2007 Annual Status Report

Presented by

the Government of

CAMEROON

to

Submission date **15 May 2008**

Submission deadline 15 May 2008
(along with the Excel spreadsheet in accordance with instructions)

Please return a signed copy of this document to:
Secretariat of the GAVI Alliance; c/o UNICEF, Palais des Nations, 1211 Geneva 10, Switzerland

Please submit any questions to Dr Raj Kumar, rajkumar@gavialliance.org or to representatives of a GAVI partner institution. All documents and appendices must be submitted in English or French, preferably in electronic format. They may be disclosed to GAVI partners, its employees and to the general public.

This report describes activities conducted in 2007 and sets forth requests for January – December 2009)

Signature pages for the SVS, the INS and the SVN

On behalf of the Government of CAMEROON

Ministry of Public Health:

Title: **Minister of Public Health**

Signature: ……

Date: ……

Ministry of Finance:

Title: **Minister of Finance**

Signature: ……

Date: ……

We, the undersigned members of the Interagency Coordination Committee (ICC), endorse this report, including the attached Excel spreadsheet. The signatures on the page following this document do not imply any financial (or legal) commitment by the partner institution or the individual.

The obligation to report on financial aspects is an integral part of the GAVI Alliance's monitoring of results within the countries. It is based on customary governmental standards concerning verification of accounts, as specified in the banking form.

The ICC Members confirm that the funds received from GAVI's funding agency were the subject of a financial audit and that their use was justified in accordance with the standard requirements of the Government or the partners.

Name/Title	Institution/Organisation	Signature	Date
S.E. André Mama Fouda Chairman of the IACC	**Ministry of Public Health**		
Dr Baye Lukong Martina Director of Family Health, Vice-Chairman of the IACC	**Ministry of Public Health**		
Dr. Nomo Emmanuel Permanent Secretary of GTC/EPI, Secretary of the IACC	**Ministry of Public Health**		
Mr. Maïna Djoulde Emmanuel, Head of the Cooperation Division,	**Ministry of Public Health**		
Dr. Ndiaye Faty Charlotte Representative	**OMS**		
Dr. Aïssata Ba Sidibe Representative, Head of Office	**UNICEF**		
Dr. Gerd Eppel Principal Technical Consultant for Health Projects	**GTZ**		
Mr. Jean Richard Bieleu Chairman of the Polio Plus National Commission	**Rotary International**		
Dr. Xavier Crespin Director	**Helen Keller International**		
Mr William Eteki Mboumoua, Chairman	**Croix Rouge Camerounaise**		
Dr. Mbessi Jean Robert Manager	**Organisation Catholique pour la Santé au Cameroun**		

Mr. Essobe John **Manager**	**Service de Santé Protestant, CEPCA**		

Signature page for SHS support

This section will be completed by the Technical Secretariat of the Sectoral Health Strategy

On behalf of the Government of …….

Ministry of Health:

Title: ……

Signature: ……

Date: ……

Ministry of Finance:

Title: ……

Signature: ……

Date: ……

We, the undersigned members of the National Committee on Health Sector Coordination (NCHSC) ……. (insert names) endorse this report on the strengthening health systems programme. The signatures on the page following this document do not imply any financial (or legal) commitment by the partner institution or the individual.

The obligation to report on financial aspects is an integral part of the GAVI Alliance's monitoring of results within the countries. It is based on the customary governmental standards with respect to account verification , as specified in the banking form.

The NCHSC Members confirm that the funds received from GAVI's funding agency were the subject of a financial audit and that their use was justified in accordance with the standard requirements of the Government or the partners.

Name/Title	Institution/Organisation	Signature	Date

Status report form: Table of contents

The text areas in this report are provided for information only. You may submit additional text outside of the space provided.

1. Report on progress achieved in 2007

1.1 Support for vaccination services (SVS)

Are funds received for SVS recorded in the budget? (Do they appear in the budgets of the Ministry of Health and the Ministry of Finance?): Yes/No
If yes, using the space below, explain in detail how they appear in the Ministry of Health budget.
If this is not the case, will they be recorded in the budget very soon?

The GAVI SVS funds appear in the Ministry of Public Health's budget each year, during budget planning coordinated by the Division of Research and Projects responsible for planning as well as in the Medium-Term Expenditure Framework.

1.1.1 SVS fund management

Please describe the SVS fund management mechanism, including the role played by the Interagency Coordination Committee (ICC).
Please report any problems you may have encountered when using these funds, such as delayed availability of funds to carry out the programme.

The IACC has a decentralised system to manage GAVI Funds which complies with rules for the management and control of public funds.

In the context of the sectoral health strategy and the EPI's comprehensive multi-year plan, an annual action plan is prepared and validated by the IACC.

GAVI Funds are deposited in a bank account in Yaoundé. In order to implement the plan and for any activities planned and being conducted by the EPI, a data sheet is prepared, accompanied by a corresponding budget, in accordance with the action plan budgeted for and adopted by the IACC. The dossier is submitted for evaluation by the Minister of Public Health, Chairman of the IACC, who authorises the activity's funding. A check co-signed by the EPI's Permanent Secretary (Secretary of the IACC) and the Director of Family Health (Vice-Chairman of the IACC) enables the funds to be paid out and made available. Like funds used for public property management, GAVI Funds are subject to the same rules related to government controls and verification.

At the operational level, an obligations framework document between the EPI and the health districts (HD) was prepared. Each HD presented its action plan setting forth objectives to be achieved and serving as the basis for allocation of funds. Supervision is arranged at the central, provincial and district levels, enabling technical monitoring of activities and traceable use of the funds.

1.1.2 Use of support for vaccination services

In 2007, the main activity sectors below were funded by resources from the GAVI Alliance's ***support for vaccination services****.*
Funds received during 2007: **$479,000 USD**
Balance (carried forward) from 2006: **$1,461,647 USD** (this balance differs from that stated in the 2006 report and in earlier reports)**
Balance carried forward in 2008: **$172,912 USD**

Table 2: Use of funds in 2007

Support for vaccination services sector	Total amount in USD	AMOUNT OF FUNDS			
		PUBLIC SECTOR			PRIVATE SECTOR*** & Others*
		Central	Region/State/ Province	District	
Quality assurance and inventory of vaccines	4,141	300	-	3,841	-
Injection equipment	-	-	-	-	-
Support personnel	160,527	88 936	71,591	-	-
Vaccine and equipment transport	30,488	-	-	30,488	-
Maintenance and general costs	98,309	97,401	908	-	-
IACC Operations and other supplies	16,803	16,803	-	-	-
Training	64,296	13,855	12,424	38,018	-
IEC / social mobilization	30,010	7,658	955	21,398	-
Actions directed at groups which are difficult to reach, frail and HD with weak coverage	45,130	-	4,330	40,800	-
Specific monitoring	33,814	26,393	7,420	-	-
Follow-up and evaluation	11,373	11,373	-	-	-
Epidemiological monitoring	14,898	5,807	-	9,091	-
EPI building construction	232,273	232,273	-	-	-
Vehicles	-	-	-	-	-
Cold chain equipment and computer equipment	0	0	0	-	-
Support for Provincial Units and Health Districts	454,545	-	113,636	340,909	-
Participation in various meetings	7,875	7,875	-	-	-
Vaccination campaigns	77,245	25,209	9,923	42,114	-
cMYP Preparation	11,149	11,149	-	-	-
Total:	1,288,735	544,731	221,187	522,817	-
Balance of funds for the following year:	-	-	-	-	-

If no information is available because block grants were paid, please note the amounts in the boxes reserved for "other" support sectors.
*** The 2006 balance in the current 2007 report is different from the 2006 report. Based on the letter sent by GAVI's SE to the Minister of Public Health No.GAVI/07/191/aba/rl of 10 October 2007, all calculations were repeated, taking into account payments and expenditures approved in the various status reports between 2001 and 2007 according to the table below.***

*** The private sector at the operational level is an integral part of the health district in Cameroon

Follow-up of payments and expenditure of GAVI-SVS funds from 2001 to 2007 in USD

Years	Received	Previous balance	Expenses	Remainder
2001-2002	553,500	-	348,000	205,500
	553,500	205,500	-	759,000
	1,107,000	759,000	-	1,866,000
	265,880	1,866,000	517,360	1,614,520
2003	1,472,980	1,614,520	543,078	2,544,422
2004	271,260	2,544,422	581,438	2,234,244
2005	1,266,000	2,234,244	1,108,532	2,391,712
2006	479,000	2,391,712	1,409,066	1,461,647
2007	-	1,461,647	1,288,735	172,912
TOTAL	**5,969,120**		**5,796,208**	**172,912**

Please attach the minutes of the meeting(s) of the ICC where the allocation and use of the funds was considered.

Please report the main activities carried out to strengthen vaccination, as well as problems that you encountered when implementing your multi-year plan.

Main activities conducted to strengthen vaccination services:

- Preparation of the EPI 2007-2011 Comprehensive Multi-Year Action Plan and its adoption by the IACC;
- Preparation of the EPI 2007 Action Plan and its validation by the IACC;
- Evaluation of EPI activities for 2006 and presentation of results to the IACC;
- The IACC met five times during 2007, with the Minister of Public Health personally presiding over the meetings;
- Vaccination data quality: immunisation cards, registers and tally sheets were made available in the vaccination centres;
- Training District Management Teams and provincial supervisors for the Centre, East, West and North provinces on the EPI management course (MLM Course); for 2007 only;
- Sign new service agreements and allocate funds to rural and community radio to increase awareness of local populations, broadcast skits and messages into isolated regions;
- Train the EPI provincial communications community;
- Train provincial logisticians and warehousemen in inventory management and logistics;
- Prepare message communication plans and educational media for vaccination campaigns and for the basic EPI;
- Training supervision: at the central level, two general EPI supervisions (in February, May and August) and specific supervision on epidemiological monitoring in 10 provinces was carried out; support for provincial supervision of districts and district supervision of health centres;
- Systematic micro-planning in health districts and signing of programme contracts to implement planned activities;
- External review of the Reach Every District approach;
- Acceleration of Basic EPI activities in health districts with low vaccination coverage in seven provinces;
- Receipt, quality control and distribution of vaccines in the provinces;
- Vaccination campaign against maternal and neonatal tetanus in 33 health districts;
- Fightback campaign against yellow fever in the Akonolinga and Zoetele health districts;
- Two fightback campaigns (Local Vaccination Days) against polio in the Extreme North province;
- Organise the monitoring campaign against the measles and distribute insecticidal bed nets in the seven southern provinces in January 2007;
- Train monitoring focal points in new health districts and hospitals in the south-west; increase

awareness among Wouri traditional healers.

Problems encountered:

- Priority and schedule conflicts between basic EPI activities and the various campaigns, especially vaccination campaigns;
- Insufficient funds to pursue courses in EPI management (MLM) in the remaining provinces and specific support for low performance districts;
- Highly inadequate rolling stock to implement the community-based strategy in isolated regions (motorcycles) and training supervision in health centres (vehicles);
- Inadequate funding for monitoring activities at all levels.

1.1.3 Quality control of vaccination-related data (QCD)

Next* QCD planned for **2009**

**If no QCD has had a positive outcome, when will a QCD be performed?*
**If the QCD had a positive outcome, the next QCD will take place five years after the positive QCD.*
**If no QCD has been performed, when will a QCD take place?*

What were the QCD's main recommendations?

N/A

Has an action plan been prepared to improve the reporting system based on the QCD's recommendations?

YES ☐ *NO* ☐

If yes, please specify the degree of progress achieved in its implementation and attach the plan.

N/A

Please attach the minutes of the ICC meeting during which ICC reviewed and adopted the action plan for the QCD.

This was already done in the 2003 and 2005 status reports.

Please provide information on studies carried out during 2007 on questions related to the QCD (for example, vaccine coverage surveys).

- External review of the Reach Every District (RED) approach;
- Evaluation of the EPI vaccine supply system
- Evaluation of the central warehouse.

1.1.4. ICC Meetings

How many times did the ICC meet in 2007? ***Please attach all minutes.***
Are there civil society organisations serving as ICC members? If yes, which ones?

The IACC met five times during 2007 on the following subjects:

- Fightback campaigns against polio in the Extreme North;
- the IACC's Adoption of the 2007 EPI action plan, the annual evaluation reports and the GAVI requests (SVS and SHS);
- Vaccination campaign against yellow fever in two HDs (Akonolinga and Zoétélé) and vaccination campaign against tetanus in 30 HDs;
- Campaign against the measles in seven southern provinces;
- Evaluation of the Reach Every District Approach.

Civil society organisations serving as members of the IACC are:

- Services de santé Catholique (Catholic Health Services);
- Services de santé du Conseil des Eglises Protestantes du Cameroun (Health Services of the Council of Protestant Churches of Cameroon);
- Conférence Islamique (Islamic Conference)

1.2. GAVI Alliance support for new or under-used vaccines (SNV)

1.2.1. Receipt of new and under-used vaccines in 2007

When was the new or under-used vaccine introduced? Please indicate any modification of doses per vial or vaccine presentation (for example, DTC vaccine + monovalent vaccine against hepatitis B into the DTC-hepatitis B vaccine) and the dates the vaccines were received in 2007.

The following vaccines were received in 2007 (with the support of GAVI):

Vaccine	Vial size	Doses	Date introduced	Date received (2007)
DTC-Hep B Vaccine	**10 doses**	**512,000 512,000 501,500 521,500**	**March 2005**	**03 May 2007 19 June 2007 16 November 2007 03 December 2007**
Vaccine against yellow fever	**10 doses**	**249,000 248,900**	**January 2004**	**24 May 2007 19 October 2007**

Note: 2008 JRF data on VAA must be updated, as the country has actually received a total of 831,400 doses of VAA. Of this amount, the Government contributed by purchasing 333,500 doses of VAA.

Please report any problems you encountered, if applicable.

We have not been informed of any problems.

1.2.2. Main activities

Please provide an overview of the main activities that were or will be carried out with regard to introduction, progressive use, strengthened services, etc. and describe any problems encountered.

Services provided

In 2007, the DTC3 vaccine coverage rate improved from 80.6% in 2006 to 82.2%, and the Vitamin A coverage rate rose from 62% to 73.6% for infants between 6 and 11 months. However, it should be noted that to maintain this performance, the Expanded Programme on Immunisation resorted to strategies to catch up incompletely vaccinated children in November and December 2007 in certain low-performance health districts in the Centre, Coastal, West, North-West, South and South-West provinces. Likewise, the percentage of health districts which have achieved a vaccine coverage rate of at least 80% for all antigens did not achieve the 47% target. The other antigens, VAR (73.5%), VAT2+ (65%) did not achieve their target performances of 78% and 68% respectively. Despite the improvements to the Reach Every District approach, its implementation has lost momentum. Indeed, a July 2007 external evaluation of the Reach Every District approach revealed a number of challenges:

- loss of enthusiasm among staff, which had already stopped implementing certain best practices as early as 2004 and 2005;
- the delayed arrival of funds and heavy dependence on outside funding;
- the need to properly carry out integration at the central and provincial levels: ensure that SWAp does not compromise the vigour of certain highly effective programmes;
- difficult working conditions: infrastructure deterioration, insufficient personnel management and loss of motivation among staff.

Communication

The recruiting and training of provincial information officers has strengthened the programme's communication's activities, along with improved monitoring of the performance of service agreements signed with rural radio. But communications activities continue to experience a lack of funding. In this regard, it should be noted that outreach directed towards industrial and commercial companies did not take place in 2007. Charitable provincial operations at the central level remain a challenge.

Vaccine supply and quality assurance

In 2007, vaccine availability was ensured, including the co-financing of new vaccines through the partnership with the Global Alliance for Vaccines and Immunization (GAVI). Quality control activities and MAPI surveillance are in operation. However, allocation of budget line items to allow pre-positioning of vaccine and equipment inventory in 2008 has not been carried out, and the evaluation of the initial phase of the PPTE project has taken longer than expected. Measures have been taken and everything is being implemented by the Ministry of Public Health and the Ministry of Finance in order to catch up from this delay. This will allow us to avoid an inventory shortage in 2008. Migratory movement of Central African populations and refugees from Chad in the eastern border provinces, from Adamaoua and the Extreme North, the areas surrendered following the decision in the Bakassi conflict, are at the root of increased demand for vaccines. This will increase the risk of a vaccine inventory shortage in 2008.

Though the quality of vaccine management has generally improved at all levels, and especially at the central and provincial levels, breakdowns continue to take place on the periphery. Such breakdowns are especially due to the quality of conservation equipment and the staff's skills. Though the MAPI notification system is functional, it is not completely so due to central coordination.

Logistics

A significant quantity of equipment was purchased with HIPC funds: 98 motorcycles, 13 Pick Up all terrain cars for supervision, to strengthen the community-based strategy, 20 compression-type refrigerators, 100 infant scales. Other equipment was the subject of calls for tender issued on C2D funds in 2007 currently underway: 1650 refrigerators, 6 generator units, 7 cold chambers, 5000 vaccine carriers, on-board spare kits and incinerators. Despite these efforts, need for rolling stock remains very high for the community-based strategy in isolated areas and for district supervision. Jailing motorcycles purchased with PPTE funds have proven fragile on the terrain, in addition to problematic maintenance due to a lack of spare parts in the local market. 3/4 of health districts to not have an operating supervision vehicle. The North-West and South-West provinces are especially affected. The same applies in the maritime and isolated areas of the Coastal province, the South-West (Bakassi) and Lake Chad which do not yet have motorized canoes to allow health care personnel to better cover these areas.

Monitoring

Epidemiological monitoring remains within normal limits at the national level. In 2007, however, very poor performance was noted in major cities (especially Yaoundé and Douala) and in provinces bordering Nigeria and Chad, countries in which poliomyelitis remains in circulation (Centre, Extreme North and South-West provinces). The risk of propagation below epidemic thresholds remains significant in light of this situation. The community remains inadequately involved in epidemiological surveillance activities.

Accelerated initiatives to fight against illness

Accelerated initiatives to fight poliomyelitis, control measles and yellow fever and eliminate maternal and neonatal tetanus continued to be implemented in 2007. With respect to poliomyelitis eradication, a case of wild polio virus that proved to be a false positive was reported in the New-Bell HS in Douala in the Coastal province; a fightback immunization campaign was conducted. It should also be noted that the fightback plan in the event of a wild polio virus has not yet been validated by the IACC and that the polio virus confinement activities that were interrupted in 2004 should be relaunched. With respect to the programme to eliminate maternal and neonatal tetanus, the third campaign cycle for the second series of districts has been carried out. However, it should be noted that the implementation calendar for the high-risk tetanus approach has been significantly delayed. Instead of a preventative vaccination campaign against yellow fever, in 2007 a fightback vaccination campaign was organised in the Akonolinga and Zoétélé health districts. The delay results from the OMS AFRO team's schedule, which must finalise the selection of high-risk health districts. In addition, it should be acknowledged that the Government has made significant efforts to raise matching funds in proportion to 700 million CFA francs in 2007.

Programme management

External review of the Reach Every District approach revealed that most districts created their action plans in 2007, and that there are resource management directives. The inventory of EPI equipment has also been updated at various levels, but a certain number of weaknesses remain, including the absence of micro plans at the health centre level, the non-existence of activity time charts in the districts and the concept of a leading health centre is not yet practical in the health centres which count several health care facilities,

especially in the cities.

Activities to strengthen the health system within the scope of SWAp implementation remain in the start-up phase in 2007. Integrated planning, coordination, monitoring and supervision will be launched in 2008.

Strengthening skills

Training of EPI personnel in management (MLM) and epidemiological monitoring is taking place in the Centre, East, West and North provinces. There is a standardized supervision form at various levels. However, we have noted low levels of supervision. Supervision reports are lacking in health centres. The quality of supervision continues to require improvement.

Funding

The funding rate for 2007 EPI activities is 87%, a deficit of $3.7 million USD. This shortfall is especially marked at the cold chain level ($1.4 million USD), operating costs ($1 million USD) and vaccination campaigns ($2.2 million USD). Funding for vaccination activities at the health district and health centre levels is not always available, all the more because budgeting has not been done and, when it is done by the district, health centres are not involved. Top to bottom integrated planning aimed at strengthening the system will correct this weakness.

Integration

Vitamin A administration is fully integrated in to the basic EPI for children between 6 and 11 months. A measles vaccination campaign integrated with Vitamin A and the distribution of insecticidal bed nets was organised in the seven southern provinces. The EPI participated in health and nutrition missions with central African refugees from the East and from Adamaoua, and in preparation for the Semaine d'Actions de Santé et de Nutrition Infantile et Maternelle (Action Week on Infant and Maternal Health and Nutrition) (SASNIM) in January 2008. However, lessons learned from these integration activities demonstrate that effective resource integration and coordination continues to require improvement.

1.2.3. Use of the GAVI Alliance's financial support to introduce a new vaccine

These funds were received: **Not received in 2007**

Please report on the portion of the allowance used for introduction, activities undertaken and problems encountered such as delayed availability of funds to carry out the programme.

N/A

1.2.4. Vaccine management evaluation/effective management of the vaccine warehouse

The latest vaccine management evaluation (VME)/effective management of the vaccine warehouse (EMVW) July 2005 for effective management of the vaccine warehouse and 2006 for vaccine management.

Please summarise the main recommendations of the VME/EMVW.

The recommendations for evaluating effective management of vaccine warehouses conducted in July 2005 were as follows:

- Strengthen the vaccine information management system;
- Prepare a document containing procedures and standards of operation;
- Strengthen the capacity of the Autorité Nationale de Réglementation to implement the four basic functions;
- Establish systematic archiving of all documents related to inventory supply and management;
- Support the country in preparing strategies and procedures to maintain EPI equipment;

- Enter into contracts for corrective maintenance of EPI equipment;
- Build an ambient temperature storehouse;
- Establish an inventory of spare parts and consumables for devices that continuously record temperature.

As for evaluation of the Cameroon supply system in 2006, the recommendations are as follows:

- Harmonise procedures and tools related to quantitative and qualitative forecasts of needs and orders for vaccine and consumables
- Formalise and implement supply procedures, taking into account the operational characteristics of each supply channel;
- Strengthen national capacities in inventory management, lot release and MAPI monitoring.
- Implement procedures and tools for the [*unknown word*] in vaccines;
- Reduce taxes and customs duties on vaccines, cold chain equipment and consumables intended for the EPI;
- Reorganise biomonitoring activity at LANACOME and equip it to handle vaccine quality control;
- Generalise the preparation of main organisational, operational and management principles for each main player such as DPM-IGSP-GTC/PEV-LANACOME-CENAME.

Have you prepared an action plan following VME/EMVS: Yes/No

If yes, please summarise the main activities that fall within the scope of the EMVS plan and those activities aimed at implementing the recommendations.

Main action plan activities to improve the supply system in Cameroon, 2007:

- Systematize vaccine certification, regardless of the acquisition method;
- Prepare/adapt lot recall procedures;
- Distribute vaccine certification updates in Cameroon;
- Prepare/adapt technical specifications for EPI vaccines;
- Prepare/adapt specifications related to acquisition procedures for EPI vaccines;
- Prepare/adapt a joint vaccine supply procedure (EPI, CENAME);
- Ensure monitoring and feedback of vaccine usage;
- Implement a maintenance system for cold chain equipment;
- Train personnel involved in vaccine management in cold chain management;
- Make funds available in the CENAME account at the time the need is expressed.

The next VME/EMVS will take place in 2009

**During phase 2 of GAVI, all countries will be required to conduct a VME/EMVS during the second year of new vaccine support.*

Injection safety (INS)

1.3.1 Receipt of support for injection safety

Received in funds / in kind *Funds not received in 2007*

Please report support received from the GAVI Alliance in 2007 for injection safety (add lines if necessary)

N/A, INS support ended in 2005.

Injection safety equipment	Quantity	Date received

Please describe any problems encountered, if applicable.

N/A

1.3.2. Status of transition plan for injection safety and sharps waste management

If support has ended, please specify how injection safety equipment is funded.

This was passed on to the government. Injection safety equipment is purchased through the Centrale Nationale d'Achat des Médicaments Essentiels (Cameroon's trading group for essential medications), through annual funding from the public budget (PPTE).

These purchases include:

- Auto-disable syringes;
- Diluter syringes;
- Safe boxes.

Please report the methods used to dispose of sharps waste.

There is a National Strategy on Injection Safety and Destruction of used injection equipment. Waste generated by vaccination injections are collected in safe boxes. These are burned and buried in trenches, or incinerated where incinerators are available.

On the other hand, the management of other hospital waste generally remains a problem.

Please described problems encountered during implementation of the transition plan for injection safety and sharps waste management.

Problems encountered:

- Inadequate means to build incinerators as set forth in the plan;
- The durable incinerator model for large scale use has not yet been adopted.
- Difficulties with peripheral storage of injection equipment, leading to a need for storage space at the provincial and central levels. To resolve this problem, new storehouses are being built both centrally (01) and in the 10 provinces. The same applies to transport and injection equipment through private providers.

1.3.3. Declaration on the use of the GAVI Alliance's support for injection safety in 2007 (if received as an inflow of funds)

The main activities set forth below were funded (specify the amount) during the year just ended through GAVI Alliance injection safety support:

N/A

2. Co-financing of vaccines, vaccination funding and financial viability

Table 2.1: Total expenses and funding for vaccination

Table 2.1 is intended to help GAVI understand trends in overall vaccination expenses and the flow of funding. A comprehensive multi-year plan (cMYP), updated for the year of this report, may be submitted in place of Table 2.1.

	2007	2007	2008	2009
	Actual	Projected	Projected	Projected
Expenses per item				
Vaccines	4,438,444	4,203,791	4,785,451	11,606,216
Injection equipment	557,704	552,293	592,132	637,423
Cold chain equipment	3,562,371	4,955,748	2,783,786	3,058,205
Operating expenses	4,818,582	5,861,113	7,680,814	7,176,133
Other (please specify)				
Vehicles and other capital costs	2,751,307	552,650	3,078,439	1,823,699
Vaccination campaigns	2,519,271	4 775 480	3,764,570	8,055,510
Shared costs	7,245,652	8 647 190	2,841,365	8,921,671
Funding by source				
Government (including World Bank loans)	8,680,145	9,533,805	10,716,784	11,636,746
PPTE	3,890,021	3,845,463	3,927,532	3,312,905
GAVI Fund	4,755,326	4,426,774	4,438,677	11,816,440
UNICEF	2,347,687	2,475,451	1,535,620	3,727,250
OMS	1,592,676	955,845	842,354	1,783,208
Other (please specify)				
France	5,237,882	4,662,648	4,819,104	1,583,002
HKI	193,124	279,169	362,000	258,710
Plan	21,000	21,000	10,000	11,672
Rotary	100,000	100,000	115,000	100,000
GTZ		11,742	11,742	11,742
Total expenses	25,793,343	29,495,270	26,778,813	34,241,676
Total funding	25,793,343	26,311,889	26,778,813	34,241,676
Total funding deficit	3,701,927	3,183,381	4,155,612	6,399,759

Please describe trends in expenses and funding of vaccinations during the year of this report, such as differences between expenses, funding and projected and actual deficits. Explain in detail the reasons for these trends and describe the prospects for the immunization programme's financial viability during the next three years. Indicate whether the funding deficits are manageable, if they represent a problem or if they are alarming. In the latter two cases, explain which strategies are being used to correct the deficits as well as the causes of these deficits – increased expenses in certain budget items, loss of funding sources, a combination of the two factors, etc.

In 2007, resource needs equalled $29,495,270 USD, but the program was able to raise $25,793,343, i.e. a deficit of $3,701,927 USD, a resource mobilisation rate of 87.4%. This shortfall is especially marked at the cold chain level ($1.4 million USD), operational costs ($1 million USD) and vaccination campaigns ($2.2 million USD).

- With regard to the cold chain, the deficit is due to the fact that, despite financing promised by France for the cold chain within the scope of C2D, there remains a gap of $1,192,255 USD, enlarged because not all of the financing from various partners could be mobilised.
- Concerning the vaccination campaign deficit, this gap is noticeable because all financing needed for the 2007 campaigns was mobilised (polio, tetanus and fightback against yellow fever in the Akonolinga health district. On the other hand, the preventive vaccination campaign against yellow fever in at-risk health districts was postponed in 2008, because it was necessary to wait for the consultant to finalize the list of concerned health districts. The same applies to the third recruitment in the context of the tetanus at-risk approach.
- The operating costs deficit is due to inadequate mobilization of funds, especially in the following entries: Control and monitoring of illnesses, supervision, community-based and mobile strategies, maintenance costs.

For the vaccination campaigns, integration of activities will allow cost reductions, and we will advocate to major companies to interest them in financing immunization activities by organizing action weeks focused on infant and maternal health and nutrition (SASNIM).

The launch of the second phase of the PPTE project and SWAp health projects in the scope of strengthening the system will enable us to reduce the cold chain equipment gap, as well as France's major contribution through C2D. Indeed, in the context of SWAp, we expect to strengthen the health care supply, including the cold chain equipment in four provinces (Adamaoua, Extreme North, North and South).

Concerning measures to guaranty the reliability and effectiveness in the use of available resources, a study is planned for 2008 and 2009 on the harmonization of programme partners' financial procedures, preparation of an administrative, financial and accounting procedures manual, computerization of financial management and strengthening the staff's capabilities on the new procedures in force.

We will reach out to new private partners in seeking additional financing, especially taking advantage of the opportunity offered by SASNIM.

Table 2.2: Co-financing by country (in $US)

Table 2.1 is intended to assist in understanding the degree of co-financing for vaccines allocated by GAVI at the national level. If your country has received more than one new vaccine, please complete a separate table for each new co-financed vaccine.

For the first vaccine allocated by GAVI Specify which vaccine is involved (Anti-amaril vaccine)	**2007**	**2007**	**2008**	**2009**
	Actual	Projected	Projected	Projected
Co-financing (in $US by dose)				
Government	0.80	0.15	0.30	0.35
Other sources (please specify)				
Total co-financing (in $US by dose)	**0.80**	**0.15**	**0.30**	**0.35**

Please describe and explain past and future co-financing trends for the first vaccine allocated by GAVI.

In 2007, the Expanded Programme on Immunisation received 978,200 doses of VAA, of which the Government purchased 333,500 doses for $667,485.46 USD, all expenses included. Thus, for the yellow fever vaccine, the Government co-financing amount equals $0.68 USD. This co-financed amount is 5.33 times higher as compared with that stated in the PPAC and in GAVI's classification ($0.30 USD per dose).

This increased co-financing cost results from the fact that the country ordered this vaccine itself through its national supply structure. In other words, the co-financing cost is calculated using tools (PPAC and Requêtes) based on the UNICEF unit cost which is lower as compared with the unit costs offered to the national supply centre from essential medications and medical consumables (CENAME).

Ultimately, projecting Government co-financing based on UNICEF unit costs distorts projections in terms of cost and the quantity of vaccines and consumables for which the Government must take responsibility.

For the second vaccine allocated by GAVI Specify which vaccine is involved: **DTC-Hepatitis B**	**2007**	**2007**	**2008**	**2009**
	Actual	Projected	Projected	Projected
Co-financing (in $US by dose)				
Government	0	0.27	0.34	N/A
Other sources (please specify)				
Total co-financing (in $US by dose)	0	0.27	0.34	N/A

Considering the introduction of the pentavalent initially planned in 2008, and considering the sufficient quantity of the tetravalent DTC-HepB vaccine available at the time in the country, the Government did not purchase this vaccine in 2007, in order not to waste it.

However, funds intended for the purchase of the tetravalent vaccine were used to purchase other traditional vaccines. This enabled us to address the needs of Central African immigrant populations in the Adamaoua and East provinces, and the Chadian refugee population in the Extreme North province.

Please describe and explain past and future co-financing trends for the third vaccine allocated by GAVI.

For the third vaccine allocated by GAVI Specify which vaccine is involved: **DTC-HepBHib**	**2007**	**2007**	**2008**	**2009**
	Actual	Projected	Projected	Projected
Co-financing (in $US by dose)				
Government	N/A	N/A	N/A	0,17
Other sources (please specify)				
Total co-financing (in $US by dose)	N/A	N/A	N/A	0,17

Please describe and explain past and future co-financing trends for the second vaccine allocated by GAVI.

The introduction of the pentavalent vaccine was rescheduled for January 2009 at the IACC held on Wednesday 12 March 2008

Table 2.3: Co-financing by your country (in $US)

The purpose of Table 2.3 is to understand, at a national scale, the process for integrating co-financing requirements in your country's planning and budgeting process.

Q. 1: What mechanisms are currently used by your country's Ministry of Health to purchase EPI vaccines?			
	Check if yes	List the corresponding vaccines	Funding source
Government purchases – international competitive bidding (ICB)	X	BCG, VAT, DTC-HepB, VPO, VAR, VAA, and soon (DTC-HepB-Hib)	PPTE
Government purchases - Other			
UNICEF	X	VAA, DTC-HepB, and soon DTC-HepB-Hib	GAVI
Renewable PAHO funds			
Gifts			
Other (specify)			

Q. 2: Are there differences between the proposed payment schedule and the actual schedule for the year of this report?		
Schedule of co-financed payments	Proposed payment schedule	Actual payment dates for 2007
	(month/year)	(day/month)
1st allocated vaccine (specify): Yellow fever	June 2006	January 2007
2nd allocated vaccine (specify): DTC-HepB	N/A	This vaccine was intentionally not ordered in anticipation of the pentavalent introduction; consequently, the quantities of other traditional vaccines were increased
3rd allocated vaccine (specify): DTC-HepBHib		Payment scheduled in 2008

Q. 3: Are co-financing requirements integrated into the national planning and budgeting systems set forth below?	
	Respond by yes or by N/A if not applicable
Budget items for purchasing vaccines	Yes
National health sector plan	Yes
National health budget	Yes
Medium Term Expenditure Framework	Yes
Sectoral Approach (SWAp)	Yes (in progress)
Analysis of PPAC financing and costs	Yes
Annual vaccination plan	Yes
Other	

Q. 4: What factors have slowed and/or held up mobilization of resources for co-financing vaccines?

1.	In 2007, the country planned to transfer funds and pre-position vaccines in 2006, but the transfer of funds was only completed in January 2007 due to slow administrative procedures to release the funds.
2.	Delays in the tender offer procedures and actual delivery also contributed to slowing deliveries.
3.	With regard to vaccine pre-positioning to be done in 2007 for 2008, the release of funds was delayed due to the PPTE project transition from the first phase to the second phase.

3. Demand for new or under-used vaccines for 2009

*Part 3 concerns the demand for new or under-used vaccines and injection safety for **2009**.*

3.1. Updated vaccination goals

Confirm/update the primary data approved in your country's proposal: the statistical data must correspond to that provided in the joint OMS/UNICEF Report setting forth vaccination activities. Any change and/or variation **MUST** be justified in the box provided for this purpose. Objectives for upcoming years **MUST** be specified.

In the box below, please provide justification for changes in the primary data, objectives, loss rates, vaccine types, etc. in relation to the previously approved plan, as well as differences in the figures provided in relation to those that had been declared in the joint OMS/UNICEF Report setting forth vaccination activities.

In 2007, the DTC-HepB3 vaccine coverage rate was 82.49%, in line with projections in the PPAC and the joint OMS/UNICEF reports, i.e. 613,051 children vaccinated against 582,319 children vaccinated in 2006.

Vaccine	Target population	Number of children vaccinated	Vaccine coverage rate
BCG	836,074	680,305	81.30
DTC-HepB1	743,177	665,578	89.55
DTC-HepB3	743,177	613,051	82.49
Polio3	743,177	604,077	81.28
VAR	743,177	548,752	73.83
VAA	743,177	546,333	73.51
Vitamin A 100,000 IU	743,179	549,674	73.96
Vitamin A 200,000 IU	2,601,130	919,896	35.37
VAT 2+	926,971	622,625	67.02
Post-partum Vitamin A	836,077	454,315	54.34

In order to demonstrate alignment with the Millennium Development Objectives and the GIVS (90% vaccine coverage for DTC-HepB3 at the national level with at least 80% vaccine coverage in all health districts in 2010, the country reviewed PPAC objectives. The DTC-HepBHib vaccine coverage objective thus moved from 89% in 2010 to 90%.

Evaluation of the quantities of DTC-HepB in various provinces in February 2008 revealed the existence of a large inventory of this vaccine that could cover a seven month period (1,886,420 doses). This situation led the country to postpone the planned July 2008 introduction of the Hib until January 2009.

Considering the postponed introduction of the DTC-HepHib, the 13% DTC-HepB loss rate for 2008 has been maintained.

Given the three reasons set forth above, the future objectives of EPI 2007-2011 are now as follows:

Table 1: Vaccine Coverage Objectives

	Vaccine Coverage Objectives				
Vaccine Type	**2007**	**2008**	**2009**	**2010**	**2011**
Routine Vaccination	**(%)**	**(%)**	**(%)**	**(%)**	**(%)**
Traditional Vaccines					
BCG	82%	85%	87%	89%	90%
Measles	78%	82%	85%	88%	90%
Polio (VPO)(1)	87%	88%	90%	92%	94%
VAT – Pregnant women	68%	75%	80%	82%	84%
Vitamin A 100000 IU	100%	100%	100%	100%	100%
Vitamin A 200000 IU	45%	55%	65%	75%	80%
New and under-used vaccines					
Yellow fever	78%	82%	85%	88%	90%
DTC-Hep B (3)	82%	86%			
DTC-HepB-Hib (3)			88%	90%	91%
Pneumococcal				90%	91%
Rotavirus					91%

Table 2: Vaccine Loss Rate Objectives

	Vaccine Loss Rate Objectives				
Type of vaccine	**2007**	**2008**	**2009**	**2010**	**2011**
Routine Vaccination	**(%)**	**(%)**	**(%)**	**(%)**	**(%)**
Traditional Vaccines					
BCG	50%	47%	45%	43%	40%
Measles	25%	22%	20%	18%	17%
Polio (VPO)(1)	15%	13%	12%	11%	10%
VAT – Pregnant women	19%	18%	16%	15%	15%
Vitamin A 100000 IU	5%	5%	5%	5%	5%
Vitamin A 200000 IU	5%	5%	5%	5%	5%
New and under-used vaccines					
Yellow fever	25%	22%	20%	18%	17%
DTC-Hep B	15%	13%			
DTC-HepB-Hib			5%	5%	5%
Pneumococcal				5%	5%
Rotavirus					5%

Table 3: Attrition Rate Objectives

	Attrition Rate Objectives				
	2007	**2008**	**2009**	**2010**	**2011**
Specific attrition rate < 5% DTC-HepB/DTC-HepBHib	90% DS	92% DS	96% DS	98% DS	100% DS

Table 5: Update of actual vaccination outcomes and annual objectives. Please provide figures indicated in the 2007 joint OMS/UNICEF report as well as forecasts for 2008 and beyond.

Number of	Outcomes and objectives									
	2006	2007	2008	2009	2010	2011	2012	2013	2013	2015
DENOMINATORS										
Births	812,511	836,074	860,320	825,269	910,942	937,359				
Infant deaths	90,279	92,897	95,591	98,363	101,216	104,151				
Surviving infants	722,232	743,177	764,729	786,906	809,726	833,208				
Infants vaccinated up to 2007 (Joint report) / to be vaccinated in 2008 and beyond with the **1st dose** of DTC (DTC1)*	626,081	665,578	688,208	723,762	760,794	791,031				
Infants vaccinated up to 2007 (Joint report) / to be vaccinated in 2008 and beyond with the **3rd dose** of DTC (DTC3)*	582,319	613,051	657,667	692,478	728,754	758,220				
NEW VACCINES**										
Infants vaccinated up to 2007 (Joint report) / to be vaccinated in 2008 and beyond with the **vaccine against yellow fever** *(new vaccine)*	N/A	N/A	672,962	708,215	744,948	783,216				
Loss rate up to 2007 and rate expected in 2008 and beyond *** for the **vaccine against yellow fever** (new vaccine)	N/A	NA	22%	20%	18%	17%				
Infants vaccinated up to 2007 (Joint report) / to be vaccinated in 2008 and beyond with the **1st dose** of **DTC-HepB** (new vaccine)	626,081	665,578	688,208	723,762	760,794	791,031				
Infants vaccinated up to 2007 (Joint report) / to be vaccinated in 2008 and beyond with the **3rd dose** of **DTC-HepB** (new vaccine)	582,319	613,051	657,667	692,478	728,754	758,220				
Loss rate up to 2007 and rate expected in 2008 and beyond *** for the **DTC-HepB** (new vaccine)	N/A	N/A	5%	5%	5%	5%				
INJECTION SAFETY**										
Pregnant women vaccinated / to be vaccinated with the tetanus toxoid	561,154	622,625	716,934	786,906	829,970	874,969				
Infants vaccinated / to be vaccinated with BCG	613,631	680,305	731,272	770,184	810,738	843,623				
Infants vaccinated / to be vaccinated against measles (1st dose)	523,758	548,752	627,078	668,870	712,559	749,887				

* Indicate the actual number of vaccinated children during past years and updated objectives (with DTC only or associated)
** Use three lines (as indicated in the chapter entitled **NEW VACCINES**) for each new vaccine introduced
***Indicate the loss rate actually recorded during past years
**** Insert required lines

3.2 Confirmed/revised demand for new vaccines (to be provided to the UNICEF Supply Division) for 2009

In the event of a change in vaccination form or increase in your demand, please indicate below if the UNICEF Supply Division has ensured that the new quantity/form of supply is available.

N/A

Please provide the Excel spreadsheet calculating the duly completed demand for vaccines.

Remarks

- **Phase-in:** Please adjust the targeted number of children that will receive the new vaccines if a phase-in is contemplated. If the target number for the three Hepatitis B vaccines and the anti-Hib vaccine is different from the three DTC doses, please provide the reasons for this difference.
- **Vaccine wastage:** countries are supposed to forecast a maximum loss of 50% for a lyophilized vaccine in 10 to 20 dose vials, 25% for liquid vaccine in 10 to 20 dose vials and 10% for all vaccines (liquid or lyophilized) in 1 to 2 dose vials.
- **Buffer inventory:** buffer inventory is recalculated each year as being equal to 25% of current vaccine requirements.
- **Vaccines due to be in stock at the beginning of 2008:** this number is calculated by counting the current balance of vaccines in stock, including the balance of buffer stock. Record a zero if all vaccines provided during the year (including buffer stock) will likely be consumed before the beginning of the following year. Countries with none or few vaccines in inventory are requested to justify their vaccine use.
- **Auto-disable syringes;** a loss factor of 1.11 is applied to the total number of vaccine doses requested from the Funds, excluding vaccine losses.
- **Reconstitution syringes;** they only concern lyophilized vaccines. Record a zero for other vaccines.
- **Safety containers:** a multiplication factor of 11.1 is applied to safety containers to account for areas where a box will be used for fewer than 100 syringes.

Table 7: Loss rates and factors

Vaccine loss rates	5%	10%	15%	20%	25%	30%	35%	40%	45%	50%	55%	60%
Equivalent loss factor	1.05	1.11	1.18	1.25	1.33	1.43	1.54	1.67	1.82	2.00	2.22	2.50

Confirmed/revised demand for support for injection safety for 2009 N/A

Table 8: Estimated supplies for vaccination safety for the next two years with . . . *(Use one table per vaccine: BCG, DTC, measles and tetanus toxoid and list them 8a, 8b, 8c etc.) Please use the same objectives as in Table 5.*

		Formula	For 2008	For 2009
A	Target number of children for vaccination . . . for tetanus toxoid: Target number of pregnant women) (1)	**#**		
B	**Number of doses per child (for the tetanus toxoid: target number of pregnant women) (1)**	**#**		
C	**Number of doses of ….**	**A x B**		
D	**Auto-disable syringes (+10% of losses)**	**C x 1,11**		
E	**Buffer inventory of auto-disable syringes (2)**	**C x 0,25**		
F	**Total auto-disable syringes**	**D + E**		
G	**Number of doses per vial**	**#**		
H	**Vaccine loss factor (3)**	**2 or 1.6**		
I	**Number of reconstitution syringes (+10% of losses) (4)**	**C x H x 1.11/G**		
J	**Number of safety containers (+10% more)**	**(F + I) x 1.11/100**		

1 Contribute up to 2 doses maximum for pregnant women (estimate provided by the total number of births)
2 Buffer inventories of vaccines and auto-disable syringes is set at 25%. This inventory is added to the initial dose inventory required to introduce the vaccination to a given geographic region. Record a zero for other years.
3 The standard loss factor will be used to perform the calculation for reconstitution syringes. It will be 2 for BCG and 1.6 for measles and yellow fever.
Only for lyophilized vaccines. Record a zero for other vaccines.

If the quantity of actual demand differs from that set forth in the GAVI approval letter, please state the reasons.

4. Strengthening the health system (SHS)

This part must only be completed by countries whose request for SHS support was approved. It will serve as the initial report to enable the release of funds for 2009. Consequently, countries must report activities undertaken in 2007.

Start of support for strengthening the health system: _____ (date)

Ongoing support for strengthening the health system will be completed on: _____ (date)

Funds received in 2007: Yes/No
If yes, date received: (day/month/year)
If yes, total amount: $US _____
Funds disbursed to date: $US _____
Balance of payment remaining due: $US _____

Amount requested for disbursement in 2009 $US _____

Are the funds recorded in the budget? (Do they appear in the budgets for the Ministry of Health and the Ministry of Finance?): Yes/No
If not, please provide the reasons. How do you make certain that the funds are recorded in the budget?

Please provide a brief statement on the SHS support programme including the main activities conducted, mentioning whether the funds were disbursed in accordance with the implementation plan, the main outcomes (especially impacts on health services programmes and especially on the vaccination programme), problems encountered and the planned or supplied solutions, and any other important information that you wish to provide GAVI. You may provide more detailed information in Table 10 to indicate, for example, whether the activities were put into practice in accordance with the implementation plan.

Do civil society organisations participate in implementing the SHS proposal? If yes, describe their involvement.

If you request a modification of the implementation plan and the disbursement schedule as set forth in the proposal, please provide the reasons and justify the modification of your disbursement request. A more detailed breakdown of expenses may be provided in Table 9.

Please attach the minutes of the meeting(s) of the NCHSC where the disbursement of funds and the request for the following payment were considered. Please attach the most recent evaluation reports for the health sector and the verification report on the account to which the SHS funds are transferred. This is a condition for the release of funds in 2009.

Table 9. SHS expenses in 2007 for SHS activities and your 2009 request. (In the event of a change in your 2009 request, please state the reasons in the summary below).			
Support sector	**2007 (Expenses)**	**2007 (Balance)**	**2009 (Request)**
Cost of activities			
Objective 1			
Activity 1.1			
Activity 1.2			
Activity 1.3			
Activity 1.4			
Objective 2			
Activity 2.1			
Activity 2.2			
Activity 2.3			
Activity 2.4			
Objective 3			
Activity 3.1			
Activity 3.2			
Activity 3.3			
Activity 3.4			
Support costs			
Management costs			
Support costs for S&E			
Technical assistance			
TOTAL COSTS			

Table 10. SHS Activities in 2007	
Main activities	**2007**
Objective 1	
Activity 1.1	
Activity 1.2	
Activity 1.3	
Activity 1.4	
Objective 2	
Activity 2.1	
Activity 2.2	
Activity 2.3	
Activity 2.4	
Objective 3	
Activity 3.1	
Activity 3.2	
Activity 3.3	
Activity 3.4	

Table 11. Benchmark indicators						
Indicator	**Source of data**	**Baseline value[1]**	**Source[2]**	**Date of baseline value**	**Objective**	**Target date**
1. National DTC3 coverage (%)						
2. Number / % of districts achieving ≥80% DTC3 coverage						
3. Mortality rate for children under five years (per 1000)						
4.						
5.						
6.						

Please describe whether the objectives have been achieved, the types of problems you have encountered in measuring the indicators, how the monitoring process was strengthened and whether any changes were proposed.

[1] If the primary data is not available, indicate whether collection of this data is planned and when it will take place.
[2] The source is important to facilitate access to data and verify their conformity.

5. Checklist

Verification of completed form

Points required in the form:	Completed	Comments
Submission date	X	May 2008
Period covered by the report (previous calendar year)	X	January-December 2007
Government signatures	X	
ICC Support	X	
Information provided on SVS	X	
Information provided on QCD	X	
Information provided on use of the vaccine introduction allowance	X	Submission scheduled on 1 May 2008
Information provided on injection safety	X	
Information provided on vaccination financing and financial viability (progress achieved in relation to country guidelines)	X	
Demand for new vaccine including completed co-financing and attached Excel spreadsheet	X	
Revised demand for support for safety of completed injections (if applicable)	X	
Information provided on SHS	X	
ICC minutes attached to the report	X	
NCHSC minutes, account verification report for SHS funds and annual health sector evaluation attached to the report.	**N/A**	

6. Comments

ICC/NCHSC Comments:

The Inter-Agency Coordination Committee (IACC) approves this annual status report on the Expanded Programme on Immunisation for 2007. It further approves the requests for support in order to strengthen vaccination services, following Cameroon's admission to GAVI Phase 2, as well as support for the yellow fever vaccine and the introduction of the vaccine against *Haemophilus influenzae b* (DTC-HepB-Hib pentavalent vaccine).

The IACC would like to thank GAVI/FV for the support it has given the country since July 2001, which widely contributed to achieving the performance levels seen today. Taking into account the IACC decision to introduce the vaccine against Pneumococcal infections into the EPI and the availability of data on the Rotavirus vaccine, the 2007-2011 EPI Complete Multi-Year Plan was updated again and validated on 24 April 2008.

The Government of the Republic of Cameroon, with the support of its partners, reaffirms its commitment to full reinforcement and support of EIP as a priority health program, and to the implementation of strategies for financial viability. It commits to continue the purchase of traditional vaccines, guaranteeing its share of payment for new vaccines through a new co-financing policy.

Finally, Cameroon continues to place additional emphasis on improving quality by implementing a supply plan, through equipment maintenance system consultation, strengthening pharmacovigilance, epidemiological monitoring and strengthening the health system through SWAp.

~ End ~