Source Name	Year	Value	Previous Value	Trend
Measles containing vaccine (second dose) coverage at the national level (MCV2)	WUENIC	2019	74	72	▲
Pentavalent 3 coverage at the national level (Penta 3)	WUENIC	2019	93	93	→
Drop-out rate between Penta1 and Penta3	WUENIC	2019	4.1	4.1	→
Difference in Penta3 coverage between children of urban and rural residences	Survey	2019	0	0	→
Difference in Penta3 coverage between the highest and lowest wealth quintiles	Survey	2019	0	0	→
Penta3 coverage difference between the children of educated and uneducated mothers/care-takers	Survey	2019	0	0	→
EVM	EVM	2016	91.3	78.2	▲
# of Underimmunised Children	Calculated	2019	90945.26	89656.98	▼

Trends and district equity





Progress against indicators and targets achievement

Vaccine Programme	Source (2019)	Intermediate results Indicator	Reported actuals	Rel. % change
PNEUMO	Admin (JRF)	Number of surviving infants who received the first recommended dose of PCV vaccine (PCV1)	1,629,262	4%
	Admin (JRF)	Number of surviving infants who received the third recommended dose of PCV vaccine (PCV3)	1,517,919	3%
PENTA	Admin (JRF)	Number of surviving infants who received the first recommended dose of pentavalent vaccine (Penta1)	1,629,570	4%
	Admin (JRF)	Number of surviving infants who received the third recommended dose of pentavalent vaccine (Penta3)	1,527,814	3%
MCV	Admin (JRF)	Number of surviving infants who received the first recommended dose of measles containing vaccine (MCV1)	1,465,532	5%
IPV	Admin (JRF)	Number of surviving infants who received the first recommended dose of IPV	1,483,188	11%
All others	EVMA Reports	Effective Vaccine Management Score (composite score)	NA	NA
	JRF	Occurrence of stock-out at national or district level for any Gavi-supported vaccine	NA	NA
	Admin (JRF) & Survey	Percentage point difference between Penta 3 national administrative coverage and survey point estimate	NA	NA

Relative % change refers to the percentage increase/decrease of the reported value from the year prior.
The cell is green when the relative change increased, yellow when it remained the same and red when the relative change decreased.

1.2. Overview of Sudan HSS grant implementation (end of 2019/early 2020; pre-COVID-19)

HSS implementation summary (as of 31 December 2019)

Recipient	Grant Amount	Funds Disbursed	Expenditure	Country cash balance
MoH	33,231,766	14,900,563	Financial report being finalized	Pending
Total	33,231,766	14,900,563		

HSS key milestones achieved in 2019

	Process Indicators			Intermediate Results		
	Indicator name	Value	Rel. % change	Indicator name	Value	Rel. % change
OBJ-1	Percent of health facilities that conducted at least 12 home visits in the last year	73	↓, -24%	Number of states with at least 90% functional cold chain equipment at all levels	7	--, 0%
	Percent of planned outreach sessions conducted out of the planned outreach sessions	90	--, 0%	Percent of PHC facilities providing the essential package of services including immunisation	NA	NA
	Percent of targeted health workforce who received training according to the standards	100	↑, 39%	Percent of vaccinated children with DTP3 through fixed immunisation services	53	--, 0%
OBJ-2				Percent of health facilities that submit complete EPI reports according to standards	100	--, 0%
				Percent of health facilities that submit EPI reports in time according to standards	90	↓, -4%
				Percent of Primary Health Care facilities submitting regular integrated reports according to standards	61	↓, -1%
OBJ-4	Percent of integrated supervisory visits conducted by state to the locality level out of the planned number of supervisory visits	0	↓, -100%	Percent of states implementing the revised organizational structure	62	↓, -25%
	Percent of localities with functional health management teams	40	↓, -45%			
OBJ-NA				Percent of underserved/disadvantaged population covered by DTP3	74	↑, 42%

Relative % change refers to the percentage increase/decrease of the reported value from the year prior.
Value cell color is green if target has been >= 90% met, yellow if 70-90% met, and red < 70% met. There is no color when no target is set in GPF.

1.3. Overview of other Gavi support, such as VIGs, OPS, PBF, switch grants, transition grants etc. (as applicable)

				In US$				
	Start Date	End Date	Recipient	Grant Value	Disbursed	Expenditure	Cash balance	Status Update
IPV c-u SIA	Aug 2020	To be completed	WHO	819,789	819,789	**	**	Campaign to be completed as yet
			UNICEF	419,653	419,653	**	**	
PBF3			FMoH	1,584,000	0	0	0	Diverted for GFA contract
Total				2,823,442	1,239,442			

** To be reported on as campaign is not terminated as yet.

1.4. Compliance, absorption and other fiduciary risk matters

- Comments on financial absorption:
  As shown in section 1.2 above, there has been low absorption of the HSS2 grant due to various implementation challenges including but not limited to unstable political environment, economic downturn, and high turnover in key positions involved in implementation of Gavi grant. To accelerate implementation, a reprogramming of activities was undertaken (late 2019/early 2020) and the grant has been extended to 30 June 2021. The covid-19 pandemic that started in early 2020 led to further delays in implementation.

  In January 2021, Gavi put a temporary freeze on spending due to end of TA contract for the finance staff assuming roles of the finance manager that followed by a lengthy recruitment and Gavi approval processes. The Gavi No-Objection was obtained for 6-month contract with 3 months' probation period. This freeze had impacted the grant implementation at a critical time as it is approaching its end by June 2021, however, a slighter risk mitigation measure could have put in place given the presence and engagement of the Fiduciary Agent with the Gavi operation at country level.

- Compliance with financial reporting requirements (periodic/annual financial reports, audits):
  Financial reports are submitted on an annual basis but there have been challenges with timely reporting. The fiduciary agent-GFA contracted by Gavi intended to support the PMU in the preparation and submission of accurate and timely financial reports to Gavi and National Audit Chamber-NAC. Some of these challenges were not resolved as it affected reports timely submission to Gavi.

  Audits for the grant managed by the PMU are conducted on an annual basis and currently by the National Chamber of Auditors (NAC). The audit report is due 6 months after year end. The audit for the year ended 31 December 2019 is underway and the report is expected soon. The audit for the year ended 31 December 2020 may be conducted by an independent audit firm, yet, in advance communication on this regard with the country is to be.

- Compliance with programmatic reporting requirements (GPF):
  To date, country does not have direct access to Gavi Country Portal. As such, GPF in Excel sheet format has been shared for update to HSS indicators and It is a longstanding issue related to PMU inaccessibility, which is affecting its operation, including submissions and M&E. Accordingly, the HSS indicators are updated either by in country partners directly to the country portal or communicated to Gavi Secretariat by MOH using the previously shared Excel sheet for inputs to the GPF.

- Other financial management and fiduciary risk comments:
  A Programme Capacity Assessment for Sudan was conducted in October 2018, and resulting Grant Management Requirements (GMRs) agreed in April 2019. Some of the key recommendations of the PCA on financial management and fiduciary risk management were the merger of both the Gavi and the Global Fund PMUs, extending the contract of the fiduciary agent to include the Gavi PMU and for procurement to be carried out by UNICEF as an interim arrangement. The fiduciary agent has been contracted for the Gavi PMU since November 2019 to pursue its role in financial risk mitigation and

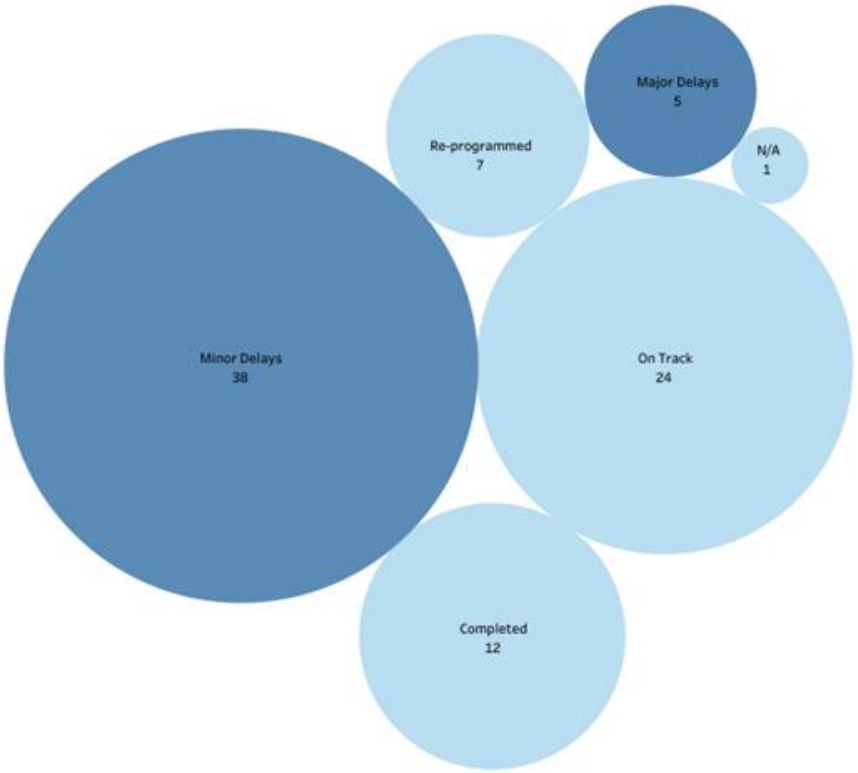
Financial capacity building. The fiduciary Agent contract is covered from the approved PBF3 fund diverted to cover this cost.
An international consultant and national consultant had conducted an assessment and a draft report shared and discussed with relevant stakeholders, where options as well as a 12-month roadmap for merger provided. The final report is due submission.

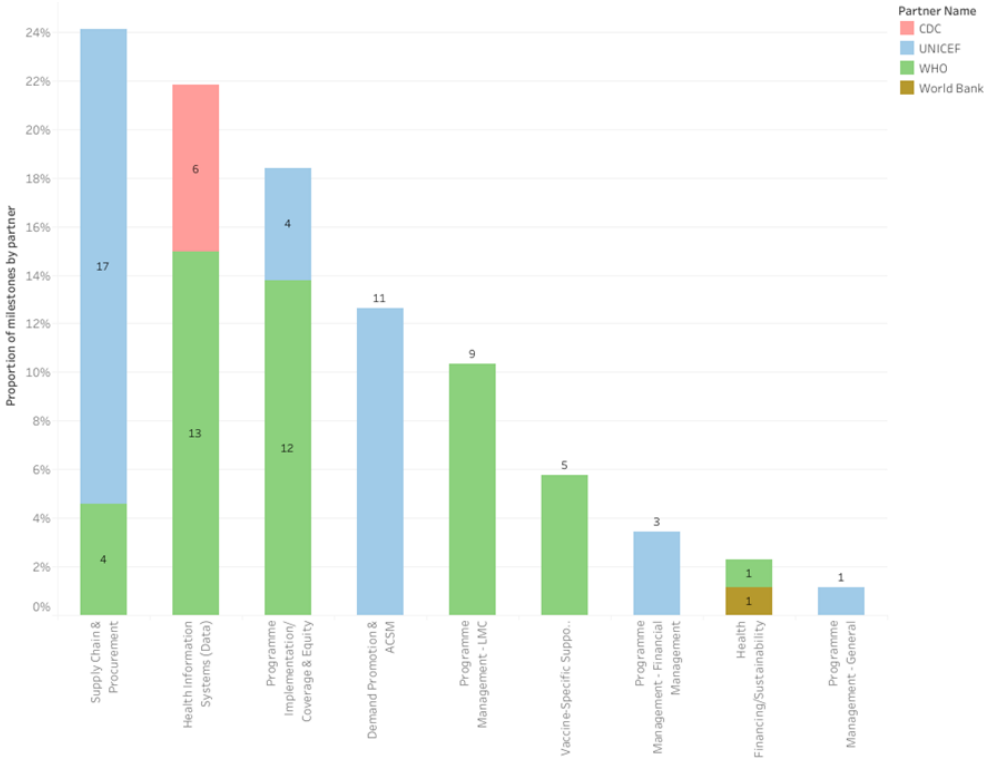
A monitoring review online mission to follow up on the PCA recommendations was held in January 2021. The monitoring mission is expected to establish the status of compliance with the GMRs and implementation of the PCA recommendations reported in October 2018, identifying what has worked well and any challenges encountered during implementation. The monitoring review report is finalised and due to be shared with the country.

1.5. Overview of PEF TCA progress (end of 2019/ early 2020)

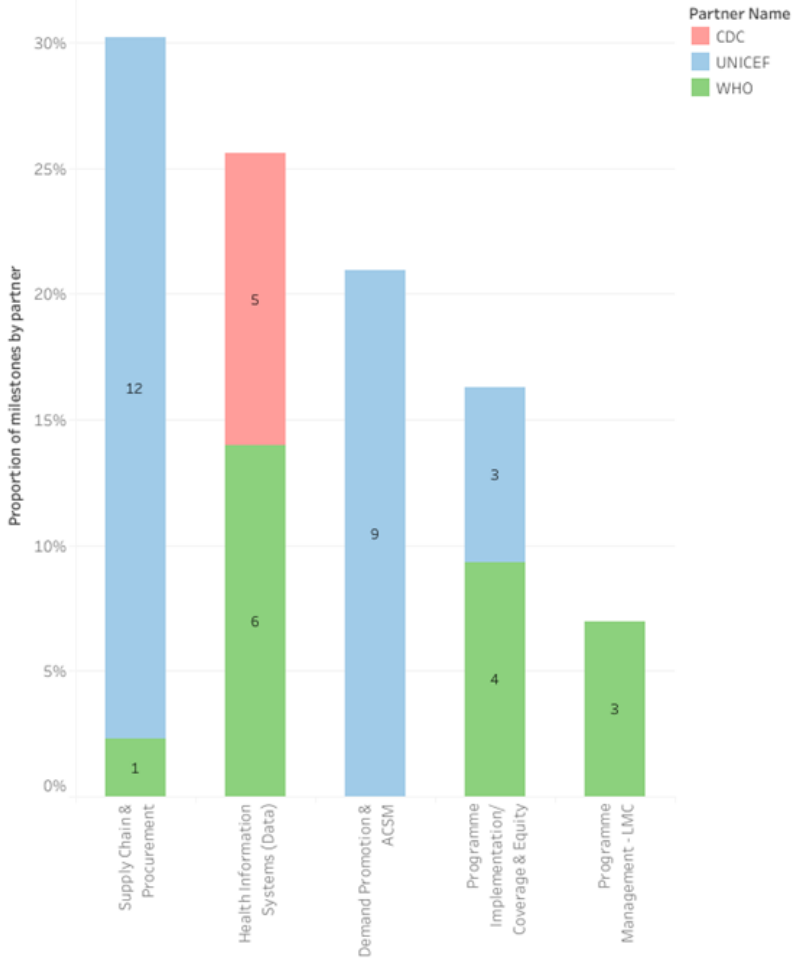
(graph provided by the PEF team)

Overall milestones for PEF TCA, June 2019 – June 2020





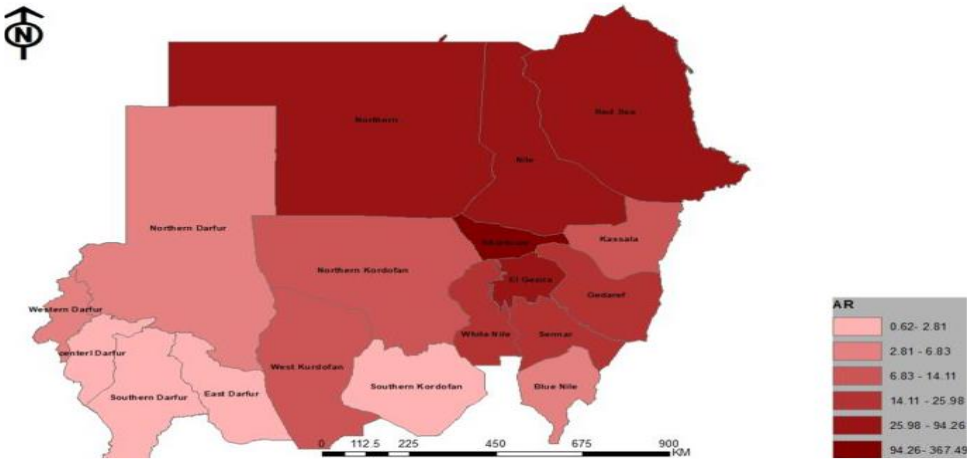
Delayed milestones for PEF TCA, June 2019 – June 2020



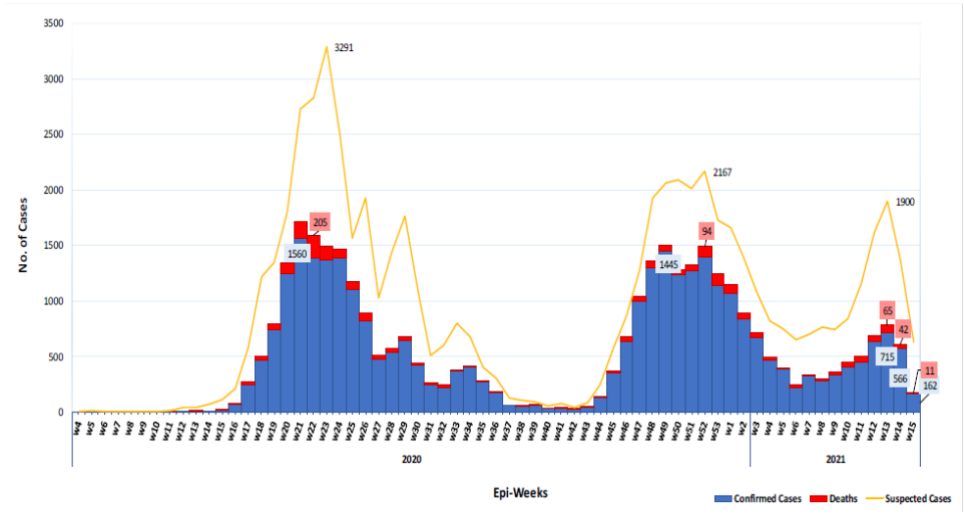
Please provide any additional comments -as relevant- on the implementation of the TCA plan
(e.g. progress in key areas, challenges, constraints, reallocations, no-cost extensions)

2. COVID-19 impact on immunisation (in 2020): Sudan current situation

2.1 COVID-19 cases and deaths as of 14 April 2021



COVID-19 Attack Rate by State April 2021



COVID-19 cases and deaths up to 14 April 2021

State	Total Confirmed	Cumulative Deaths	CFR%
Khartoum	22650	1000	4.4
Gezira	2825	422	14.9
Sinnar	576	74	12.8
River Nile	951	146	15.4
Kassala	438	50	11.4
Gedarif	814	101	12.4
Northern	714	84	11.8
Red Sea	994	79	7.9
White Nile	466	64	13.7
Blue Nile	50	3	6.0
North Kordofan	398	45	11.3
West Kordofan	208	7	3.4
South Kordofan	50	4	8.0
North Darfur	281	102	36.3
South Darfur	137	7	5.1
West Darfur	82	8	9.8
Central Darfur	7	3	42.9
East Darfur	38	8	21.1
Unknown	149	0	0.0
Total	**31828**	**2207**	**6.93**

COVID-19 cases and deaths up to 14 April 2021

Up to April 14th 2021, cumulative confirmed COVID-19 cases reached 31,828 including 2,207 associated deaths, CFR: 6.9%. Recorded recoveries signify 75.2% since the beginning of the outbreak.
COVID-19 confirmed cases reported during week 14 shows 21 decrease compared to week 13 and 10% compare to week 12 2[2].

In the first quarter the 2020 and part of the COVID pandemic, the EPI program as part of the whole country was affected. The COVID-19 pandemic has implicated seriously on the government, health system and EPI. WHO has described four levels of COVID-19 transmission, Sudan has passed the 4 stages where the first phase there was no cases reported, few sporadic cases all cases were linked to travel from cases coming from affected neighbouring countries. The current situation is that Sudan is passing through community transmission and entering the high wave of the pandemic.

The government declared a complete lockdown which had a serious implication on the day to day work as well as long term. Routine services were compromised, reprioritization of services and all senior policy makers were solely devoted to the COVID pandemic work which had the implication on the other competing priorities. EPI program updated national guidelines for the immunization services during COVID with technical support from WHO and UNICEF, the guidelines was disseminated to all states as a part of MCH guideline for service delivery during COVID, but still the services affected for many reasons, the availability of the PPE for the vaccinators and the fear from the care taker this led to reduction of immunization services and

[2] COVID-19 daily situation report, FMOH 14 April 2021

utilization. In addition to that as per government instruction of reduction of the workforce and lockdown the routine work of the EPI program was highly affected e.g. the supportive supervision, implementation of planned activities e.g. IPV campaign and introduction of yellow fever in routine. Yellow fever introduction in routine services planned first of July and postponed due to COVID to January 2021. Even the delay of detection of cVDPV2 outbreak for about 5 months because of lockdown

The VPDs surveillance also affected by the pandemic of the COVID19, as the lockdown affected case reporting, notification, sample collection and transport. Lack of PPE affected the sample collection especially the oral and nasopharyngeal samples

The immunization services started to improve with the advocacy from H/E minister of health when he strongly mentioned the importance of completion of the child vaccination, the program used the opportunity of the world immunization week to advocate for child vaccination during COVID 19, accelerated defaulters' registration and procurement of the PPE for the EPI staff at all levels.

2.2 Disease Surveillance and Incidence

[Information from CCM team and/or https://www.who.int/immunisation/monitoring_surveillance/data/en/]

Impact of COVID-19 on disease surveillance

Briefly describe the impact of COVID-19 on the sensitivity and specificity of vaccine preventable disease surveillance. Measles surveillance data are one option to illustrate that impact, including:

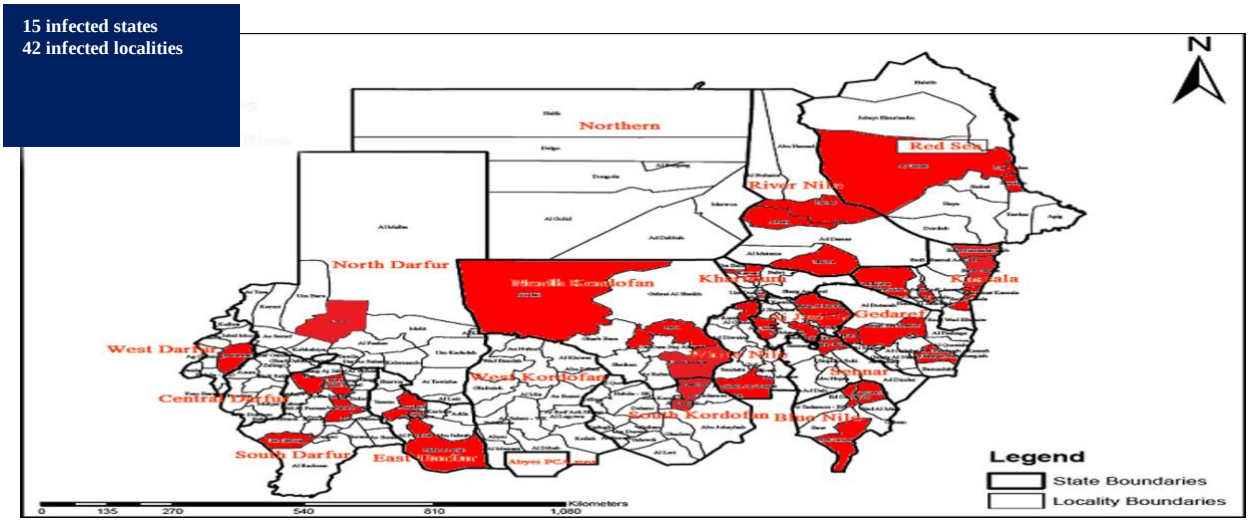
- Changes in the number of reported suspected measles cases
- Changes in the number or rate of discarded suspected measles cases
- Changes in the proportion of suspected measles cases that undergo laboratory testing

Surveillance data from other diseases can be used as well to highlight key areas of impact.

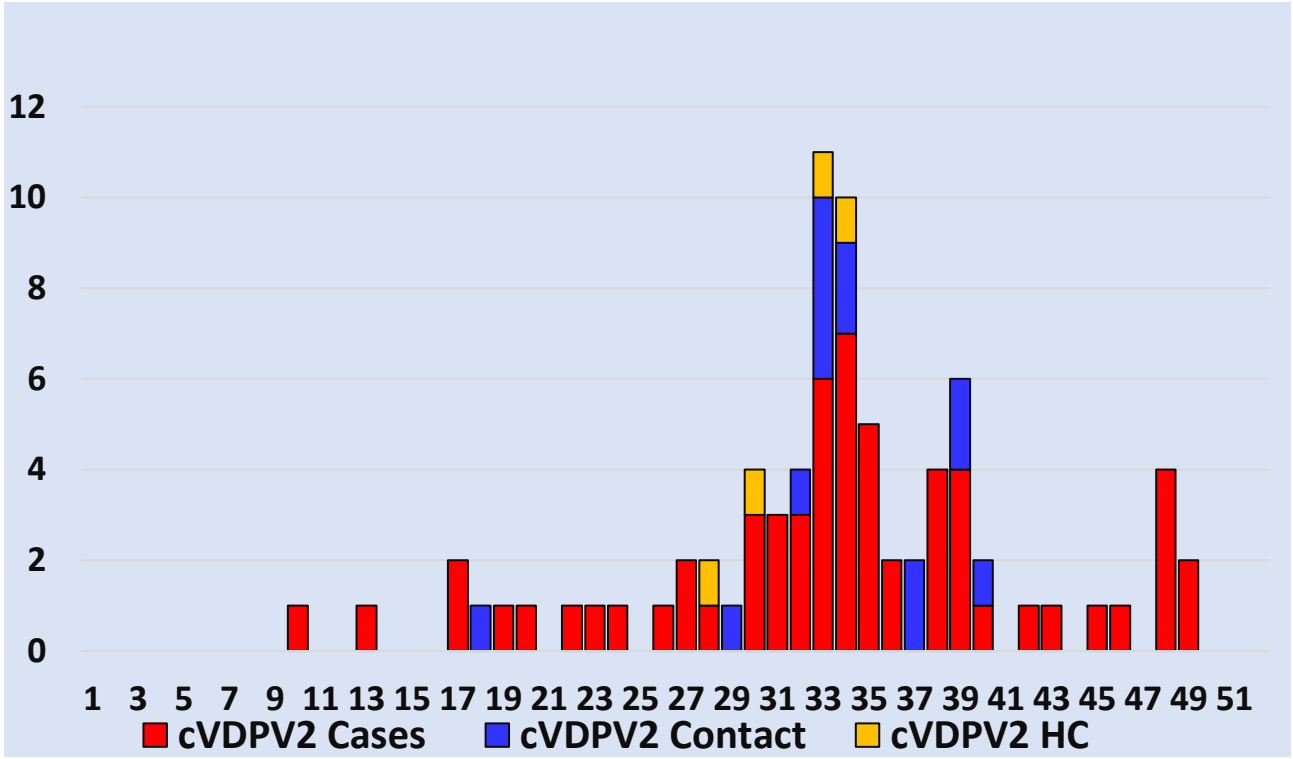
The COVID 19, in addition to the delay of the planned SIAs, has accentuated the gap in routine vaccination coverage during 2020; put the country at high risk of VPD outbreaks that needs immediate and corrective intervention.

The most cartographic effect of COVID-19 in VPDs was the delay in detection of cVDPV2 in Sudan by 5 months. The first cVDPV2 case was reported from South Darfur with date of onset on 7th March, notified on 12th of March 2020, result of RRL was in 8/8/2020 due to lockdown.

cVDPV2 Infected Localities, Sudan, 2020 and 2021 up to week 4.

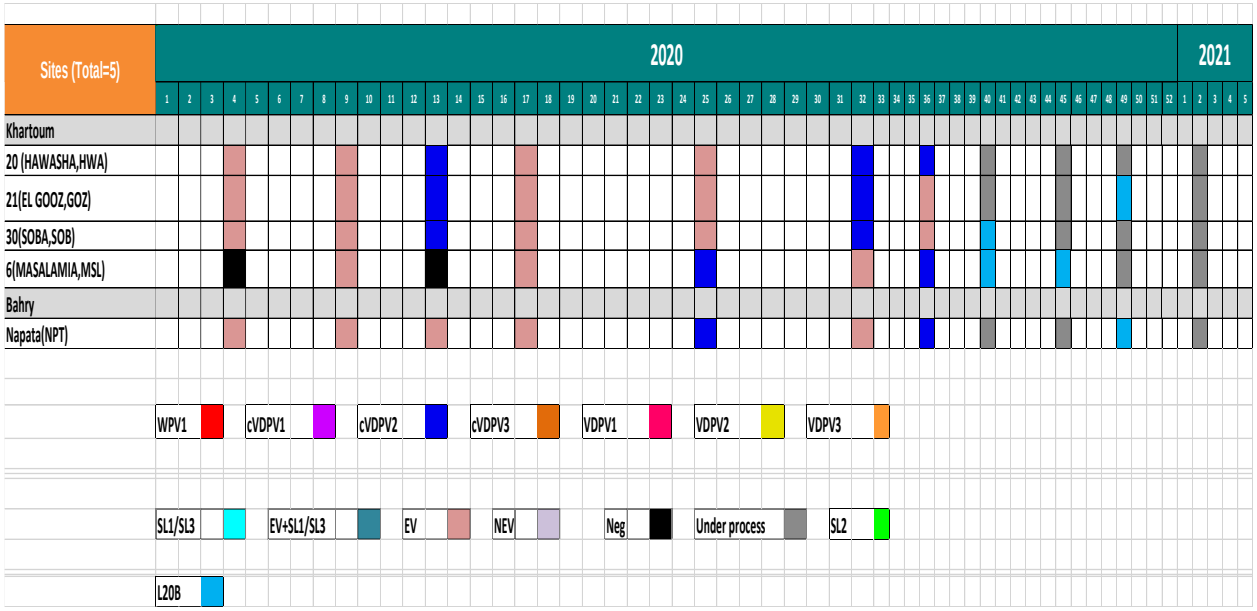


Epidemic Curve of cVDPV2 Cases and Positive Contact / Healthy Children by Week of Reporting Sudan, 2020 and 2021 up to week 4.



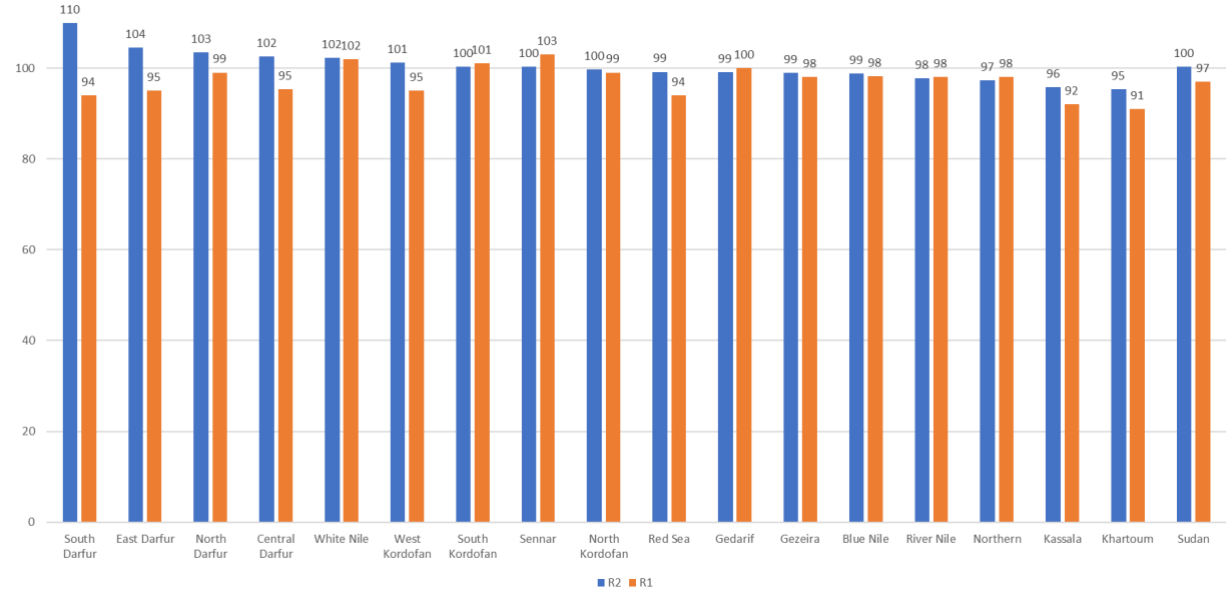
Isolation of 11 cVDPV2 in environmental samples of Khartoum State collected during March 2020 to Jan 2021

Environment Surveillance Performance Lab Result, 2020. Up to January, 2021.



Two rounds of outbreak response campaign using mOPV2 vaccine were conducted with reported coverage:

Comparison mOPV2 coverage by states, R1 and R2 Sudan



Impact of COVID-19 on disease cases

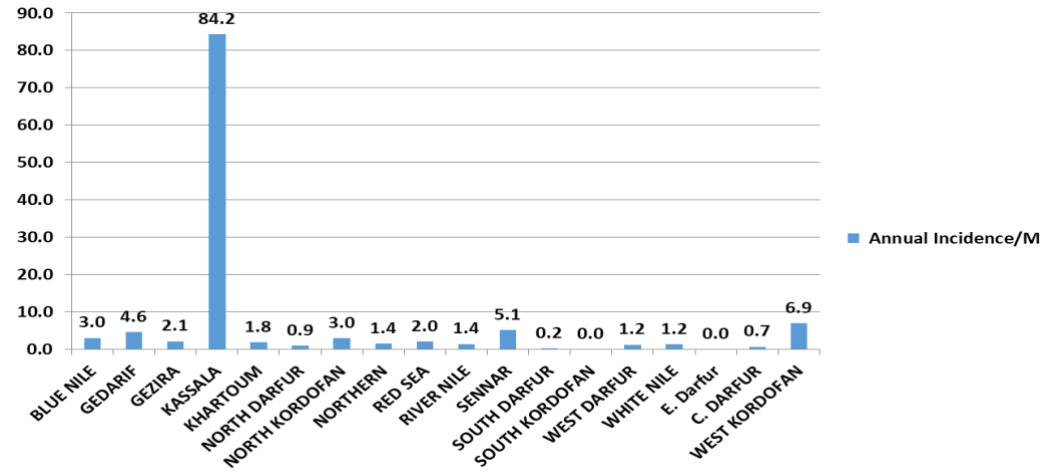
Briefly describe the impact of COVID-19 on vaccine preventable disease incidence. Since measles is the vaccine preventable disease most likely to have a rapid increase in incidence due to declines in immunisation coverage associated with COVID-19, measles data can be used to illustrate this impact, including:

- Changes in the number or rate of confirmed measles cases
- Interpretation of changes in the number or rate of confirmed measles in light of changes in surveillance performance. For example, assessment of whether decreases in measles incidence are due to actual declines or decreased sensitivity of measles surveillance.

Similar data for other diseases can be used as well.

The Measles surveillance also affected by the COVID-19 pandemic, the notification rate was less and samples were collected and kept at states, but fortunately there was no late detection of outbreak as 2020 witness measles outbreak in one state which was Kassala at quarter one in 2020

Measles Incidence Rate by State, 2020



Summary of Measles outbreaks in 2020

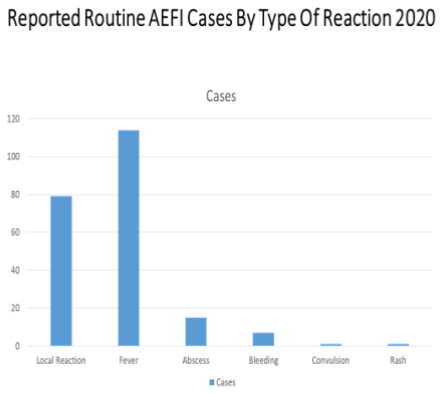
# of affected states	# of affected localities	Total # of outbreaks	No. of cases	Deaths	CFR	# of outbreaks had response campaign
1	3	1	173	0	0	0

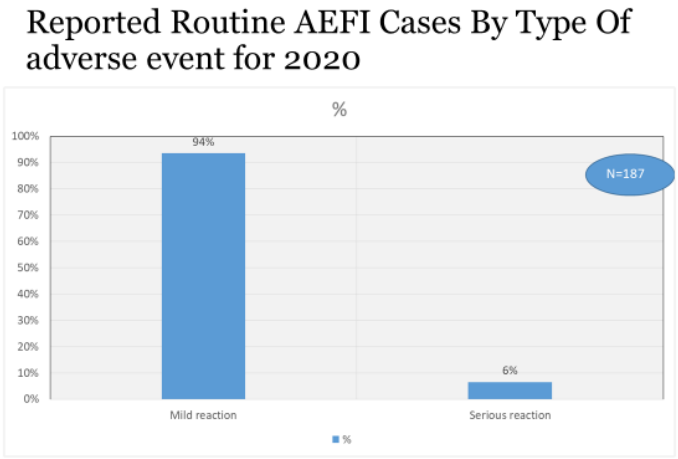
As per Measles elimination indicators Sudan remained so far from elimination and essentials indictors is the MCV1 and MCV2 RI coverage which deteriorated more during 2020.

Measles Elimination Indicators 2020

Indicator	Target	Current Situation
Measles incidence	Zero endemic cases	6.4/1000,000 pop
Sudan Measles coverage	95%	MV1 86% MV2: 68%
States Measles coverage	95%	MV1: 1/18 (5.5%) MV2: 0/18 (0%)
Localities Measles coverage	95%	MV1: 36/186 (19.3%) MV2:4/186 (2.2%)

The Adverse Event Following Immunization surveillance need more enforcement. The training conducted early in 2020 expected to increase the reporting rate but the lockdown of some Health facilities affect the system affected adversely making the measure of the training impact difficult





Elsunta locality in South Darfur state had Diphtheria out beak late 2019 and extended to early 2020 with total cases 87 cases with 11 deaths and CFR 14% 3 rounds of diphtheria outbreak mass vaccination campaign were conducted with Penta and dT vaccine according to appropriate age group and vaccine standard in between doses.

The whooping cough outbreak occurred in June 2020 with total number of 60 cases diagnosed clinically because of COVID*19 and lockdown in West Darfur state. And there was no death

2.3 Impact of COVID-19 on immunisation

Briefly describe the impact that COVID-19 has had on your ability to effectively deliver immunisation services, including:

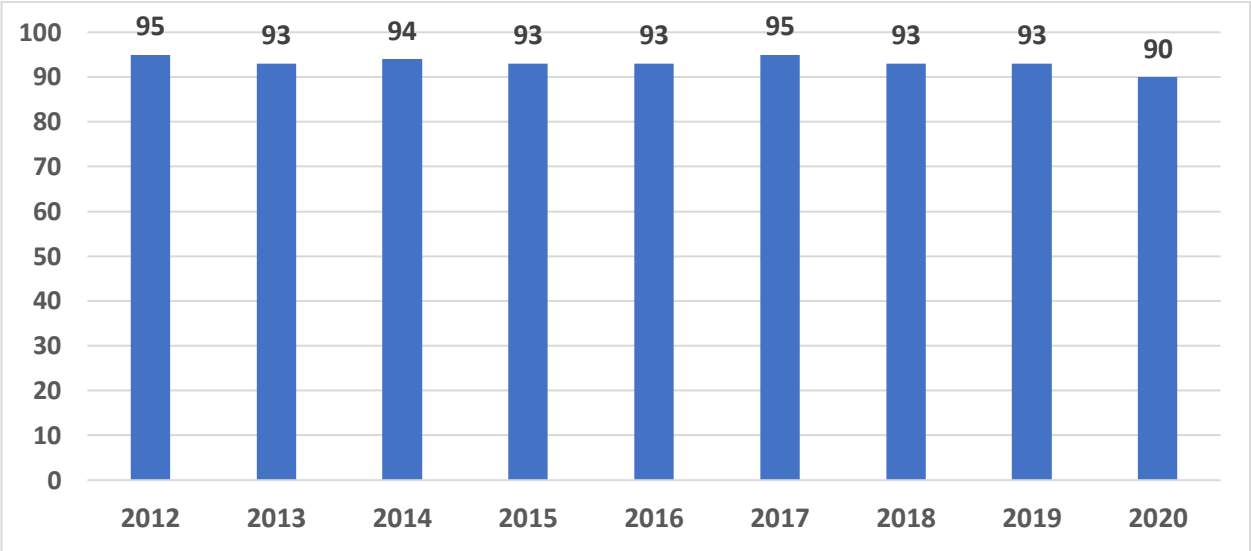
- Constraints on routine immunisation services (e.g. are health workers still carrying out immunisation services? What barriers do health workers face?)
- Impact of the pandemic that may have exacerbated gender related barriers to immunisation experienced by caregivers, adolescents and/or health workers.
- Impact on uptake, demand and community engagement (including impact of rumours or misinformation)
- Impact on any planned new vaccine introductions or campaigns
- Impact on vaccine stocks (e.g. restocking of vaccines and related supplies, risk of expiry, updating dose requirements, reallocating stocks internally within the country/districts to ensure equity of supply)
- Impact on health and immunisation (incl. vaccines) financing (e.g. repercussions on the health/ immunisation/ vaccine budget; delays in budget disbursements relating to immunisation activities; intention of other donors to make additional funding available for health/ immunisation/ vaccines)

Performance of RI in 2020

Program to achieve less even by conducting RI acceleration campaigns.

Reported coverage of Penta

Throughout the last decade Sudan Expanded Program on Immunization with support from partner (Gavi the Alliance, WHO, and UNICEF) managed to sustain high routine vaccination coverage of 93% and above. Since the mid-March 2020 when Sudan was hit by the emerging global COVID 19, with the presence of many others challenges (economic crisis, civil and political unrest, fuel shortage) which affected the performance and routine immunization services, that led the **3 by year 2012-2020**



The above-mentioned economic crisis and shortage of fuel became more deteriorating that led to high cost in routine immunization services and with receiving no budget for RI from WHO (Gavi Support) during the whole year of 2020. This combined with the severe turnover of staff at national and state level resulted in 3% decline of coverage at the national level for Penta 3 coverage for the last 10 years the penta 3 coverage didn't below 93%

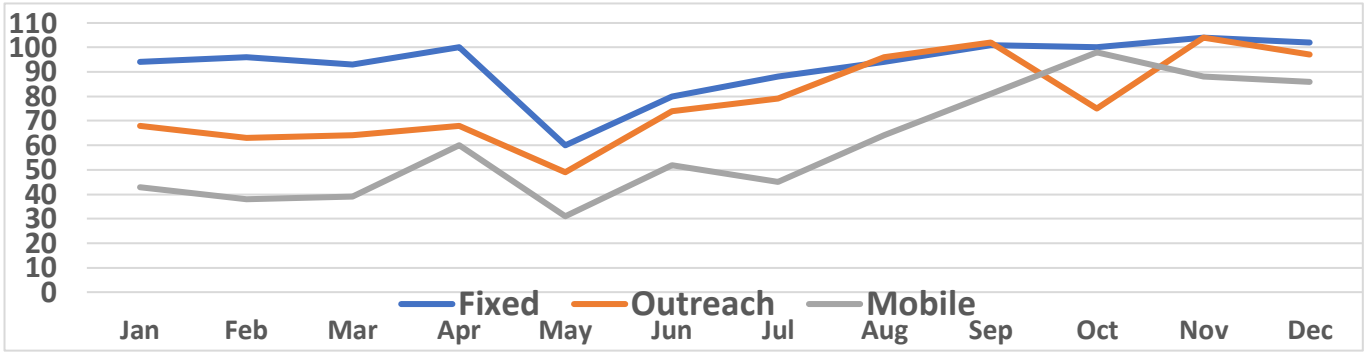
1. Direct effect of COVID -19 in Routine vaccination

The lockdown was accompanied by closure of most of PHC facilities including immunization started in Khartoum. And with the increase and spread of COVID 19 to states, lockdown extended to all states leading to non-functionality in many vaccination sites during quarter 2- and 3 in 2020.

The limited functioning vaccination sites faced many challenges as result of COVID 19 that further affected vaccination coverage and session implementation:

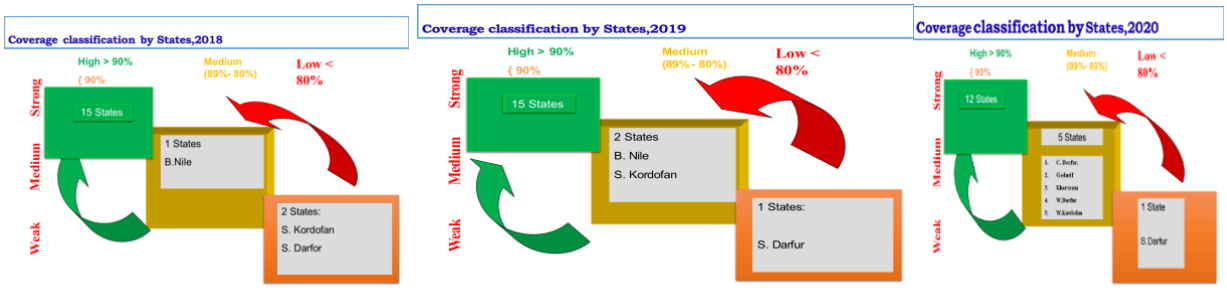
1- Unavailability of PPEs (face mask, gloves and alcohol-based hand sanitizers) for PHC service delivery including immunization led to refusal of many service providers to continue working.
2- Community fear from being infected by COVID 19 led to affect service utilization adversely.
3- Lockdown affected accessibility to Health workers and caretakers to reach health facilities (no public transportation).
4- No implementation of monitoring and supervision activities.

All above mentioned factors led to further drop-in session implementation and ultimately reduction in vaccination coverage. Graph below shows session implementation in year 2020 by months.



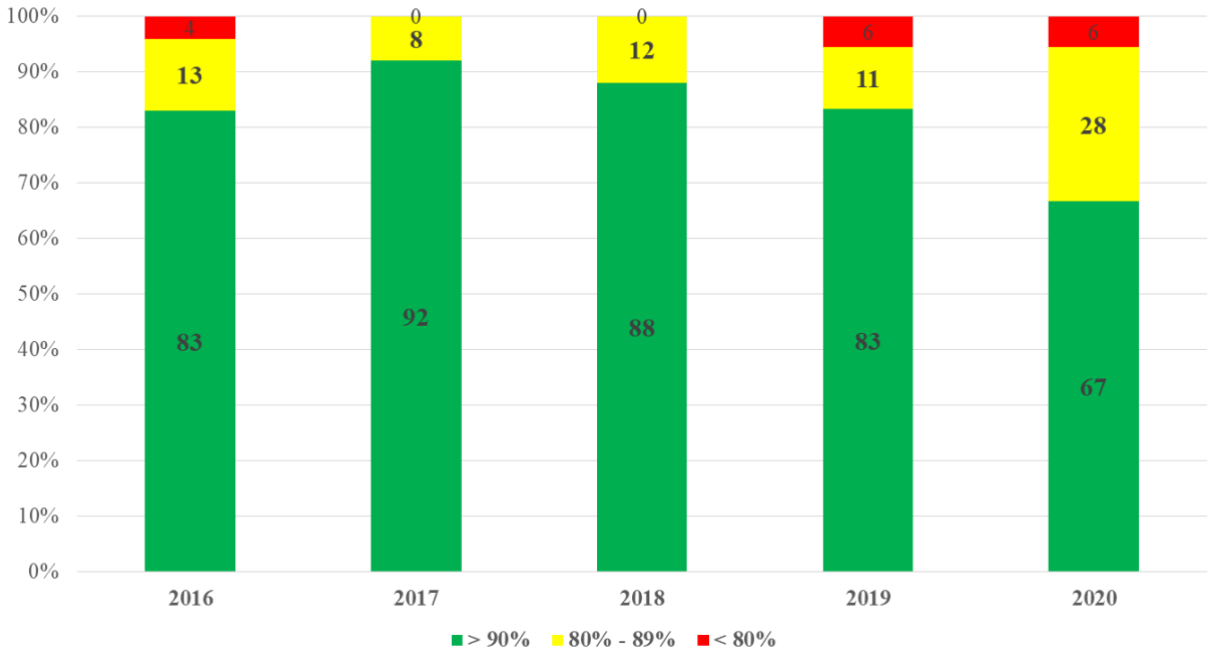
Fixed Session implementation for the first time was far less than 90% (60% in May and 80 in June 2020) mainly due COVID-19. Outreach and mobile session's implementation were low through 2020 due to the Non-COVID factors mentioned earlier but still become more worse by COVID-19 during May and July 2020.

Furthermore, the implementation of the Reach Every District (RED) approach was deteriorating result in 6 states classified as week performing compared by 3 for the year 2018 and2019.



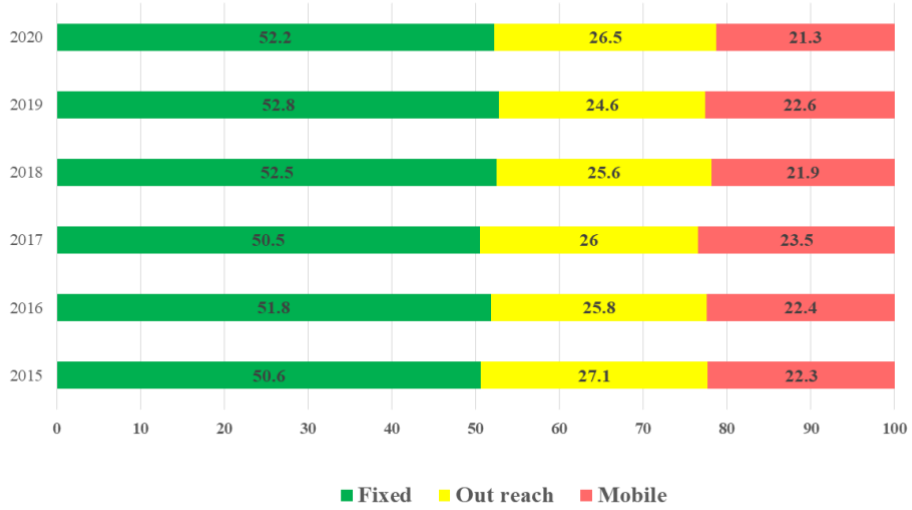
At locality level although the number of low performing localities stayed the same 6 but the Well performing reduced from 83 to 67

Implementation of RED approach by Localities, 2016-2018



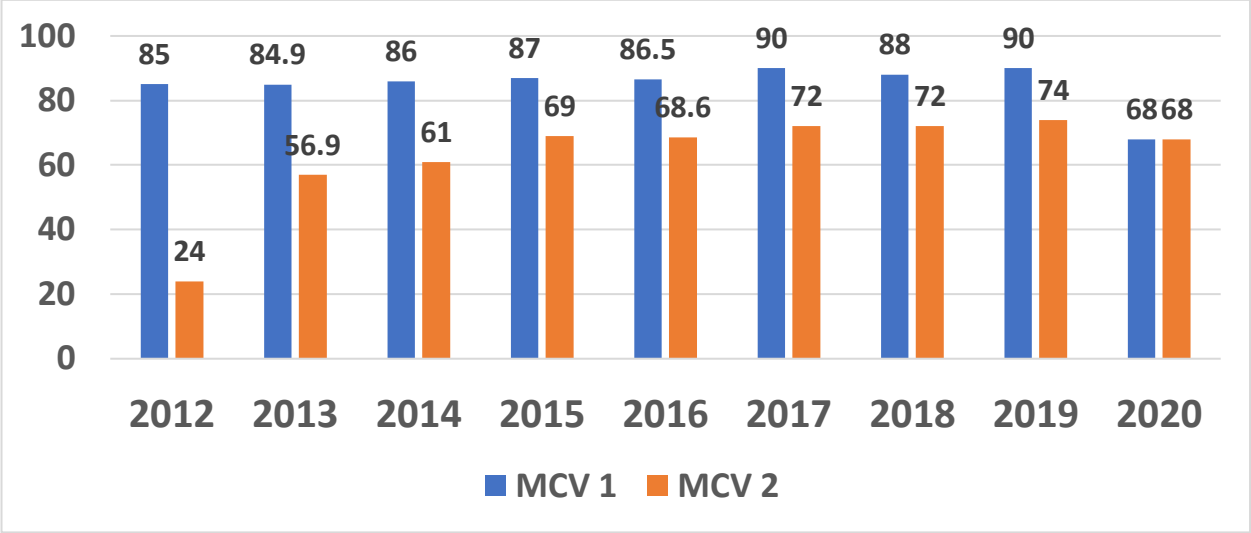
From point of sustainability perspective, the population covered by fixed strategy were reduced from 52.8 to 52.2 and there was increasing in population covered by outreach from 24.6 to 26.5 %

% of population covered by strategies, 2015 – 2020.



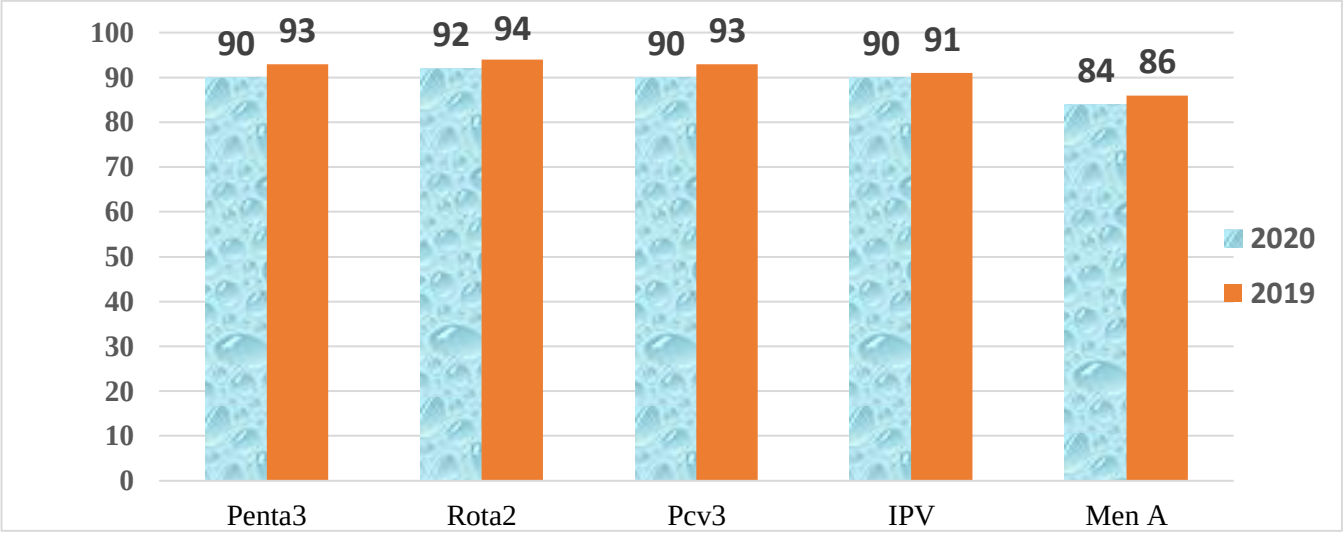
Since introduction of MCV2 in 2012, MCV1 never went below 85% and MCV2 coverage was in linear increase but 2020 marked reduction in both MCV1 and MCV2 put the country at great risk to have Measles outbreak

Routine Coverage with MCV1 and MCV2, 2012-2020



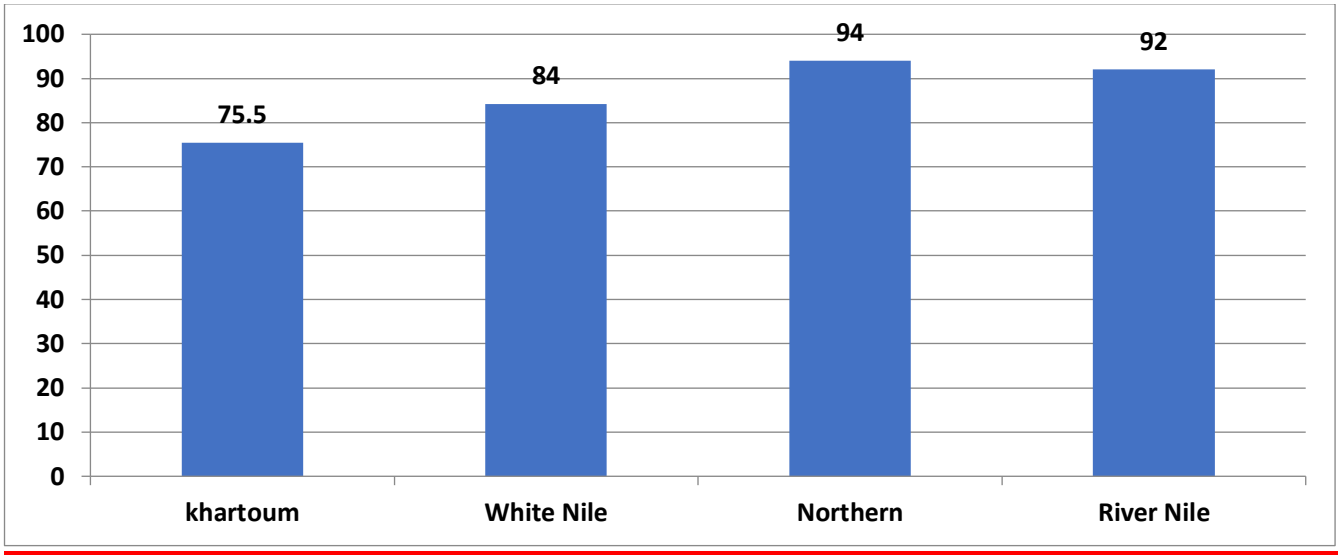
While all new vaccines witnessed reduction in national coverage from 1 to 3% by the end of 2020

New Vaccines Routine Immunization Coverage, 2019-2020.

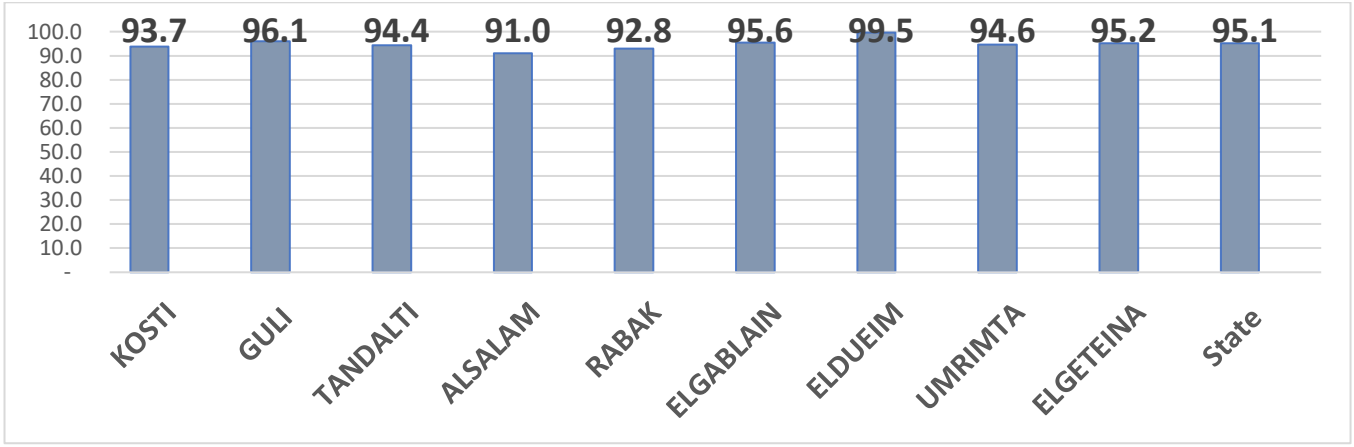


2. Effect of COVID -19 in SIAs

The COVID 19, led to delay of the planned SIAs, the IPV campaign implemented in only 4 states namely the Northern, River Nile, Khartoum and White Nile states resulting in reducing the immunity profile against Polio viruses mainly type 2 as the IPV is the only available vaccine in the RI to build immunity against type 2 polio virus, with reported coverage for phase one states as in the figure below.



While the YF catch-up campaign was carried out only in White Nile state with the reported coverage:



Challenges/ constrains

1. Economic crisis, inflation and devaluation of SDG
2. Fuel shortage and increase in the price because of phase manner reduction of government support to fuel;
3. COVID -19 Pandemic and its consequence's in health services, curfew and lockdown.
4. The FMoH didn't received any budget for RI activity for the whole year 2020
5. The rainy season at the time of RI acceleration campaign

Actions done to mitigate the risk of service interruption by COVID 19 pandemic and overcome the main other non -COVID related challenges:

1. Immediate development and distribution of guidelines on service continuity during COVID time that ensure minimal cross spreading the disease.
2. Provision of PPE which was had some problems of interrupted and commonly not adequate
3. Utilized the immunization week to inform the community on the importance of completing and vaccinating their children even during COVID time with taking personal protecting measures.
4. Borrow the states RI budget for the first 5 months
5. Conduction of 5 rounds of RI acceleration campaigns supported by UNICEF in low performing localities which were accessible during rainy season.

2.4 Already agreed budget reallocations of HSS grant for COVID-19 response

[Please complete table to reflect any budget reallocations already approved – example below]

	COVID-19 activity	Amount reallocated	Status of implementation
Activity 1	Procurement covid-19 supplies	1,560,518.75	According to the utilization report the total expenditure is USD998,977.64

2.5 Already agreed modifications in Technical Assistance (if applicable)

[This refers to modifications already agreed as part of the COVID-19 emergency response]

Two activities from TCA 2019 has been reprogrammed due to COVID impact namely the Cold Chain Technician training and Study tour on Immunization Supply chain. The fund meant for these two activities are now reprogrammed to cover translation, printing and dissemination of Cold Chain Maintenance, Building Maintenance and Vaccine and Cold Chain Handlers TOT for TCA 2020 one activity “Support the piloting of integration of EPI dry store and transportation with national NMSF” has been changed as it’s part of the new PSR and the fund is used to complete the Vaccine and Cold Chain Handlers TOT.

2.6 Unspent funds and savings from Gavi support, available for re-allocation

[Brief narrative and/or table. Considering that some activities have been cancelled, delayed or modified, this is an overview of funds available to be re-allocated.]

As of now, there is no available fund for re-allocation under UNICEF activities.
There is unspent fund saved from the yellow fever mass campaign at WHO. Proposal will be submitted by EPI to WHO to use the saving in strengthening routine immunization as a preparation for introduction of the Yellow Fever in routine immunization.

3. Discussions on priorities, action plan and technical assistance needs; Roadmap for further re-allocation/planning

Based on the analysis of the current programmatic and financing status of your immunisation programme (captured in Sections 1 and 2), the questions below provide guidance for a multi-stakeholder dialogue.
This should result in an outline of your plans to reinforce/re-establish routine immunisation activities, catch-up on missed children, and potentially re-activate some of the planned new introductions and/or campaigns, in the context of the country epidemic response/recovery plans while taking into account the guidance provided by the Alliance.

The country is expected to:

- Define short/medium-term activities to maintain/restore routine immunisation and catch-up on coverage as needed. For these, a work plan and budget will be required.

- Define a roadmap for further re-allocating/planning of activities not captured here, considering the medium/long-term country recovery plan, domestic resources and those available from other development partners, lessons learned and innovative approaches used to cope with the epidemic, and synergies with all relevant stakeholders, including CSOs, with the vision of "building back better".

The multi-stakeholder dialogue may consider the following questions, taking into account the latest programmatic guidance provided by the Alliance:

Short/medium-term activities to maintain/restore routine immunisation

- COVID-19 recovery plan: does the country have a recovery plan which includes restoring essential health services including immunisation?
  - If not, is the recovery plan being developed? Please give a brief overview of the process and timelines for its completion.
- Immunisation services: What strategies have been implemented at the service delivery points to re-activate immunisation services and to address any immunisation gaps resulting from COVID-19?
  - Are any additional strategies/delivery mechanisms planned (e.g. updated demand strategies, community outreach, PIRIs, new campaigns, etc.)?
  - If so, how are these measures incorporated into broader primary healthcare considerations and are they in line with WHO guidelines?
  - What plans exist regarding risk communication and community engagement in the response?
  - What lessons learned and/or innovative approaches to immunisation service delivery that were used to cope with the epidemic are worth broader adoption and scaling-up?
- Equity approach: What are the plans to ensure that underserved and missed communities, including zero-dose children, are prioritised within the country's recovery plan?
  - Does the plan consider any additional cohort of children or any new communities that might have missed immunisation due to COVID-19 and have strategies to address them?
  - Does the plan consider disproportionate impacts of the pandemic on women and girls or other vulnerable groups (including migrant, disabled, HIV+, LGBTQI communities) and propose gender responsive/transformative strategies to mitigate them?[3]
  - Does the plan consider new or strengthened partnerships to reach underserved communities, including CSOs?
  - What are the gaps in immunisation data and information that will limit the ability to identify missed children, track reaching those children, and monitor the effect of recovery strategies/service delivery mechanisms?
  - Does the recovery plan include activities to improve known gaps in immunisation data?
- Immunisation financing: Has sufficient funding been secured to ensure availability of vaccines, including the co-financing portion, and to enable continuous immunisation service delivery going forward? Please

[3] Gavi's revised gender policy was launched on July 1, 2020 and can be downloaded here https://www.gavi.org/programmes-impact/programmatic-policies/gender-policy

give a brief overview of the funding landscape for the immunisation program[4] and highlight any gaps in support. Describe efforts underway to close any financing gaps.

The Expanded Programme on Immunization in Sudan was established in 1976, which comes under the Maternal and Child Health Department, as one of the 4 departments under the Basic Health Care Directorate that lies under the supervision of the Undersecretary FMOH.

The Programme comprises of five main sections: Planning and policy, supply chain, Supplementary Immunization Activities (SIA), monitoring and evaluation including operational research, Polio eradication and integrated disease surveillance. The EPI Manager oversees the overall Programme.

Immunization services structure is composed of four levels as following:

- **The National (central) level:** It is responsible for national policy formulation, decision-making, development of strategies and plans, development of guidelines and tools, resource mobilization, monitoring and evaluation and coordinating the immunization services delivery in the country.
- **Sub-national Level:** the states levels is the next level in the federal structure, all states have an EPI manger under the supervision of the state Director General administratively and under central EPI supervision technically. They are responsible of developing and implementing the immunization plans for their states, monitoring and evaluation and coordinating immunization activities in the state and supervise the levels under them.
- **Districts (Locality) level:** district level is the third level; it is considered as the lowest administrative level. There is an immunization officer in each district, responsible for implementation, monitoring the immunization activities and services in his/ her district. Shortage of adequate human resources, especially in remote areas is a concern for the EPI and the health system at the sub national and districts levels as well.
- **Health Facilities:** The health facility is the last level in the immunization services structure which is the service delivery points. The data/ reports are generated at facility level to its districts on immunization related coverage and activities. At the service provision level, implementation of immunization activities is done by a PHC cadre or immunization officer who is responsible for immunization, social mobilization, outreach activities and record keeping.

Many challenges facing the EPI program in Sudan, summaries mainly in the following most important:

1. The finance of the program and being completely donor driven program supported by government endanger the program sustainability
2. Human resources: Rapid and frequent turnover, and brain drain of the immunization expert, in addition to dependency on the volunteers at service delivery level
3. Open borders with seven countries and no separate registration for the refugees.
4. The PHC service not reached 100% of the population, the program uses the outreach and mobile services to reach the targets, both considered as more expensive than the fixed services
5. Fragile states that suffered of the armed conflict in Darfur domestic conflicts led to damage of the health services, the program covering these states using the acceleration campaigns that have both technical and financial impact on the program.
6. Security closed areas in three localities in South Kordofan state
7. Sudan represents a model of all special groups, nomads' that change their routes regularly, refugees, IDPs, closed and post conflict areas which all considered as underserved population.

Despite these challenges the program succeeds to reach above 90% of the target children with Penta 3 over the past years, still the unimmunized children are high and zero dose children representing high risk of susceptible and VPDs outbreak

[4] Including sources of funding.

Coronavirus disease 2019:

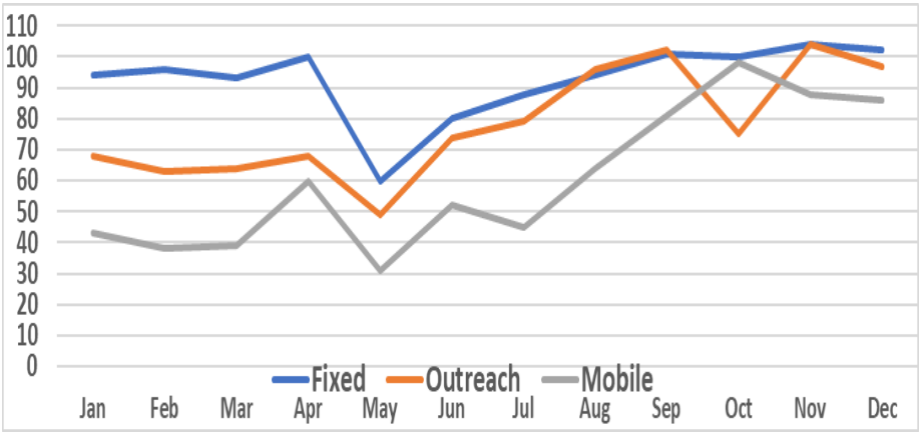
March 13th (week 11/2020) Sudan FMoH declared the first COVID-19 case, following this Sudan has passed through four stages the phase where there was no cases reported, then few sporadic cases at which all cases were linked to travel from cases coming from affected neighboring countries to the community transmission. Up to April 14th, 2021, cumulative confirmed COVID-19 cases reached 31,828 including 2,207 associated deaths, CFR: 6.9%. Recorded recoveries signify 75.2% since the beginning of the outbreak

Impact of COVID 19 in immunization services:

The COVID-19 pandemic has implicated seriously on the government, health system as well as immunization program. The utilization was extremely reduced due to public fear of the health facilities and disease spread. In addition to that as per government instruction of reduction of the workforce and lockdown the routine work of the EPI program was highly affected e.g. the supportive supervision, the VPD surveillance, implementation of planned activities e.g. IPV campaign and introduction of yellow fever in routine.

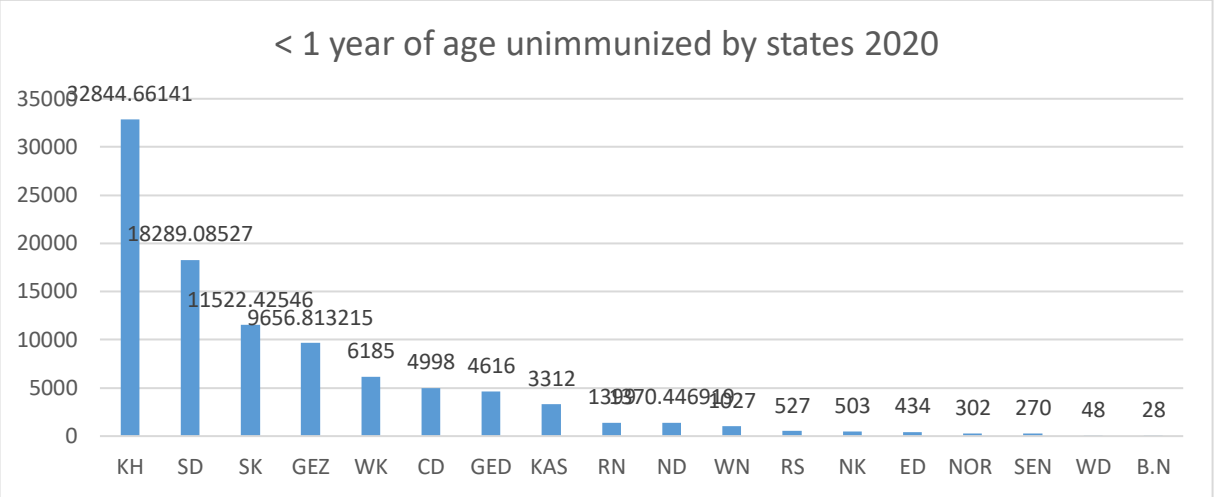
Implementation of the immunization sessions:

Immunization session implementation was severely affected by the COVID 19 pandemic, despite the development of national guidelines for implementation of immunization sessions during COVID 9 and the program efforts to avail the PPE for the EPI health workers but still remarkable reduction in the session implementation was occurred during the peak of the pandemic, as shown in the graph below shows



Routine immunization coverage:

Expanded Program on Immunization with support from partner (Gavi the Alliance, WHO, and UNICEF) managed to sustain high Penta 3 coverage of 93% and above for the last years. As impact of the COVID 19 pandemic aggravated the other challenges (economic crisis, civil and political unrest, fuel shortage), 10% of the targeted children not reached, total of 97332 child < 1 year of age were unimmunized distributed in all 18 states, in 100 localities out of 189 localities including the 3 inaccessible localities in S. Kordofan..(the average of 973 child < 1 year of age unimmunized per locality)



Vaccine preventable disease surveillance & VPDs outbreaks

COVID 19 had impact in all VPDs surveillance, the notification, reporting and sample collection and testing all have been affected, this most reflected in the delay in detection of cVDPV2 in Sudan by 5 months. The first cVDPV2 case was reported from South Darfur with date of onset on 7th March, notified on 12th of March 2020, result of RRL was in 8/8/2020 due to lockdown. This resulted in the spread of the cVDPV2 outbreak to involve 15 states in 42 localities, in the situation of the low OPV coverage and delayed implementation of the SNIDs in the high-risk localities.

The AFP cases with zero dose was increased in 2020 compared to 2018 &19 as shown in the below table:

Province	District	2020	2019	2018
Blue Nile	Wad Al Mahi			
	Alkormuk	1		
East Darfur	Abu Karinika			
	Alfardos	1		
	Aldiain	1		
Gedarif	Alrahad	1		
	East Algalabat	1		
Gezira	Madani	1		
	Um Algora	1		
Kassala	Hamashkoraip	2		
	Kassala Town	1		
	North Aldalta	1		
	Rifi West Kassala	2		
Khartoum	Bahry			
	Gebal Awleya		1	
	Sharg Elneel		1	

	Um Durman			1
North Darfur	Altina			1
	Alfashir			
	Saraf Omra	1		
	Kabkabiya	1		
North Kordofan	Jbrat Alsheik	2		1
	Um Rwaba	1		
Northern	Dongola		1	
Red Sea	Toker	1		
	Port Sudan	2		3
	Sinkat			1
	Alganip Olaib			1
River Nile	Barbar	1		
	Shandi		1	
Sennar	Abu Hugar	1		
	Aldali Almazmom	1		
	Singa			
	Sinnar			
South Darfur	Alsalam	1		
	Id Alfirsan	1		
	Rihaid Albrdi	1		
South Kordofan	Alabasiya			1
	Habilaa			1
	Altdamon	1		
West Darfur	Alginaina			
	Kiraink	1		
	Forbranga			1
	Kilaik			1
West Kordofan	Alodaya	1		
White Nile	Aldiwaim	1		

The Measles surveillance also affected by the COVID-19 pandemic, the notification rate was less, and samples were collected and kept at states, only Kassala state was hit by measles outbreak in the first quarter of 2020.

The impact of COVID 19 on the VPDs that led to outbreaks exploded by end of 2020 and 2021, River Nile and South Darfur states reported Diphtheria outbreak with high CFR

Efforts done by MOH and partners to overcome the impact of COVID in 2020:

July 2020, EPI technical committee held many meeting and the impact of COVID 19 on the immunization program was assessed, the localities with annualized Penta 3 and MCV1coverage compared to the previous years were identified as low performing localities, acceleration

campaigns were implemented started in August up to December 2020. The supportive supervision was revitalized at all levels.

Objectives of the road map

The main objective of this road map is to overcome the impact of the COVID 19 on the immunization program on the short term and long term, this will be through:

Short term plan will be as:

1- Acceleration campaign to reach the unreached children in the low performing localities
2- Special plan for the unimmunized children (Annex 1) to be considered and vaccinated to avoid accumulation of susceptible

Long term plan will focus on strengthening the program capacity to enable it to stand through any future crisis, this will be part of the cMYP with focus on the localities that most affected by the COVID

Outlines of the short-term activities:

Proposed Activities:

#	Objective	Activity
1	Reached the unimmunized children	Mapping of the children per locality
		Arrange for their vaccination as part of the 2021 targets
		Home visits
		Supportive supervision
2	capacity building	EPI officers training/MLM
		Vaccinators training/refresher training
3	supervisory visits	18 states
		100 localities
		Vehicle maintenance
4	Expand fixed HF	

The country's draft recovery plan is focusing in the poor performing localities and communities with special attention to IDPs, nomads, people living in semi camp situation, refugees, tribal groups, conflict affected areas and all other groups. As part of the country efforts to ensure zero-dose children are well mapped and planned for, FMoH held micro planning meeting for all EPI managers form all states with participation of UNICEF and WHO field and main offices to ensure there is bottom-up micro plan to reach those children and provide access to routine immunization services. Due to COVID-19, economic deterioration and intertribal conflict, more groups with low coverage are identified and included in the planning process. These groups include people who missed their immunization session, not reached because of difficulty to secure logistic and financial needs due to economic situation and people who missed the regular access due to insecurity.

In order to reach the zero-dose children, children in conflict areas and those who live in difficult to reach areas, the states programmes will focus on the following additional measures

1. Increase the equitable coverage through fixed immunization sites; the investment from CCEOP and HSS2 in procurement and deployment of cold chain equipment and the support from UNICEF will contribute to opening new fixed immunization sites mainly in communities with no previous access to fixed immunization services
2. Intensification of home visits to trace the defaulter and search and find the zero-dose children to link them with the immunization site in their catchment areas in the context of fixed and outreach

3. Coordinate with the local stakeholders to map areas with low coverage in areas depend on the mobile teams and acceleration and use of community health workers in defaulter tracing and children with zero dose to link them with the monthly mobile visits
4. In the areas of poor access during the rainy season, routine immunization must be intensified during the dry seasons early in the year and then after the rainy season; also, these areas should be prioritized for extension of new sites and cold chain installation in short and long term
5. In areas affected by conflict, refugees and IDPs communities EPI will work with local and international NGOs to grantee the maximum access to routine immunization services
6. Special plan made available for the gap areas in south Kordofan and Blue Nile to reach children whom missed their access to regular immunization services in the last decade.
7. Coordination with other related government bodies and community leaders, UN partners and NGO`s to ensure establishment of sustained immunization services for Ethiopian refugees affected by Tigray crises.

For immunization data gaps, it's noted that EPI has very strong vertical immunization data system in place, however, due to COVID-19 there were challenges and gaps that affected the system as part of the overall COVID impact. The main areas of gaps are:

1. Interruption of regular EPI monitoring meeting at the level localities with facilities and states with localities
2. Delays in timely data flow from different level due to the lockdown and economic difficulties
3. Interruption of timely implementation of home visits due to physical distance which affected the activities of tracking and retrieving the defaulters and also affect identification of zero-dose children and linking them to the nearby health facilities

All these identified gaps and others, has been analysed and discussed during and interventions have been planned and included in EPI micro plan at the locality level, the identified interventions have been customized to each locality context.

What support is required from Gavi for the planned short/medium-term response efforts?

- What are the key technical assistance needs to be funded through PEF TCA[5]?
- Does the country anticipate requiring additional HSS flexibilities or support?
- Do any planned new vaccine introductions or campaigns need to be adjusted in light of the current situation? (Please confirm or indicate any changes in assumptions from section 1.1)
- Is the country intending to apply for new vaccine support or a product/presentation switch[6] in next 6-24 months? If so, please mention for which vaccines/support.
- Is the country interested in innovation initiatives[7] from the innovation catalogue[8] available to countries?

FMoH and Partners developed and submitted the draft TCA 2021, the draft reviewed by Gavi and provided comments which are being currently addressed by FMoH and partners.
Below are key TCA activities for 2021:

1.	TA to review and update immunization module of pre-service and in-service for different health cadres
2.	Conduct study to estimate the prevalence and economic impact of HPV in Sudan, to guide the introduction of HPV vaccine.
3.	conduct study to asses equity to immunization including zero dose children/communities services in Sudan
4.	2 posts of NOA level to strengthen the national EPI technical capacity mainly for: routine immunization and planning

[5] The TA needs mentioned in this report are a key input into the process to classify Gavi TA support (PEF TCA). The TA plan will however be subject to follow-up discussions and a separate approval process, which may require supplementary information to be provided.
[6] For information on available products/presentations, please refer to: https://www.gavi.org/news/document-library/detailed-product-profiles
[7] Definition of innovation: new products, practices or services that unlock more efficient and effective ways to accelerate Gavi mission.
[8] An innovation catalogue will be made available to countries in the coming weeks.

5.	Conduct study the prevalence CRS as base line study for Rubella contain vaccine introduction into RI.
6.	Contextualize E-learning training courses covering all EPI modules (Planning- Vaccine management- Surveillance- Vaccine safety - Program management - Supervision- M&E ....)
7.	TA to support enumeration for EPI coverage survey
8.	TA to assess the barriers for delivering EPI key messages by vaccinators to caregivers/parents and to strengthen the capacity of health promotion at national and state level to use data for action.
9.	Develop strategies to increase immunization program visibility and increase access to information through mass media and penetration of social networks, to boost public demand for immunization, increase awareness and public trust
10.	TA to maintain the current technical support for implementation of solar electrification of health facilities with focus on monitoring, capacity building and documentation.
11.	TA to support Ministry of Health on both state and federal level to oversee, coordinate and document the deployment of cold chain equipment under HSS/CCOP and other funds.
12.	Support MoH in implementing and monitoring Gavi related projects - staff costs
13.	TA to improve efficiency and effectiveness in planning, budgeting and execution to improve health service delivery in Sudan. The task will include two activities: a. Review and support the FMOH on implementation of PBB and roll out of the planning template to additional states to ensure value for money and equity, and b. Conduct a study on budget execution practices in the health sector with the objective of identifying PFM bottlenecks and unravelling what can be done across budgetary stakeholders to ensure the efficient use of resources to address health sector priorities.

The political context of Sudan has changed dramatically during the past two years, which witnessed the start of the protests, and the progress into changing the regime and establishment of the transitional government.

The impacts of the economic downturn have translated into devaluation of the local currency, increasing inflation, a rising cost of living and shortage of fuel. This situation has affected basic livelihoods and health services, people movements and risks of public health threats and health security hazards particularly, for vulnerable and disadvantaged population. Moreover, Health system has been confronted with rapidly increasing demand generated by the COVID-19 pandemic and other protracted health emergencies and outbreaks.

There are great opportunities to address inequities following the recently signed peace agreement between the new transitional government and the Sudan Revolutionary Front, who is controlling inaccessible areas in Blue Nile and parts of Darfur in October 2020. For South Kordofan and other parts of Darfur State, negotiations have started. There is an agreement to open corridors for humanitarian assistance in all closed and inaccessible areas.

Instability in neighboring countries has resulted in influx of refugees particularly from Ethiopia and South Sudan. For all these reasons, Sudan is expected to request additional HSS flexibilities and support.

Two vaccines were planned to be introduced into the routine immunization services in early 2021, namely, Yellow fever, and IPV second dose. The Yellow fever introduction delayed to mid-year

because of delay in vaccine arrival which expected to be in the country by end of May 2021, while the IPV second dose introduction expected in May according to the fund availability status.
Other two campaign related to above- mention NVI are the Yellow fever mini catch-up campaign which implemented in three states (White Nile, Red sea and Kassala) and rest of the states were planned before the end of the year 2021. While IPV campaign for the missed cohort implemented in 5 state (White Nile, Khartoum , Northern , Kassala and Red sea) while the rest of the states will conduct IPV and YF campaign as joint campaign for cost effectiveness and bridging the gap in both campaign budget.
Switching from IPV 10 doses to IPV 5 doses is planned in 2021 due to supply issues. Although the country has the capacity for this switch, however, this need additional arrangement. On the other hand an application for introducing MR vaccine into RI instead of Measles only with MR catch-up campaign will be submitted in May 2021.
The country will be more interested in exploring and considering different innovation initiatives to address health and immunization systems' challenges and therefore, achieve programs objectives focusing on equity related challenges.

Roadmap for further medium/long-term planning

Please briefly outline your roadmap for developing a more detailed medium/long-term recovery plan to restore immunisation services and address any immunity gaps created by the COVID-19 pandemic. In your response, you can consider the following:

- Is there a need to conduct an assessment of the COVID-19 pandemic impact on immunisation services in order to best facilitate the development of a longer-term response plan?
- What is the envisioned planning process, including efforts to engage communities in the development of the plans, to join broader health sector planning exercises, and to ensure harmonisation of support with all relevant bi-lateral and multi-lateral development partners?
- Will a technical assistance plan be developed alongside the recovery plan? Will it be holistic and ensure support from all TA partners is harmonised?
- Finally, please note whether planning has already begun for a potential introduction of a COVID-19 vaccine if/when such vaccine becomes available?

Sudan' health systems has been confronted with rapidly increasing demand generated by the COVID-19 outbreak. Overwhelming of health systems may result in increased both direct mortality from an outbreak and indirect mortality from other diseases such as vaccine-preventable and treatable conditions. The health system was severely compromised due to overwhelming demand, resource diversion and closure of health facilities.
FMOH conducted an assessment of the impacts of COVID-19 on access to Essential Health Services during the first lockdown in Khartoum State. The assessment revealed critical gaps in service availability, shortage of supplies and inadequate implementation of IPC measures. Substantial reductions in healthcare utilization were reported during the first half of 2020. Below are key findings:

Assessment of the impacts of COVID-19 on Essential Health Services in Khartoum State June 2020

Locality	**Immunization**					
	Defaulters tracing	Vaccines Storage		Forms and records available	Service available	PPEs sufficient for at least one week
		Existence of temp SOPs	No stock-out			
Jabal Awlia	80%	80%	40%	80%	83%	25%
Khartoum	100%	100%	100%	100%	100%	37%

Umdurman	0%	30%	30%	40%	100%	49%
Umbada	25%	17%	17%	0%	100%	48%
Karary	50%	40%	40%	30%	100%	43%
Khartoum North	56%	33%	44%	44%	82%	34%
East Nile	46%	38%	31%	46%	100%	43%

FMOH is planning to continue monitor the impacts of COVID-19 on health services availability and utilization through strengthening the routine supportive supervision at different levels.

The assessment findings were used to develop and implement improvement plan in Khartoum State supported by FMOH.

Sudan had received invitation to participate in the COVAX facility, the MOH expressed their willingness in participation in the COVAX Facility and received confirmation from COVAX in December 2020. Vaccine requested to cover the first 20% of the population without cost sharing with an overall objective initially to directly reduce the morbidity and mortality and maintenance of most critical essential services. The expansion of vaccination will take place to reduce transmission and disruption of social and economic functions. The plan is to further expand the coverage for additional 45-60% of the population using the window with cost sharing. The target population prioritized following SAGE recommendation and contextualized through the NITAG. Health care workers, the workers dealing with the COVID patients' bodily secretions and aerosols and elderly with co-morbidity are considered as the top priority for the first wave vaccination.
The country submitted the national deployment and vaccination plan on 9th February 2021 followed with indemnification and EUA for COVISHEILD vaccine late in February. After approval of the NDVP the country allocated with 2.9M vaccine doses for the first phase of the vaccination program.
The first shipment arrived to country on 2nd of March 2021 and the launching of the vaccination program was on 9th of March to vaccinate the COVID 19 treatment centre's staff. Up to now, the vaccination has been rolled out in nine states targeting the Health care workers and adult aged above 45 years with co-morbidities. The rest of states expected to kick off the vaccination within days based on their readiness. For vaccination safety especially with this novel vaccine, the vaccination organised to be delivered only through fixed and outreach health institutions but in a way that will not affecting the routine immunization. The AEFI committees at all levels are activated, up to now 72 notification of AEFI received through multiple platforms (surveillance system, hotlines, social media and others).