Ministry of Public Health
General Directorate of Preventive Medicine and PHC
National EPI Directorate

NATIONAL EPI POLICY
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1-Background:

Introduction:
Vaccine preventable diseases like Measles, Neonatal Tetanus, Diphtheria, Pertussis, Hepatitis B, Polio, Tuberculosis and Hemophilous influenza Type B are leading contributors to infant and under five years children morbidity and mortality in Afghanistan. Tetanus is also a main cause of puerperal sepsis and many deaths among postpartum women.

EPI services were initiated in 1978 in different parts of the country, most of which concentrated in the urban areas. According to the national health policy, out of the nine priorities the following are the two top priorities for the MoPH:
- Prevention and control of communicable diseases
- Child health

2- National EPI policy has been developed in line with the National Health Policy. when the new vaccine is available it will be added to the national EPI schedule.

3- Health System and service delivery
- National Health Policy and strategy
- Position of EPI in Health system

4- Policy Statement:
The core intention of MoPH is to deliver safe, potent, reliable and free immunization services which are available and accessible to all eligible children and women regardless of their ethnicity, race, religion, gender, geographical location and political affiliations.

- EPI situation analyses
- Immunization system

5- Organizational structure of EPI

6- Objective of National Immunization

7- Goal and objectives:

Goal:
The goal of EPI is to reduce morbidity and mortality due to vaccine preventable diseases among the target population.

Objectives:
- To achieve and sustain 90% coverage of childhood immunization of all antigens among under one years old children by the end of 2012.
- To achieve and maintain 80% coverage of TT2+ among pregnant and 75 among women of childbearing age (15-49 years), eliminate tetanus in line with global goal by the end of 2012.
- To interrupt poliovirus transmission by end of 2012 and sustain till global certification is achieved.
- To reduce measles morbidity rate by 90% from the pre-immunization level (baseline data from 2001) by end of 2012.
- To improve injection safety and provide 100% safe immunization injections.

Target population and antigens
- Routine: Target population for child immunization (DPT-HepB-Hib, OPV, BCG, Measles) is children under one year, even though children up to 23 month will not be refused when brought to the health facilities (except BCG is only for under one year). The
same age groups should be targeted during out-reach and mobile activities. At the age of 18 months second dose of measles vaccine should be given.

- Target for TT immunization is all Women of Childbearing Age (15 – 49 years).
- OPV Zero should be given to all newborn as soon as possible within the first 14 days of their life.
- BCG should be given as soon as possible after birth(0-11 months).
- OPV-4 should be given along with measles immunization at age 9 months or whenever the child is given the first dose of measles.
- SIAs: The target for supplementary immunization activities (NIDs for Polio Eradication, MMRC, MNTE) will be determined by specific SIAs guidelines and epidemiological considerations. (Annexes – 2,3,4)

8- EPI vaccines in Afghanistan routinely administered according to the following schedules

**Standard Child Immunization Schedule**

<table>
<thead>
<tr>
<th>Age</th>
<th>Vaccines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth(0-11 Months)</td>
<td>BCG</td>
</tr>
<tr>
<td>Birth (as soon as possible within 14 days of life)</td>
<td>OPV0</td>
</tr>
<tr>
<td>6 weeks</td>
<td>DPT-HepB-Hib1, OPV1</td>
</tr>
<tr>
<td>10 weeks</td>
<td>DPT-HepB-Hib2, OPV2</td>
</tr>
<tr>
<td>14 weeks</td>
<td>DPT-HepB-Hib3, OPV3</td>
</tr>
<tr>
<td>9 months</td>
<td>Measles,OPV4</td>
</tr>
<tr>
<td>18 Months</td>
<td>Measles</td>
</tr>
</tbody>
</table>

**Standard TT Immunization Schedule**

<table>
<thead>
<tr>
<th>Dose</th>
<th>When to give</th>
</tr>
</thead>
<tbody>
<tr>
<td>TT1</td>
<td>At first contact with woman of childbearing age (15-45 years old); Or as early as possible in pregnancy.</td>
</tr>
<tr>
<td>TT2</td>
<td>At least 4 weeks after TT1.</td>
</tr>
<tr>
<td>TT3</td>
<td>At least 6 months after TT2.</td>
</tr>
<tr>
<td>TT4</td>
<td>At least 1 year after TT3.</td>
</tr>
<tr>
<td>TT5</td>
<td>At least 1 year after TT4.</td>
</tr>
</tbody>
</table>

9- National Immunization strategies

**Strategy:**

- Routine EPI Services will be provided through the following:
  - **Fixed** (Annex-1) EPI training manual.
  - **Outreach** (Annex-1), including TT immunization in Schools.
  - **Mobile** (areas which are not covered on daily outreach and need additional time for travel). The implementing partner should plan at least four visits annually and try to include other services.

**Sub-Center:**

- Health facilities in specific geographical areas with significant population which are not covered through outreach and mobile activities. The sub-center should have cold box and vaccine carrier, and the midlevel should be trained on EPI. Immunization
sessions should be scheduled according to the population. One recommendation is to provide immunization sessions four times per year.

- Supplementary Immunization Activities (SIAs): Strategies to be adopted according to the specific objectives through specific guidelines.
  - (NIDs – Annex -2,
  - MMRC-Annex -3,
  - MNTE-Annex - 4)

10- Target population
Still National EPI has to use the UNDATE for all EPI activities except Polio Eradication, till new CSO DATA.

11- National Immunization Schedule
12- EPI service delivery strategies
- Routine immunization
  - Polio Eradication
  - Measles Elimination
  - Maternal and Neonatal Tetanus Elimination
  - Accelerated child survival initiative
  - Surveillance of Vaccine Preventable Diseases

Vaccine preventable diseases surveillance (AFP, Measles, MNT, Rota virus and AEFI)

Logistics and Cold Chain:
Based on the EPI logistic review done in 2002 the cold chain system in Afghanistan will have to be rebuilt renovated expanded and sustained to address existing and future needs. (Annex - 6)
- All vaccine procurement should meet WHO standards.
- All vaccine should be kept between +2 to +8 ºC at fixed center and out reach and mobile activities.
- Vaccine should be preserved at national and regional level, according to the manufacturer guidelines.
- Vaccine should be preserved maximum for 6 months at national level, 3 months at regional level, 2 months at provincial and one month at fixed center levels.
- The computerized stock management system should be maintained for vaccine and non-vaccine supply at national level and in the future at regional level.
- Procurement of vaccines and related supplies should be done considering the bundled supplying method, including auto-disable syringes and safety boxes.
- The party responsible for Basic Package of Health Services should include the cold chain equipment in planning according to capacity required standard at each level and the cost of cold chain equipment should be transfer to ISS account in Ministry of Finance.
- The party responsible for Basic Package of Health Services should manage (utilize and maintain) cold chain equipment based on their functionality, to ensure standard storage and transport of vaccines.

Vaccine supply and logistic
Multi dose open vial Policy:

Based on Revised WHO multi dose open vial policy, EPI policy advice is as follows:
Multi dose vials of OPV,TT and DPT-HepB-Hib and liquid formulation vaccines from which one or more doses of vaccine have been removed during an immunization session
may be used in subsequent immunization sessions for up to a maximum of 4 weeks, provided that all of the following conditions are met.

- The Expiry Date has not passed.
- The vaccines are stored under appropriate cold chain condition ( +2 to +8 °C).
- The vaccine vial septum has not been submerged in water.
- Aseptic technique has been used to withdraw all doses.
- The vaccine vial monitor (VVM) if attached has not reached the discard point.

The revised policy does not change recommended procedure for handling vaccine that must be reconstituted, that is, BCG, Measles.
Once they are reconstituted, vials of these vaccines must be discarded at the end of each immunization session or at the end of 6 hours, whichever comes first.

**Using of open multi dose vaccine vials during campaign or outreach.**

The new policy applies to all liquid vaccine vials including those that have been transported in the cold chain for outreach immunization sessions, provided that all the mentioned conditions outlined above are met. It is the responsibility of the vaccinator to ensure the above five conditions or dispose of the vaccine.

**Human Resource Management:**

- **Gender:**
  The policy is to increase the participation of females at all levels in routine and supplementary immunization activities for Polio eradication, Measles reduction and neonatal tetanus elimination efforts. The gender issue is an integral criteria / requirement for approving any NGOs’ proposal for EPI activities.

- Responsibility of National EPI

**Capacity building:**

All categories of EPI/health staff should be trained on refresher training periodically based on the program requirements.

**Co-ordination Mechanisms:**

- **ICC**

**Co-ordination Mechanisms:**

- Interagency Co-ordination Committee (ICC) at the National level should meet once in three months.( TOR ICC- Annex 5)
- National EPI Task Force should meet once in 15 days at MoPH. (TOR Annex-6)
- EPI Working Groups (TOR EWG – Annex..) should meet monthly at provincial level and present analysis and plans at monthly Provincial Health Coordination Committee (PHCC).
- Each region should have quarterly EPI review with all EPI partners.
- Each province should have EPI monthly review will all partners
- **District Health Officer should coordinate analysis of EPI routine coverage and surveillance data at district level on monthly basis.**
- Similarly, each facility In-charge should supervise and evaluate the EPI program on monthly basis.
  - Taskforce
  - NITAG
National Surveillance committee

**Partnership:**

- Ministry of Public Health (MoPH’s) main responsibilities are:
  - Approval and issue policy/strategies, guidelines, setting priorities, providing human resources;
  - Training, monitoring, supervision and evaluation, provision of centers/places, security, and salary for national staff;
  - Leadership, coordination, communication and ensuring quality of immunization services.
- BPHS-implementing-NGOs responsibilities are program implementation under the leadership of REMT and PEMT, provision of technical/financial support and contribution in supervision, monitoring and evaluation. The responsibility for program implementation includes service delivery in the whole district and maintenance of cold chain with support from PEMT. The NGOs will work under the policy and guidance of MoPH and will strictly follow the roles and regulations of the government.
- MOPH implements program in areas not covered by BPHS.
- BPHS Implementer should provide monthly salary or incentive at least 6000 Af/Month.
- BPHS Implementer should provide 200 Af for normal outreach and 500 Afg for Mobile (stay night) activities.
- BPHS Implementer should provide one EPI supervisor for 12-15 EPI fixed centers in respective area.
- BPHS Implementer should cover all contracted district through fixed, outreach and Mobile activities.
- Donors’ responsibilities are fund provision and program audit.
- UN responsibilities are provision of technical support, capacity building, assisting MoPH in procurement of EPI equipment, spare parts, and supplies, logistics, and operational support.
- Community responsibilities are provision of local resources in the form of EPI volunteers, guidance/social mobilization, logistic support and commitment in utilization of services.

**Responsibility of NGOs**

**Advocacy and Communication:**

**Communication:**

All EPI communication activities should be according to comprehensive EPI communication package/guidelines (Annex-7).

**Data management system:**

**Surveillance and data management system:**

- All EPI Date should be collected based on Afghan Calendar (Hiry Shamsi) and National EPI has responsible to adopt the Date for Donors and related departments.
- EPI information management system will be strengthened, expanded and linked to the current Health Management Information System (HMIS) at all levels.
- The EPI surveillance will gradually shift to the current structure of EPI under MoPH by institutionalizing it at all level.
- Active case-based surveillance of measles will be improved and maintained.
- Active surveillance of neonatal tetanus, diphtheria, and pertussis including reporting, clinical and epidemiological investigation will be institutionalized into the MoPH surveillance by the end of 2008
An AEFI surveillance system should be maintained for reporting AEFI at all levels.

Investigation and follow up actions must be done according to the Standard Guidelines. (Annex 9)

- EPI data has to be collected compiled and analyzed at the district, provincial and regional levels on monthly basis. PEMTs and REMTs have to lead and coordinate data processing with concerned partners in their respective areas.
- REMTs have the responsibility to provide compiled regional, provincial and district wise EPI data to national EPI office timely through all available communication channels on monthly basis.
- National EPI office is leading EPI data management process including compilation, analysis, reporting to MoPH related departments and authorities, UN partner agencies, donors and feedback. National EPI Office is the only official source for EPI information dissemination.

Supervision and monitoring:

- National, regional and provincial EPI staff and district health officers are responsible to supervise and monitor EPI activities. National staff provide supportive supervisory field visits at least biannually to REMTs/PEMTs. Scheduled supportive supervisory activities by REMT, PEMT and district health officers for service delivery will be conducted at least on quarterly, monthly and weekly basis respectively.
- EPI specific monitoring: All health implementing agencies are responsible to coordinate their EPI supervisory activities with the concerned MoPH EPI departments / staff at all levels.
- For all EPI supervisory visits standard EPI checklist should be used and on copy of the feedback sheet should be kept on file at the facility while the complete filled checklist should be kept on file at the PEMT. (Annex )
- Joint monitoring team: BPHS implementers and Provincial Health Team monitor health activities at selected centers on a monthly basis.

Monitoring of immunization data should be done at Provincial, Regional and National levels on Monthly base feedback should be give to the primary level.

Vaccine safety:

Safety of injection and disposal:

- All immunization injections given in EPI must be safe. This means that every injection must be given with a sterile, single-use (including auto-disable syringe and needle combination), which is then safely disposed of after use. (Annex –8).

Policy applies equally for (SIAs) Supplementary Immunization Activities.

Safety of injection:

Method of sharps and waste disposal

Coverage Survey and Evaluation:

- The EPI coverage survey will be conducted every 3 years with in depth program evaluation at the end of 3 years program cycle. ????? 5 provinces every year

Outbreak response:

- Outbreak of any EPI targeted diseases must be reported immediately to concerned departments of MoPH and other relevant organization at different levels.
- The response to the reported outbreaks should be according to standard MoPH guidelines, implemented jointly by BPHS implementer / MoPH with other EPI partners.

Sustainability:
EPI will be a sustainable project because the Ministry of Public Health is the main implementing agency and the main focus of the project is capacity building of the government staff at all levels. Through EPI the PEMTs and the REMTs have a capacity to store and manage vaccines and cold chain supplies as well as report on performance and outcomes. More than 40,000 Afghans health workers and volunteers are involved in polio eradication and measles campaigns. Simultaneously through UNICEF and WHO regular programs, routine EPI are being supported and will take the place of campaigns.

The strategies and lessons learned from EPI can be applied to future health interventions. Experience from other countries with successful EPI shows that this program can be used as the foundation for integrating health information, health worker training and distribution and logistics particularly for essential drugs, maternal health services and control of communicable diseases. Integration with other services in the basic package is a necessary ingredient for sustaining the EPI program. Overall EPI is one of the most cost-effective of all strategies available to the health sector. Recurrent costs are related to vaccine and cold chain equipment and salary support for government workers.

Though MoPH is currently unable to assume financial responsibility particularly at the provincial and district levels. Therefore external funding through major partners might be needed over the next 2-3 years as accountability mechanisms and management capacity are put in place.

**Immunization financing**

**Future resource requirement**

Introduction of new vaccine

Vaccine and cold chain management

Monitoring of Vaccine Wastage

**Wastage**

**General**

- The maximum acceptable level of wastage rate for Measles and BCG vaccines is 50%, for Penta 5% and for the other vaccines are 15%. All concerned are instructed to take and implement local initiatives for reduction of the wastage to an acceptable level.
- National Cold Chain Manager and all PEMTs are instructed to provide vaccines and supplies based on the absorption of the concerned teams (target and stock reports).
- All vaccinators are instructed to administer BCG only to children aged 0-11 months.

**To Reduce Vaccine Wastage at the Fixed centers (see also Annex 1)**

All PEMTs, NGOs are instructed that:

- In cases of few patients and high wastage, decision can be made by the immunization program in consultation with the head of the facility to reschedule sessions on alternate days or weekly with good communication to avoid missed opportunity.
- The schedule should be communicated to the communities. EPI Teams have to make a sign for Vaccination days, get it signed by head of the facility and hang it in visible places for information of staff and clients.
- All Health staff is instructed to screen and refer the eligible clients to EPI room for vaccination.
- The vaccinators should visit the targeted villages of the fixed center to:
  - Mobilize the women and children to visit EPI fixed centers
  - Follow immunization defaulters.
  - Collect information on AEFI or any rumors regarding immunization.
  - The above visit should be part of vaccinator’s activity plan and monitored by head of health facilities.
To Reduce Vaccine Wastage at Out-Reach (see Annex 1 below)

All PEMTs, NGOs are instructed to:

- Update district/team level micro-planning and reschedule immunization sessions on annual basis and plan outreach sessions for each three months to be signed by head of health facility
- Improve planning of outreach sessions in order to maximize number of eligible children and women in each session by:
  - Focusing on highly populated villages
  - Appropriate interval between out reach sessions for the same village
  - Planning outreach sessions in advance and communicating the schedule with the communities.
  - Plan with Community Health Worker Supervisors in order to use CHWs and implement joint interventions
  - Include Vaccine Promotion Days in the work-plan of vaccinators. Visit the out-reach target village prior to the immunization sessions and inform/mobilize the community about the session.

Additional Responsibility to Reduce Wastage

- All PEMTs and BPHS implementers are responsible to monitor vaccine wastage, vaccine ordering and monthly reporting of vaccine wastage at the provincial, district and EPI fixed center levels.

EPI Structure:

National EPI Office:
  - National EPI Manager,
  - Communication Officer,
  - Training Officer,
  - Monitoring and Evaluation Officer,
  - Surveillance Officer,
  - Admin /Finance Clerk,
  - 2 Drivers

National Cold Room:
  - National Cold Room Officer,
  - 4 Cold Chain Technicians,
  - 2 Guards, 1 Driver

REMT:
  - Regional EPI Manager,
  - 2 Supervisors,
  - 3 Cold Chain Technicians,
  - 2 Guards
  - 1 Driver

PEMT:
  - Provincial EPI Manager,
  - Supervisor,
  - 2 Cold Chain Technicians
  - 1 Guard
The EPI services will be provided by vaccinators; however other health workers in the health facility will be trained and provide EPI service delivery as back up during vaccinators’ absence from the facility.

- Standard training package to be applied for all categories of EPI staff and at all levels. MoPH with the support of WHO/UNICEF will take lead in the training.