FINANCIAL SUSTAINABILITY PLAN
FOR
THE EXPANDED PROGRAMME ON
IMMUNIZATION IN
BHUTAN

VACCINE PREVENTABLE DISEASE PROGRAMME
DEPARTMENT OF PUBLIC HEALTH
MINISTRY OF HEALTH
THIMPHU : BHUTAN
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Executive Summary

Introduction:

The Kingdom of Bhutan is a small landlocked South Asian country located in the Eastern Himalayas, covering an area of 38,394 square kilometres. More than 72.5% of the area is covered by forest. The total GDP estimated in 2003 was Nu 24,895 million, and the GDP per capita was USD 775 in the same year. Bhutan has an average GDP growth rate of 6.6%.

The socio-economic development in Bhutan started with the launching of the First Five Year Plan in 1961 and ever since, modern health care delivery system has also been gradually expanded throughout Bhutan. The health infrastructure has improved both in number and quality through successive Five year Plans and by now a well established infrastructure and service delivery network is in place. The consistent and systematic expansion of the health services with focus on primary health care, education and safe water supply provision has had major impact on the overall health and well being of the people. Today Bhutan has a gross primary school enrolment rate of 84.2%, life expectancy of 66.1 years, and adult literacy of 54%. Bhutan was ranked 0.551 on the Human Development Index in 1998 (Bhutan National Human Development Report).

Bhutan signed the Alma Ata Declaration in 1978 and adopted primary health care (PHC) approach to health delivery in 1979. Currently, the health care is provided free of cost to all the people in the country through a network of 29 hospitals, 166 Basic Health Units (BHUs) and 455 outreach clinics (ORCs) which are spread throughout the country.

The development policy of Bhutan:

The central unifying development concept that is preferred above all others to guide Bhutan’s future direction is the goal of maximizing gross national happiness. This concept propounded by His Majesty King Jigme Singye Wangchuck has always been at the core of the nation’s development philosophy and will provide the underlying rationale for development objectives in the future. The ultimate development vision of gross national happiness is to be achieved partly through the promotion and implementation of policies and programmes that aim at expanding human potential, opportunities, choices and well being of all people. Significant achievements have been made in bringing social services to the population since the start of the First Five Year Plan.

The long-term objectives of the health services is to improve the quality of life by promoting the health of the population and providing better health care in the spirit of social justice and equity.
The Expanded Programme on Immunization:

The Expanded Programme on Immunization was first launched on 15 November 1979 coinciding with the International Year of Child with the objective of reducing the seven vaccine preventable diseases (TB, Diphtheria, Pertussis, Tetanus, Polio, Measles & HepB). Tenatus Toxoid (TT) immunization of pregnant mothers was introduced in 1983. And in 1987 the National Plan of Action for the acceleration of EPI was formulated. The strong government commitment and the community mobilization resulted in the achievement of the Universal Child Immunization (UCI) in 1991.

Bhutan joined the Global Polio Eradication programme in 1995. National & Sub-National Immunization days were implemented from 1995-2002. Bhutan has been able to maintain “Zero” polio status since 1986. In mid 1996 Hep B vaccine for children under one year of age was introduced as an integral part of the programme. Neonatal tetanus has not been reported in the country since 1994 clearly indicating that immunization in Bhutan has been a very successful public health intervention. Encouraged by the success of the programme, the government has taken a decision to add newer vaccines into the child immunization schedule, if indicated by the disease burden.

EPI services have been fully integrated into the general health services and mainly with Maternal Child Health/Family Planning in particular. It is delivered through existing Hospitals, BHUs and ORCs. Overall immunization services are aimed for effective coverage with all seven antigens aimed at all infants less than one year of age and to all pregnant women and women of child bearing age.

Partner Involvement in EPI:

WHO and UNICEF are key partners in delivering immunization service to the mothers and children of Bhutan. Their support to the EPI program is mainly in the areas of consultancies and short-term human resource development focusing on updating knowledge and skills in vaccine delivery and cold chain management. Vaccines & injection equipments are procured through JICA and GAVI support. However, there is no agreement signed between UNICEF, JICA and Ministry of Health specifying the period of support for immunization service. JICA provides support on request through UNICEF.

Vaccines are procured annually through UNICEF-Japan multi-bilateral assistance to EPI program for Bhutan based on the immunization requirement and as per the National Essential Medicine List using WHO/UNICEF recommended forms. The firms are required to produce the necessary pharmaceutical related documents in order to qualify for the international bids. Prior to calling for bids, the recommended firm negotiates with the National Drug Regulatory Authority (NDRA) of the Ministry of Health. Competent officials based on the competitive price, pack size of vaccines, shelf life, possession of necessary documents and route of shipment make the selection of vaccine.
Indicators for the Health sector:

The health sector has made remarkable progress in all areas of health developments over the last four decades since the modern health service was introduced in the country. The Infant Mortality Rate has reduced from 102.8 in 1984 to 60.5 in 2000, and Maternal Mortality Rate has reduced from 7.7 in 1984 to 2.55 in 2000. Population Growth Rate also has seen a marked decrease from 3.1 in 1994 to 2.5 in 2000. The life expectancy at birth has increased remarkably from 47.5 in 1985 to 66.1 in 2003 (Statistical Yearbook of Bhutan 2003). These vital indicators speak well of the rapid socio-economic development in the country.

Government-Donor relations:

In the past, donors played a significant role in supporting the health sector. However, to reduce over dependence on donors, the Government is now taking steps to bear the major portion of the cost. On an average the Royal Government now bears about 50% of the total budget outlay. The main development partners in the health sector are Government of India, DANDIA, UNICEF, UNFPA and other international Non Governmental Organizations.

The Royal Government has maintained good relations with the development partners all through the years. There never has been a policy shift that risked the government and donor relations. In health, the working relationship with the partners have been exceptionally good, and its outcome is well reflected by the fact there has been increasing external assistance over the years. However, the nature of donor assistance is changing from direct program support to budget support. For instance DANIDA, one of the major donors’ assistance to health is now channelled through Ministry of Finance as budget support, in which case, the public health programs traditionally dependent on external program support loose out in competing priorities. This change is being instituted basically to give a balanced fund allocation to all programs proportionate to the set priorities. And as such, this policy shift will not impact negatively on the immunization service since Vaccine Preventable Disease Program (VPDP) continues to receive government’s topmost priority. In fact the Ministry of Health is intending to move a budget head for the immunization service with full justification for priority share from the donor budget support provision in the next round of annual budget proposal to the government. In view of the priority importance attached to the immunization service by the government, it is expected that the proposal will be given favourable consideration.
Debt relief prospects:

Given Bhutan’s preference for grant aid and its caution about incurring debt even on concession terms, its overall debt situation has been relatively comfortable with debt servicing at manageable levels. Bhutan’s debt policy has been judicious and the Royal Government of Bhutan (RGOB) chooses to maintain its borrowing comfortably within its capacity to service debt, and avoid taking loans not meant for development programmes. To this end the Royal Government also adopted certain strict evaluation procedures and criteria that take into account grant elements, repayment schedules, foreign exchange risks, hidden costs, economic rates of return, and viability. Therefore, Bhutan is not considered a Highly Indebted Poor Country (HIPC) country, and for the same reason, will not benefit from the multilateral World Bank debt relief scheme. The national debt to GDP ratio is around 67% and debt services ratio is under 4%.

The development of hydropower and power intensive industries are expected to grow to become an important sector that not only will provide a much needed diversification of the economy but will also contribute significant foreign exchange earnings and creates employment opportunities. Hydro power has been the country’s largest export for the last fifteen years and now accounts over 40% of the country’s total revenue. The powerful and fast flowing rivers afford the country enormous hydropower potential estimated at 30,000 MW, which remains still largely untapped. One of Bhutan’s mega hydro projects, Tala Hydro Project, which has a capacity of generating 1020 MW of electricity is expected to be commissioned by March 2005. The export of power from this project is expected to boost the GDP and help to reduce the dependency on foreign aids. Similar types of hydro projects are in the pipeline.

During the 9th Five Year Plan (9FYP), Ministry of Health and Education has been allocated 10.7% the total planned outlay of Nu 70 billion. Health will receive 6.4% of the planned budget during the 9FYP. And for sometime in the future Bhutan is expected to continue receiving substantial bilateral and multilateral aid.

Bhutan Health Trust Fund:

A highly relevant issue to for the Health sector is that of the future sustainability of health care in the country, particularly with regard to the most critical components of primary health care. In order to ensure the future sustainability and availability of a permanent source of fund to meet the cost of essential drugs and vaccines for the primary health care system in the country, the Government has established a Health Trust Fund. The Bhutan Health Trust Fund (BHTF) has been created with the noble objective of providing basic health care free of cost to the Bhutanese citizens at all times. This is in keeping with the desire of His Majesty the King. Of the targeted capital fund of US$ 24 million, the contributions to the fund now stand at US$ 17.9 million. The income generated from the fund will be used to purchase the most essential vaccines and medicines required for the hospitals and BHUs. Therefore the operationalization of the Bhutan Health Trust Fund represents an important activity that will help achieve an equitable and a sustainable primary health care system in the country.
**Political Stability:**

Bhutan enjoys a relatively stable political situation in the region. The Bhutanese citizens have enjoyed peace and prosperity since 1907 with the crowning of His Majesty the King, Sir Ugyen Wangchuck as the first hereditary king of Bhutan and it was because of this stable environment that Bhutan has been able to make rapid socio-economic development progress in a short span of time.

**Government’s prioritisation:**

The Royal Government of Bhutan has been placing priority on the Health services and as such, the Ministry of Health and Education was bifurcated in July 2003, thus laying a better focus on the health services in the country. In pursuit of sustainability, the Health Trust Fund was established to finance essential drugs and vaccines. The fund has passed US$ 17 million mark and is slowly approaching the targeted US$ 24 million. Resource mobilization for this noble cause is a continuing process.

The Government has always accorded a high priority to the social sector. Policy of self-reliance and sustainability will be pursued in view of limited resources generated by the government and high dependency on external aid.

It is expected that the present trend in financing and supporting the health sector by the government and donors will continue. It is also assumed that traditional collaborating partners like GOI, DANIDA, WHO, UNICEF, UNFPA, JICA, etc will continue to provide financial and technical assistance.
Bhutan – Financial Sustainability Plan

Section 1 - Macroeconomic and Health Sector Context

1.1 - Macroeconomic Context

1.1.1 Country Background

The Kingdom of Bhutan is a small landlocked South Asian country located in the Eastern Himalayas, covering an area of 38,394 square kilometres. More than 72.5% of the area is covered by forest. From the rolling plains of India, the mountains of Bhutan rise to their misty heights. The southern border touches with four Indian states of Sikkim in the far west, West Bengal, Assam, and Arunachal Pradesh in the Far East. In the north, the mighty and majestic Himalayas form the natural border with the Tibetan Province of China.

Administratively, the country is divided into 20 Dzongkhags (districts) and these are further divided into 201 geogs (blocks). Each Dzongkhag is headed by a Dzongda (governor) appointed by the central government. The Dzongda is the overall in-charge of all socio-economic development activities in the Dzongkhag.

Bhutan is the least populated country in the South East Asian Region. In 2003 (NSB) the total population of Bhutan was estimated to be 734,340 with a growth rate of 2.5%. On an average 79% of the population reside in the rural areas. The average size of the household estimated in 2000 was 5.53. The next round of census is scheduled for 2005.

1.1.2 Socio-Economic Status

The total GDP estimated in 2003 was Nu 24,895 million, and the GDP per capita was USD 775 in the same year. Bhutan has an average GDP growth rate of 6.6%. The Bhutanese currency Ngultrum is tied at par with the Indian currency Rupee.

Bhutan is predominantly a subsistence agrarian economy where 79% of the population is engaged in agricultural farming. The share of agriculture to GDP remains at 34.3% as of March 2003. GDP has increased by 6.5% during 2003. Inflation rate has decreased to 1.3% compared to 2.7% during 2002. A total foreign reserve of USD 366.71 million provides sufficient security to cover around 22 months of imports including an Indian rupee reserve of 3,575.920 million as of December 2003.

The consistent and systematic expansion of the health services with focus on primary health care, education and safe water supply provision has had major impact on the overall health and well being of the people. Today Bhutan has a gross primary school enrolment rate of 84.2%, life expectancy of 66.1 years, and adult literacy rate of 54%. Bhutan’s Human Development Index was 0.551 in 1998 (Bhutan National Human Development Report).
Table 1: Comparative Socio-Economic Indicators for Bhutan (National Statistical Bureau)

<table>
<thead>
<tr>
<th>Indicators</th>
<th>June 1998</th>
<th>March 2003</th>
<th>March 2004</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INCOME (2002)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GDP in Million Nu</td>
<td>11,714</td>
<td>24,895</td>
<td>29,086</td>
</tr>
<tr>
<td>Per capita GDP in US$</td>
<td>551</td>
<td>755</td>
<td>835</td>
</tr>
<tr>
<td>Average GDP growth rate (%)</td>
<td>6.7</td>
<td>6.6</td>
<td>6.7</td>
</tr>
<tr>
<td>Share of agriculture to GDP</td>
<td>38.6</td>
<td>34.3</td>
<td>32.7</td>
</tr>
<tr>
<td>Savings as % of GDP</td>
<td>26.3</td>
<td>20</td>
<td>28.5</td>
</tr>
<tr>
<td>Investment as % of GDP</td>
<td>44.4</td>
<td>48</td>
<td>49.7</td>
</tr>
<tr>
<td>Export of goods &amp; Services as % of GDP</td>
<td>30.3</td>
<td>23.3</td>
<td>20.8</td>
</tr>
<tr>
<td>Import of goods &amp; services as % of GDP</td>
<td>38.6</td>
<td>43.3</td>
<td>40</td>
</tr>
<tr>
<td>Inflation rate (%)</td>
<td>6.6</td>
<td>2.3</td>
<td>1.55</td>
</tr>
<tr>
<td>Foreign exchange reserves (MUS$ @ US$)</td>
<td>210.7</td>
<td>303.9</td>
<td>344.97</td>
</tr>
<tr>
<td>Rupees 4,168.31 mill (Exchange base rate US$=Nu 45.27)</td>
<td>165.9</td>
<td>244.5</td>
<td>252.89</td>
</tr>
<tr>
<td><strong>PUBLIC FINANCE (Budget Appropriation for Financial year 2003/2004)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government Revenue receipt (M Nu)</td>
<td>2,931.5</td>
<td>5,100.2</td>
<td>5,100.2</td>
</tr>
<tr>
<td>Tax revenue</td>
<td>1,360.9</td>
<td>3,086.6</td>
<td>3,086.6</td>
</tr>
<tr>
<td>Non tax revenue</td>
<td>1,570.6</td>
<td>2,013.6</td>
<td>2,013.6</td>
</tr>
<tr>
<td>Govt expenditure (M Nu)</td>
<td>2562.7</td>
<td>4,597.3</td>
<td>4,863.8</td>
</tr>
<tr>
<td>Current</td>
<td>3,662.1</td>
<td>6,318.8</td>
<td>6,024.2</td>
</tr>
<tr>
<td>Capital</td>
<td>449.5</td>
<td>28.3</td>
<td>73.6</td>
</tr>
<tr>
<td>Net Lending</td>
<td>-</td>
<td>240.3</td>
<td>240.3</td>
</tr>
<tr>
<td>Repayments</td>
<td>-</td>
<td>147.9</td>
<td>185.8</td>
</tr>
<tr>
<td>Dollar loan (Million US$ as of Dec. 20003)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>HUMAN RESOURCE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated Population In 2003</td>
<td>6,00,000</td>
<td>7,16,424</td>
<td>734,334</td>
</tr>
<tr>
<td>Population growth (%)</td>
<td>3.0</td>
<td>2.5</td>
<td>2.5</td>
</tr>
</tbody>
</table>
Given Bhutan’s preference for grant aid and its caution about incurring debt even on concession terms, its overall debt situation has been relatively comfortable with debt servicing at manageable levels. Bhutan’s debt policy has been judicious and the Royal Government of Bhutan (RGOB) chooses to maintain its borrowing comfortably within its capacity to service debt, and avoid taking loans not meant for development programmes. To this end the Royal Government has also adopted certain strict evaluation procedures and criteria that take into account grant elements, repayment schedules, foreign exchange risks, hidden costs, economic rates of return, and viability. Therefore, Bhutan is not considered a Highly Indebted Poor Country (HIPC) country, and for the same reason, will not benefit from the multilateral World Bank debt relief scheme. The national debt to GDP ratio is around 67% and debt services ratio is under 4%.

The Government of Bhutan has initiated a Poverty Reduction Strategy Paper (PRSP) process as a part of the broader ongoing efforts to combat poverty. The main objectives of the PRSP are to strengthen the strategic framework for poverty reduction, improve donor coordination, and to build support for new initiatives in public expenditure management and poverty monitoring and assessment system. To institutionalise Poverty Monitoring and Assessment System, the Government has identified the Department of Planning as the focal agency responsible for poverty monitoring and assessment that will be integrated within the overall Planning and Information Network system being developed in the Department of Planning.

To this effect, a series of surveys like the Household Income and Expenditure Survey 2000, Bhutan Poverty Assessment and Analysis 2000 and The Bhutan Living Standard Survey 2003 have been conducted. Based on the surveys, strategies for the delivery of social services include the following:

(a) Continuation of the policy of free universal primary education and basic health care;
(b) In the Health sector, the strategies include the targeting of health services to the hitherto un-reached communities. In addition, intensification of reproductive health services and safe motherhood and child survival programs will receive priority.
(c) Other interventions focus on intensifying prevention and control of prevailing (e.g. Malaria, TB and ARI) and emerging (e.g. heart disease) problems.
(d) Innovative means of enhancing the mental well being of the disadvantaged will be promoted through community based rehabilitation and mental health services.

The strengthening of the poverty monitoring and assessment system is a long-term process but is central to the effective implementation of poverty reducing programs. The improvements of statistical capacity in the years ahead will provide a sound underpinning for future PRSP activities.
1.1.3 Economic Forecast

Good economic forecast for the future- Bhutan's GDP expected to grow by around 7% after 2004. The country’s future growth areas are in the modern sector. The development of hydropower and power-intensive industries are expected to grow and become an important sector that will not only provide much-needed diversification of the economy but will also contribute significant foreign exchange earnings and create employment opportunities. Hydropower has been the country’s largest export for the last fifteen years and now accounts for over 40% of the country’s total revenue. The powerful and fast-flowing rivers afford the country enormous hydropower potential estimated at 30,000 MW, which still remains still untapped. One of Bhutan’s mega projects, Tala Hydro Project which has a capacity of generating 1020 MW of electricity is expected to be commissioned by March 2005. The export of power from this project is expected to boost the GDP and help reduce dependency on foreign aids. Similar types of hydro projects are in the pipeline.

Bhutan's goal of economic self-reliance will be within reach. The key driver for growth will be the development of Bhutan's hydroelectric power and construction projects connected to this industry, when the Tala Project begins to export electricity to India. The next service sector that will make significant contribution to the country’s revenue is the tourism.

Consequent upon the fall in the price of rice and low inflation rate in India, Bhutan is currently enjoying the lowest inflation rate recorded since 1980. Bhutan's currency, the ngultrum, is tied at par to the Indian rupee.

Table 2: Selected Economic Indicators for Bhutan

<table>
<thead>
<tr>
<th></th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>GDP at market prices (NGU Millions)</td>
<td>19,161</td>
<td>21,911</td>
<td>25,278</td>
<td>29,086</td>
<td>33,159</td>
</tr>
<tr>
<td>GDP (US$ Millions)</td>
<td>$430.6</td>
<td>$574.6</td>
<td>$507.7</td>
<td>$571.5</td>
<td>$711.9</td>
</tr>
<tr>
<td>Real GDP growth (%)</td>
<td>7.70%</td>
<td>5.50%</td>
<td>7.10%</td>
<td>6.70%</td>
<td>6.50%</td>
</tr>
<tr>
<td>Consumer price inflation (average %)</td>
<td>6.90%</td>
<td>4%</td>
<td>3.40%</td>
<td>2.50%</td>
<td>1.60%</td>
</tr>
<tr>
<td>Population</td>
<td>646,134</td>
<td>662,287</td>
<td>678,844</td>
<td>695,816</td>
<td>713,211</td>
</tr>
<tr>
<td>Total external debt (US$ Millions)</td>
<td>$183.8</td>
<td>$203.3</td>
<td>$265.2</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Exchange rate (average NGU:US$)</td>
<td>43.06</td>
<td>44.94</td>
<td>47.19</td>
<td>48.61</td>
<td>46.58</td>
</tr>
<tr>
<td>GDP Per Capita (US$)</td>
<td>$666</td>
<td>$868</td>
<td>$748</td>
<td>$821</td>
<td>$998</td>
</tr>
</tbody>
</table>

* No data available.

Public expenditures have risen by 3% from 2002/03. Health alone will account for 11% of total public budget allocation for the 2004-2005 fiscal year. During the 9FYP, Health will receive around 9% of the planned budget. And for sometime in the future Bhutan is expected to continue receiving substantial bilateral and multilateral aid.
1.1.4 Political Stability

Bhutan enjoys a relatively stable political situation in the region. The Bhutanese citizens have enjoyed peace and prosperity since 1907 and it was because of this stable environment that Bhutan was able to make rapid socio-economic development progress in a short span of time. In the early 1990’s however, there were political disturbances and acts of terrorism in southern Bhutan that began after Royal Government’s attempts to stem out illegal immigration. The serious security situation posed by the anti-national activities then prompted the government to close down most of the service centres including hospitals and schools. As a result of this untoward political development, immunization services saw a major drawback during that period. As the situation improved, the developmental activities were resumed with greater impetus than ever before in order to make up for the lost time.

A more recent cause of concern and security threat to Bhutan’s stability was posed by the incursion of insurgent militants from Assam into the southern belt of Bhutan. These militants, camped deep inside Bhutan’s dense jungles along the border with Assam, operated across the border against the government of India, and on numerous occasions also terrorized Bhutanese citizens. The ensuing security threat, therefore, affected the immunization services in the country once again. Now that the Indian militants have been successfully flushed out from their camps in December 2003 by the Bhutanese security forces, the public services are being delivered as usual. But the security situation along the border continues to be at risk because of the potential militant threats from across the border. This uncertain security situation will continue to affect the health services to the people of southern Bhutan for some time in the future.

Considering Bhutan’s economic potentials, the economic forecast and prospects for Bhutan are looking bright. This should have a positive impact on health budgets whereby increasing fund allocations for immunization service will be a matter of certainty. The immunization program will continue to receive top priority under the overall health sector. Presently, the programme receives 2% of the total health budget outlay.

1.2 Health Sector Context

Bhutan adopted Primary Health Care (PHC) approach to the health delivery system in 1979. Currently, the health care is provided free of charge to all its citizens including foreign nationals working in the country through a network of 29 hospitals, 166 Basic Health Units (BHUs) and 455 outreach clinics (ORCs). These health facilities spread throughout the country, covering almost all the remotest population pockets are manned by doctors, nurses, paramedics and technicians. At the community level, village health workers assist regular health staff in reaching out healthcare to the communities particularly in the far-flung areas of the country.

The Royal Government initiated decentralization policy in 1981, and since then health has been in the forefront in implementation of the decentralization policy. Today the health service is fully decentralized to the dzongkhags and all primary health care programs are integrated into
dzongkhag health care delivery system. Through this far-reaching health service delivery reforms, today, over 90% of the population are accessible to health services. The challenge now is to cover the remaining population groups, and the Ministry of Health is fully committed to reaching out to the un-reached population.

The Expanded Program on Immunization was first launched on 15 November 1979 coinciding with the International Year of Child with the objective of reducing the seven vaccine preventable diseases (TB, Diphtheria, Pertussis, Tetanus, Polio, Measles & HepB). Tenatus Toxoid (TT) immunization of pregnant mothers was introduced in 1983 and in 1987 the National Plan of Action for the acceleration of EPI was formulated. The strong government commitment and the community mobilization resulted in the achievement of the Universal Child Immunization (UCI) in 1991.

Bhutan joined the Global Polio Eradication programme in 1995. National & Sub-National Immunization days were implemented from 1995-2002. Bhutan has been able to maintain “Zero” polio status since 1986. In mid 1996 Hep B vaccine for children under one year of age was introduced as an integral part of the programme. Neonatal tetanus has not been reported in the country since 1994 clearly indicating that the immunization program in Bhutan is a very successful public health intervention. Encouraged by the success of the programme, the government has taken a decision to add newer vaccines into the child immunization schedule, if indicated by the disease burden.

EPI services have been fully integrated into the general health services and mainly with Maternal Child Health/Family Planning in particular. It is delivered through existing Hospitals, BHUs and ORCs. Overall immunization services are aimed for effective coverage with all seven antigens aimed at all infants under one year of age and to all pregnant women and women of child bearing age.

1.2.1 Health Trends

The health sector has made remarkable progress in all areas of health developments over the last four decades since the modern health service was introduced in the country. The Infant Mortality Rate has reduced from 102.8 in 1984 to 60.5 in 2000, and Maternal Mortality Rate has reduced from 7.7 in 1984 to 2.55 in 2000. Population Growth Rate also has seen a marked decrease from 3.1 in 1994 to 2.5 in 2000 (see table 3). The life expectancy at birth has increased remarkably from 47.5 in 1985 to 66.1 in 2003 (Statistical Yearbook of Bhutan 2003). These vital indicators speak well of the rapid socio-economic development in the country. However, the top ten disease morbidity trend and EPI coverage trends over the past five year have remained same despite marked improvement in safe water supply provision, sanitation and hygiene and immunization services (see table 4 & 5). This is an obvious challenge to the health professionals, and as such, programs have affected major program revisions and strategies to address these issues.
### Table 3: Key Health Indicators (National Health Survey 2000)

<table>
<thead>
<tr>
<th>Type of Indicator</th>
<th>1984</th>
<th>1994</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Fertility Rate</td>
<td>169.60</td>
<td>172.7</td>
<td>142.7</td>
</tr>
<tr>
<td>Total Fertility Rate</td>
<td>NA</td>
<td>5.6</td>
<td>4.7</td>
</tr>
<tr>
<td>Crude Birth Rate (per 1000 population)</td>
<td>39.1</td>
<td>39.9</td>
<td>34.09</td>
</tr>
<tr>
<td>Crude Death Rate (per 1000 population)</td>
<td>13.4</td>
<td>9</td>
<td>8.64</td>
</tr>
<tr>
<td>Infant Mortality Rate (per 1000 population)</td>
<td>102.8</td>
<td>70.7</td>
<td>60.5</td>
</tr>
<tr>
<td>U5 MR (per 1000 live births)</td>
<td>162.4</td>
<td>96.9</td>
<td>84.0</td>
</tr>
<tr>
<td>Maternal Mortality Rate (per 1000 live births)</td>
<td>7.7</td>
<td>3.8</td>
<td>2.55</td>
</tr>
<tr>
<td>Population Growth Rate</td>
<td>2.6</td>
<td>3.1</td>
<td>2.5</td>
</tr>
<tr>
<td>Contraceptive Prevalence Rate</td>
<td>NA</td>
<td>18.8</td>
<td>30.7</td>
</tr>
<tr>
<td>Doctors per 10,000 population</td>
<td>NA</td>
<td>NA</td>
<td>1.7</td>
</tr>
</tbody>
</table>

### Table 4: Top 10 disease morbidity trend over the past 5 year period

<table>
<thead>
<tr>
<th>Sl No.</th>
<th>Diseases</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Cough and cold (ARI)</td>
<td>212,277</td>
<td>217,237</td>
<td>207,347</td>
<td>259,083</td>
<td>270,559</td>
</tr>
<tr>
<td>2.</td>
<td>Skin diseases</td>
<td>99,082</td>
<td>102,610</td>
<td>115,276</td>
<td>99,637</td>
<td>90,219</td>
</tr>
<tr>
<td>3.</td>
<td>Diarrhoea/dysentery</td>
<td>88,546</td>
<td>92,075</td>
<td>90,228</td>
<td>68,641</td>
<td>105,163</td>
</tr>
<tr>
<td>4.</td>
<td>Peptic ulcer syndrome</td>
<td>60,982</td>
<td>65,648</td>
<td>70,797</td>
<td>53,640</td>
<td>57,095</td>
</tr>
<tr>
<td>5.</td>
<td>Conjunctivitis</td>
<td>54,421</td>
<td>48,737</td>
<td>49,612</td>
<td>47,906</td>
<td>54,635</td>
</tr>
<tr>
<td>6.</td>
<td>Worm infestation</td>
<td>46,168</td>
<td>39,277</td>
<td>34,897</td>
<td>27,697</td>
<td>23,606</td>
</tr>
<tr>
<td>7.</td>
<td>Diseases of Teeth &amp; Gums</td>
<td>35,516</td>
<td>39,508</td>
<td>44,548</td>
<td>29,474</td>
<td>28,062</td>
</tr>
<tr>
<td>8.</td>
<td>Urinary tract infection</td>
<td>31,406</td>
<td>16,698</td>
<td>18,147</td>
<td>15,763</td>
<td>18,186</td>
</tr>
<tr>
<td>9.</td>
<td>Otitis media</td>
<td>22,110</td>
<td>21,824</td>
<td>24,892</td>
<td>23,472</td>
<td>19,354</td>
</tr>
<tr>
<td>10.</td>
<td>Nutritional deficiency</td>
<td>21,381</td>
<td>21,426</td>
<td>22,994</td>
<td>4,657</td>
<td>4,404</td>
</tr>
</tbody>
</table>

### Table 5: EPI trend over the past five year period

<table>
<thead>
<tr>
<th>Year</th>
<th>BCG</th>
<th>Polio</th>
<th>DPT</th>
<th>Measles</th>
<th>Hep.B</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>12,493</td>
<td>12,303</td>
<td>12,228</td>
<td>10,757</td>
<td>11,864</td>
</tr>
<tr>
<td>2000</td>
<td>12,197</td>
<td>12,429</td>
<td>12,330</td>
<td>10,721</td>
<td>12,088</td>
</tr>
<tr>
<td>2001</td>
<td>13,958</td>
<td>13,818</td>
<td>14,061</td>
<td>13,317</td>
<td>13,682</td>
</tr>
<tr>
<td>2002</td>
<td>13,746</td>
<td>13,711</td>
<td>13,389</td>
<td>12,805</td>
<td>13,889</td>
</tr>
<tr>
<td>2003</td>
<td>13,720</td>
<td>13,571</td>
<td>13,363</td>
<td>12,434</td>
<td>12,976</td>
</tr>
</tbody>
</table>
1.2.2 - Trends in Financing for the Health Sector

Although only 2.9% of total outlay for the First Plan (1962-1967) was given for health, the Government recognized the importance of the social sectors. The current Government allocation for health is 9% of the total budget outlay, which comes to 4% of the GDP. This is perhaps highest for health in the Region.

In the past plans, donors played a significant role in supporting the health sector. However, to reduce over dependence on donors, the Government is now taking steps to bear the major portion of the cost. On an average the Royal Government now bears about 50% of the total budget outlay. The main development partners in the health sector are the Government of India, DANIDA, UNICEF, WHO, UNFPA and other international Non Governmental Organizations.

1.2.3 Health Sector Reforms

The Royal Government of Bhutan initiated decentralization process since the early eighties and health sector was one of the government sectors that took pioneering steps in implementing the government’s decentralization policies. As of now, the health care service is decentralized right down to the geog (block) levels. All plans and programs in the health sector are dzongkhag based, and as the dzongkhag capacity keeps improving, the areas currently under central authority will gradually be transferred to the dzongkhag health sector. Some of the major health sector reforms undertaken under the guiding philosophy of decentralization policies are as follows:

(a) Community Participation

In order to bridge the gap between the organized health service and the community, the Government trains village health workers (VHWs) who are chosen by the communities themselves. As of 2000, there were 1,327 village health workers who advocated health to the people and who help in bringing the health problem of the people in the communities to the health workers. They are also taught and allowed to dispense a few basic allopathic medicines. The communities also look after the development schemes like those for drinking water supplies in their own areas. Programs assist the communities by providing them the required training.

Then there are the traditional faith healers, astrologers and religious leaders in the communities. The Ministry also takes the support of these respected people in imparting specific health messages like the need to take iodized salt or family planning methods to the people in the communities along with their routine work.

(b) Health Information system

Realizing the importance of information in management, Health Information Unit was established in 1983. Since then the Annual Health Bulletin is compiled and published on yearly basis. WHO has put in substantial support to develop the Health Information System in the 1990s. During 1999-2000, the information system was reviewed and the Health Management
Information System (HMIS) was instituted with support from DANIDA. Presently HMIS is being computerized and experimented.

The basic health facilities have been given standardized reporting forms to report the morbidity, mortality and other health data collected at their levels. This is compiled and consolidated every month and submitted to the District Health Supervisory Officers (DHSO) who, in turn, reviews and submits to the national level every quarter. At the national level the Health Information Unit compiles and makes it available to all concerned.

However, the human resource for the Health Information Unit has to be further improved both in terms of expertise and number to make the HMIS dynamic and helpful for evidence-based planning for the future.

(c) Inter-sector coordination

Inter-sector coordination at different levels of the Government is achieved through different ways and means. At the national level, the Department of Planning (DOP) coordinates the plans of various development sectors and the Department of Aid and Debt Management (DADM) of the Ministry of Finance coordinates resource allocation. At the district level, when the plans are implemented, the Dzongda is the overall head overseeing and reviewing the implementation processes. All the sector representatives at the district level function under the Dzongdag. Thus duplication of efforts is avoided and the actions are coordinated.

Even at the Department and program level, there are a lot of coordination mechanisms through Policy and Planning Division of the Ministries. Additionally, individual programs have their own coordination mechanism with other concerned sectors. Malaria program, for instance, has direct coordination mechanism with the agriculture and municipal departments. Similarly environmental health program liaises with the National Environment Commission, Municipal Corporations of each district and even the police force. The nutrition program coordinates its efforts with the Agriculture, Trade, and other relevant sectors. Furthermore, there are the multi-sector task forces (MSTF) like the Steering Committees (SC), National HIV/AIDS Commission (NHAC) e.t.c. that also address the issues that cut across many sectors.

(d) Emergency Preparedness

Of the numerous emergency situations, the one that concerns the country most is the traffic accidents. Flash floods and landslides also contribute to the problem. The country being in an earthquake zone, severe earthquake is also read about in its history but it is less frequent. Glacial flood also cause damage to the life and property. A rough study in the recent years revealed numerous glacial lakes that are potentially dangerous to the country. In order to deal with all these eventualities, the Ministry of Health has established a rapid response team consisting of several relevant sectors. All health facilities in the kingdom are staffed with health workers trained in emergency medical procedures.
(e) Health research

Health research is comparatively new for Bhutan although Bhutan has been a participant to WHO’s research consultations in the South East Asia Region. To be able to carry out research for the health sector so that there will be evidence-based health interventions; the country has been building its research unit. The Research Unit was formally established in 1995. The key staffs are still being trained abroad. The unit has played crucial roles in conducting vital studies for health in the recent years. It has contributed in the conducting of the National Health Survey in 2000 and in carrying out the survey on mental health in 2002.

Coming to the area of other kinds of research, the Pharmaceutical and Research Unit at the National Institute of Traditional Medicines conduct researches in the areas of indigenous medicines. Further it is also documenting the medicinal plants and herbs that are found in Bhutan.

1.2.4 Financing Essential Drugs & Vaccines

Bhutan has no modern pharmaceutical industries and relies on imports for its entire requirements. Traditional medicine is manufactured at the Pharmaceutical and Research Unit of the National Institute of Traditional Medicine. As Bhutan is dependent on the outside world for the medicines, vaccines and reagents, Bhutan relies on WHO collaborating laboratories in the region for testing the quality of imported drugs and vaccines.

In order to sustain achievements in Primary Health Care and to reduce the dependency on donors, the Royal Government has created the Bhutan Health Trust Fund (BHTF). It was formally launched in Geneva on 12th May 1998 with the objective to supply basic vaccines with a target of USD 24 million. As of today, BHTF has secured USD 17.9m. As per the Royal Charter of the Health Trust Fund, the Royal Government matches, on a one-to-one basis, any donor contribution to the fund. The fund is maintained in US dollars and invested in reliable financial institutions abroad. The Management Board consisting of high-level member representatives from the relevant Ministries and organizations govern the BHTF Board. This initiative is expected to support the Royal Government’s policy of providing free basic health care.

The purpose of the Charter is to govern the management of the Trust Fund investments and program activities for the sustainability of primary health care services through the provision of continued and uninterrupted supply of core primary health care supplies of vaccines, essential drugs, needles, syringes, cold chain equipment and other related drugs/equipment; strengthen programme management and human resources development through staff training in the storage and management of drugs & vaccines, repairs and maintenance of health equipment; develop and implement management plans for drugs and vaccines, and strengthen monitoring capacity on the proper use of drugs and vaccines and other activities related to primary health care that the board might recommend.
1.2.5 Global Fund

Bhutan’s Global Fund proposals for Malaria and Tuberculosis have received approval by the GFATM Board in Round 4. The proposals are submitted as separate components with the estimated budget of USD 1,737,190 for Malaria and USD 994,298 for Tuberculosis respectively over a five-year period. Currently the programs are in the process of completing the background assessment of the Principal Recipient (PR) capacity and the sub-recipient’s implementation capacity by KPMG, the Local Fund Agent (LFA). The actual negotiation of the grant agreement is expected to take place by November end. The project implementation is expected to begin from January 2005.

1.2.6 Government and Donor Relations

The Royal Government has maintained good relations with the development partners all through the years. There never has been a policy shift that risked the government and donor relations. In Health, the working relationship with the partners have been exceptionally good, and its outcome is well reflected by the fact there has been increasing external assistance over the years. However, the nature of donor assistance is changing from direct program support to budget support. For instance DANIDA’s (one of the major donors) assistance to health is now channelled through Ministry of Finance as budget support, in which case, the public health programs traditionally dependent on external program support loose out in competing for priority within the government. This change is being instituted basically to give a balanced fund allocation to all programs proportionate to the set priorities. And as such, this policy shift will not impact negatively on the immunization service since Vaccine Preventable Disease Program (VPDP) continues to receive government’s topmost priority. In fact the Ministry of Health is intending to move a budget head for the immunization service with full justification for priority share from the donor budget support provision in the next round of annual budget proposal to the government. In view of the priority importance attached to the immunization service by the government, it is expected that the proposal will be given favourable consideration.

The procurement process makes the best use of limited resources as per the prevailing procurement procedures. The main constraint for the immunization programme is the unsecured fund. JICA provides funding support only on request. Moreover it has no earmarked budget for the immunization program. The GAVI support for DPT-Hep B combination and injection equipments for all vaccines, which may continue up to 2007, is seen as a starter for making proper procurement for the immunization program. Hence, the sustenance and further improvement of the program plans and policies greatly hinges on the wishful expectation of the donor support.
1.2.7 National Health Policy

The concept of health in Bhutan must be seen in the context of the overall development strategy that, defines development as the preservation of spiritual and emotional, as well as economic well being. Therefore, the health sector policy objectives reflect the national ones: equity, social justice, sustainability and efficiency, in the context of preservation of national culture. The long term objective of the health services is to “facilitate, through a dynamic professional health care, the attainment of a standard of healthy living by the people of Bhutan to lead a socially, mentally and economically, enhanced quality of life of the people in the spirit of social justice and equity”. The focus of health sector has been to increase the accessibility to health care. Basic health care service and essential drugs are provided free of charge to all Bhutanese citizens and foreign nationals working for the Royal Government of Bhutan.

1.2.8 Constraints of the Health Sector

(a) Shortage of human resource

Shortage of human resource has been one of the most deriding factors in the health development system. To strengthen the overall health service and particularly the decentralized management of health services, human resource is required at all levels be it for program management and promotional areas or curative services. The government has been able to train only about 3-5 medical doctors annually that can barely meet the attrition due to retirement, transfer to other ministries, etc. of medical doctors. The situation has been improving with more candidates joining the medical line in the recent years. The number of specialists trained in medical and management areas are even less. As the training of paramedics can be carried out within the country, the situation is much better in this area. It is this category of people who manage the primary health care system as well as service delivery. It is also mainly this category of people who manage most of the public health program in providing health care and services. Because of the same reason of human resource shortage, one or two program personnel have to cover a lot and many times, it leads to over working of the staff.

As the government’s own fund is limited, the ministry relies much on collaborating partners to develop human resources for health. However, as many collaborating partners do not want to commit funds for long-term trainings, it will take a long time to achieve self-sufficiency in human resources for health and unless the gap in this key component is filled, the programs will suffer.

(b) Geography and scattered settlement

Bhutan is situated in one of the worlds most rugged surfaces and hence, the settlements are scattered and far-flung. This makes delivery of health and other social services extremely difficult and expensive. Coupled with the lack of qualified specialists at the district and regional levels, this poses a great challenge to efforts in curbing mortality that could have been prevented with timely care. In order to overcome this problem, the
Government, with support from DANIDA and WHO, initially started the solar-powered radio communication system to link the basic health units (BHUs) to the district hospitals. To complement this initiative, the government has then embarked upon the telemedicine program in collaboration with WHO and the Japanese government. As electricity and basic telecom infrastructure were also getting developed slowly at that time, the progress in this area has been slow but the country has been able to connect at least one of the two Regional Referral Hospitals to the National Referral Hospital and improving the referrals and consultations between them. The facility is also being used by the hospital staff to access important health literature. But much needs to be done, and materials required for this program are usually very expensive.

(c) Dependency on imports for all health requirements

Be it equipment or drugs and vaccines, the country has to depend on supplies from outside the country. Even if the quality of drugs and vaccines can be assured by purchasing them from WHO authenticated suppliers in the region, the hospital equipment and other supplies are a problem. The long time taken to procure the equipment or their spare parts and consumables (like reagents and x-ray films) continues to hinder surveillance and other vital works at the hospitals and health centers.

(d) Political disturbance

This little country has not been spared from the political disturbance in the region. Ethnic Bodo and Ulfa militants in the northeast India who are fighting for independence had taken unauthorized refuge in the forests inside Bhutan in the southern districts, thereby disrupting service delivery and the service providers at times. The issue has now been resolved after the government’s operation to flush out the militants in December 2003 proved successful. The social service delivery has been resumed in these areas with greater impetus than before.

(e) Shift from coverage to quality of services

Having achieved the desired level of coverage by health, the country now focuses on improving the quality of health care services. There have been cases of enormous structures in the districts with no doctor and hence, patients. The situation has been steadily improved over the years yet large rooms for improvements remain. As three people – one health assistant, one assistant nurse, and one basic health worker staff the basic health units, their functions can hardly be distinguished, as one has to substitute the other every now and then. Similarly, not all the district hospitals have similar facilities. Hence, the whole of next five years will be devoted to setting standards of services and facilities and working towards fulfilling them.

(f) Double burden of diseases

While the battle would continue against HIV/AIDS, Tuberculosis, Malaria and the like, emerging diseases, especially non-communicable ones, will entail strengthening their
surveillance and development and following strategies for prevention and control. At the tertiary care level facilities need to be expanded to deal with the problem of rheumatic heart diseases, cancer, diabetes, etc.

(g) Sustainability of development in the health sector

Although Health Trust Fund initiative has been launched already, much work remains to be done to accumulate the required capital, invest it to a reliable financial institute, and regularize the use of the proceeding from the Trust Fund. Only when everything is in place will Bhutan be able to assess how much impact the Trust fund initiative has made on making health care services sustainable. On the other hand, the contributing factors to health extend beyond the health sector. Unless due attention is given to coordinate efforts with other important government organizations like Environment, Trade, Industries and Mines, Agriculture, Education, Municipal corporations, Ministry of Health will land up containing the problems caused by other sectors and this aspect is viewed seriously in order to consolidate the progress that has already been made in various areas of health.

(h) Meeting the Challenges

When Bhutan first started its development process, the Ministry of Development contained all social sector departments. Later, the Ministry of Social Services established in 1985 included Health, Education, Culture, and Public Works Departments, concentrated mainly on Health and Education Departments. To give full attention to these two most important public welfare sectors, the government bifurcated the Education and Health Sector in mid 2003. Today Education and Health are separate ministries.

With the major challenges in mind, the Government has already looked two decades ahead and developed its vision for the future. In the document, “Bhutan Vision 2020”, the Government has set its priorities for all the sectors for the next 15 to 20 years. Eight priorities have been spelled out in this same document to guide the health sector during this entire period. These long-term priorities are further taken into priority consideration during the formulation of the Five-Year Plans of the Health Sector.
Section 2 - Programme Objectives and Strategies

2.1 Main Programme Objectives

The overall objective of the programme is to reduce the seven vaccines preventable diseases to a level at which they are no longer a public health problem by maximising opportunity, minimising risk and increasing acceptability and reaching of immunization programme in the unreached areas. Some of the objectives of the EPI programme are:

2.1.1 To sustain the high national immunization coverage level at or above 90% for the children of one year of age
2.1.2 To achieve poliomyelitis certification by 2005
2.1.3 To eliminate maternal and neonatal tetanus by 2005
2.1.4 To achieve 90% reduction of measles cases
2.1.5 To increase the safety of injection used for all EPI vaccines through the use of auto-disable syringes for all injection by the end of 2004
2.1.6 To develop sustainability in the EPI programme through national capacity building
2.1.7 Establishing and strengthening surveillance for EPI diseases
2.1.8 Sustainable inclusion of newer vaccines in the EPI, if indicated by diseases burden studies.

2.2 Main Program Strategies

2.2.1 Immunization service delivery as a part of comprehensive primary health care
2.2.2 Capacity Development to maintain a critical mass of trained immunization managers, technicians and service providers as specified in the Human Resource for Health Master Plan
2.2.3 Efficient vaccine logistics management
2.2.4 Develop and implement guidelines for immunization service delivery, immunization safety, logistics management, surveillance and out breaks response
2.2.5 Advocacy and programme communication
2.2.6 Periodic evaluation of coverage, cold chain and overall programme functioning
2.2.7 Develop and implement medium and long term plans
2.3 Trends in Program Performance

2.3.1 Coverage Trends
The reported immunization coverage (0-11 months) for 2002 in Bhutan as reported in the Annual Health Bulletin 2002 is as shown in the chart below.

![EPI coverage trends](chart)

The EPI coverage trend over 3 year period from 2000 to 2002 are as follows:

1. BCG 90%
2. Measles 85%
3. DPT3 89%
4. OPV3 91%
5. Hep B 80%.

The reported coverage is consistent with the assessed coverage study conducted in early 2002.

2.3.2 Vaccine Wastage Trends

Bhutan is reported to have one of the highest vaccine wastage rates in the world. It is as much a serious concern to the Health Ministry as it is for the external donors. The program is trying various strategies to reduce the wastage rate, but the nature of the difficult geographic terrain and sparse and scattered communities poses a limiting factor. The fact can only be comprehended by experiencing the situation in Bhutan’s context. The current wastage rate for BCG at 80% is the highest while DPT at 41% is the lowest among the antigens (see table 6).
Table 6: Vaccine Wastage Rates

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Wastage Rate (%)</th>
<th>Wastage Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCG</td>
<td>80</td>
<td>5</td>
</tr>
<tr>
<td>Measles</td>
<td>72</td>
<td>4</td>
</tr>
<tr>
<td>OPV</td>
<td>45</td>
<td>2</td>
</tr>
<tr>
<td>DPT</td>
<td>41</td>
<td>2</td>
</tr>
<tr>
<td>TT</td>
<td>67</td>
<td>3</td>
</tr>
<tr>
<td>HepB</td>
<td>49</td>
<td>2</td>
</tr>
</tbody>
</table>

Vaccine wastage rate, however, has not been calculated in the past years, and therefore, no target was set for wastage reduction. In the absence of the wastage trend it is difficult to see how the program has fared in terms of reducing the vaccine wastage over the years. But with the preparation of FSP in immunization, annual target wastage rates for different antigens are being set, and the strategies are developed for reducing the wastage as per the set targets (see table 7).

Table 7: Target Vaccine Wastage Rate

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Estimated wastage</th>
<th>Target wastage rate</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCG</td>
<td>90</td>
<td>60</td>
<td>90</td>
<td>80</td>
<td>70</td>
<td>65</td>
<td>60</td>
<td>60</td>
<td>60</td>
<td>60</td>
<td>60</td>
<td>60</td>
</tr>
<tr>
<td>DPT-Hep.B</td>
<td>60</td>
<td>40</td>
<td>60</td>
<td>50</td>
<td>40</td>
<td>40</td>
<td>40</td>
<td>40</td>
<td>40</td>
<td>40</td>
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<td>40</td>
</tr>
<tr>
<td>OPV3</td>
<td>60</td>
<td>40</td>
<td>60</td>
<td>50</td>
<td>40</td>
<td>40</td>
<td>40</td>
<td>40</td>
<td>40</td>
<td>40</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td>Measles</td>
<td>80</td>
<td>60</td>
<td>80</td>
<td>70</td>
<td>60</td>
<td>60</td>
<td>60</td>
<td>60</td>
<td>60</td>
<td>60</td>
<td>60</td>
<td>60</td>
</tr>
<tr>
<td>TT2</td>
<td>60</td>
<td>20</td>
<td>60</td>
<td>50</td>
<td>40</td>
<td>30</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>20</td>
</tr>
</tbody>
</table>

2.3.3 EPI Disease Trend

The EPI program was first launched in 1979 coinciding with the International Year of Child with the objective of reducing and preventing the six vaccine preventable diseases namely, Tuberculosis, Diphtheria, Pertussis, Tetanus, Polio and Measles. HepB was introduced in 1996, and Tetanus Toxoid (TT) immunization of pregnant mothers in 1987. Bhutan’s successful implementation of the EPI program resulted in achieving Universal Child Immunization (UCI) in 1991. Since 1986 Bhutan maintained “zero” polio status. Neonatal tetanus has also not been reported since 1994. Over the past five years from 1999 to 2003, there has been no case of
Diphtheria and Pertussis (see table 8). Measles cases (clinical diagnosis) reported in 1999, 2000 and 2001 could have been rubella because measles cases when subjected to laboratory diagnosis for measles and rubella in 2003 and 2004 confirmed rubella. The tests were negative for measles.

Table 8: EPI case report

<table>
<thead>
<tr>
<th>Year</th>
<th>Polio</th>
<th>Measles</th>
<th>Diphtheria</th>
<th>Pertussis</th>
<th>Neonatal Tetanus</th>
<th>Rubella</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>0</td>
<td>350</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2000</td>
<td>0</td>
<td>460</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2001</td>
<td>0</td>
<td>682</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2002</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2003</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>350</td>
</tr>
</tbody>
</table>

2.4 Emerging Vaccine Preventable Diseases

2.4.1 Rubella

Despite achievement of 85%–90% coverage of measles vaccine, a substantial number of clinically diagnosed measles cases continued to be reported every year (see table 8). In the absence of the capability for laboratory diagnosis of measles, clinical judgement was respected and the cases were recorded as measles. But with the establishment of the laboratory diagnostic facility for measles and rubella in the Public Health Laboratory in Thimphu in April 2003, suspected measles cases were routinely subjected to measles IgM and rubella IgM tests. Between April to November 2003, a total of 159 serum specimens were tested both for measles and rubella. Of these, 33% tested IgM positive for rubella and none for measles (WHO, IVB/VAM, 1 March 2004). This finding is clear evidence that rubella infection has been prevalent in the communities for a long time, and that all suspected measles cases reported thus far were in fact cases of rubella. Knowing the serious consequences of Congenital Rubella Syndrome (CNS), the Ministry of Health has completed the Rubella Vaccination Strategy to be implemented by 2005.
2.4.2 GAVI support for DTP-HepB-Hib

Bhutan conducted the Hib Rapid Assessment study in 2002. A retrospective review of laboratory and clinical records at Jigme Dorji Wangchuck National Referral Hospital in Thimphu (JDWNRH) and Mongar Regional Referral Hospital for the eastern region was undertaken to identify children under 5 years with purulent or confirmed bacterial meningitis. The study yielded 100 possible cases of meningitis. Of the 100 specimens 27 met the definition of purulent meningitis and 19 met the definition for confirmed case definition (as defined by Hib Rapid Assessment Tool) using worksheets 2 of Hib Rapid Assessment Tool. The estimate of the national burden of Hib disease was generated based on the observed Hib meningitis incidence and by extrapolation from meningitis incidence to pneumonia incidence. Using the estimate incidence of 15 cases of Hib meningitis/100,000 it was estimated that there are approximately 96 cases of Hib meningitis and pneumonia and 13 deaths each year of under 5 children. GAVI has therefore, granted conditional approval for providing DPT-HepB-Hib vaccine on the submission of the reports of 2002 EPI coverage survey, EPI review and Hib burden disease study.

2.4.3 Japanese Encephalitis (JE)

Bhutan has not reported Japanese Encephalitis (JE), and in the absence of JE cases, no standard case definition has been adopted. However, there is a possibility of encountering occasional suspected cases. Through routine surveillance & reporting of malaria cases, the data gathered so far indicate the existence of epidemiological factors conducive for JE. JE vectors (Cx vishnui, Cx pseudovishnui and Cx tritaeniorhynchus) are present in high density along with malaria vectors in all malaria endemic areas. Therefore, the threat of JE outbreak looms large over all malaria endemic areas of the country.

2.4.4 Dengue & Dengue Haemorrhagic Fever (DHF)

Suspected Dengue/DHF outbreak was first reported in Phuntsholing in 1997, but failed to confirm due to lack of laboratory diagnostic facility. In the first week of July 2004, suspected Dengue/DHF was again reported from Phuntsholing. Serum samples sent to referral laboratories at Kolkata, New Delhi and Bangkok confirmed the outbreak as Dengue/DHF and by the time the outbreak was declared contained and controlled in the second week of August, a total of 2,544 cases compatible with Dengue/DHF were reported. Of these, only 123 cases had to be hospitalised. There was no mortality in this outbreak.

Phuntsholing, situated in the foothill plains bordering with Jalpaiguri district of West Bengal state of India, is Bhutan’s major financial and commercial centre. Vectors for Dengue/DHF (Aedes aegypti & Aedes albopictus) are found abundant in all townships located in the southern part of the country. Therefore, there lies the perpetual risk of Dengue/DHF outbreak in the townships in the southern dzongkhags particularly in malarious areas.
2.5 Strategy to reach the Un-reached

All hospitals and BHUs have their own annual work plans covering at an average of three to four Out-Reach Clinics (ORC) per month by each health centre depending on the size of the area and the population. The number and the site of ORCs are based on the remoteness of the community and the estimated clients. The date for the clinic is fixed as per the convenience of the local population and are conducted once a month. Coverage of the seasonal mobile population groups are affected in close coordination between and among the concerned dzongkhag health authorities. A daylong clinic covers the immunization; antenatal and postnatal check ups, health education services and general treatment for the patients in the locality. In the capital town, Thimphu, satellite clinics have been started essentially to provide better EPI coverage for mothers and children residents in the capital who are otherwise inaccessible.

2.6 Challenges

The difficult terrain and the sparsely populated areas of the country pose daunting challenges in providing equitable access to health service to all the citizens. One of the major challenges are bringing vaccine wastage reduction to an internally acceptable level and reaching the un-reached populations.

2.6.1 Wastage

Many factors affect vaccine wastage starting from vaccine to vaccinator, Vaccine & syringe related factor, procurement practices factor and immunization related factors. These vaccine wastage factors will be encountered by adopting the following tools:

(a) Changing vial size by assessing all the factors and cost per immunized child,
(b) Encouraging multi dose vial policy adoption,
(c) Vaccine vial monitoring use should be encouraged and staff must be trained to interpret the same,
(d) Avoiding programmatic errors such as toxic shock.
(e) Practising first expiry first out (FEFO) formula
(f) Improving procurement practices, right quantities at right time with adequate cold chain space.
(g) Ensuring more number of children per session than number of session.
(h) Preventing freezing of vaccines.
(i) Implementing safe immunization practices
(j) Improving vaccine management practices.
(k) Prevention of vials submerging in water.
2.6.2 Reaching the un-reached

Special attention shall be given to mobile population and migrant workers, children, as they are likely to miss routine immunization and are also at risk of importing vaccine preventable diseases. To reach these children, each facility shall map out the mobile population and migrant workers camps. Each facility shall then make special outreach micro-plans to deliver at least four doses of OPV to these children each year and together with that, all other vaccines. Special focus is given to seasonal migratory groups that move from one place to another through traditional routes and stay in usual places. The immunization service to such mobile population groups is well coordinated by the concerned health authorities in the dzongkhags.

2.6.3 Good coverage and target reporting

The standards required for quality health services and the simultaneous changing need of various programmes and projects have resulted in numerous changes and modifications in the recording and reporting procedures of Health Information System over time. As a consequence, it had only amounted to duplication of efforts and resources, but also has become unmanageable to deal with, ultimately leading to the degradation of quality of information. The Information Unit, under the spearhead of Planning and Policy Division of Health, reviewed the entire recording and reporting system of the various programmes and developed Bhutan Health Management & Information System (BHMIS), a computerized record keeping of routine reporting system for the districts and the centre. The system was developed with the following objectives:

(a) To bring the system in line with current priorities in the health sector,
(b) To streamline recording and reporting where possible, and
(c) To take advantage of information technology to make data management and information use more efficient and effective.

Procedure manual has been produced which is a self-learning material for the health staff. The Information Unit has trained all the In-charges of BHUs, Hospital in BHMIS, and the system is functioning as desired.

2.7 Immunization and GAVI

GAVI has awarded DTP-HepB and Injection safety for all vaccines from the year 2003 to 2007. An amount of $439,500 for new and underused vaccines with $29,000 for injection safety (see table 9) and a sum of $100,000 for other support which has been donated to the Bhutan Health Trust Fund has been awarded. The Fund is an organisation with an aim to provide vaccines free to the Bhutanese people. GAVI has also awarded conditional approval for DTP-HepB-Hib.
Prior to the introduction of the new vaccines, training for all health workers on the usage and administration of the new vaccine was conducted. DANIDA used to provide Hep B vaccines from 1996-2002, but with the emergence of GAVI, DANIDA has withdrawn its support for the vaccine and is now supporting the Health Ministry through budget support.

Table 9: GAVI award for DPT-HepB

<table>
<thead>
<tr>
<th>Country</th>
<th>Surviving Infants at first approval</th>
<th>DTP3 coverage at first approval</th>
<th>5 years New and Under-used vaccine Support</th>
<th>5 years Immunization Services Support</th>
<th>3 years Injection safety support</th>
<th>Other support</th>
<th>5 years New and Under-used vaccine Support</th>
<th>Vaccine presentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bhutan</td>
<td>15,902</td>
<td>88%</td>
<td>439,500</td>
<td>29,000</td>
<td>100,000</td>
<td>439,500</td>
<td>DTP-hepB 2003; C for DTP-hepB+Hib</td>
<td></td>
</tr>
</tbody>
</table>

2.8 Partner Involvement in EPI

WHO and UNICEF are key partners in delivering immunization service to the mothers and children of Bhutan. Their support to the EPI program is mainly in the areas of consultancies and short-term human resource development focusing on updating knowledge and skills in vaccine delivery and cold chain management. Vaccines & injection equipments are procured through JICA and GAVI support. However, there is no agreement signed between UNICEF, JICA and Ministry of Health specifying the period of support for immunization service. JICA provides support on request through UNICEF.

Vaccines are procured annually through UNICEF-Japan multi-bilateral assistance to EPI program for Bhutan based on the immunization requirement and as per the National Essential Medicine List using WHO/UNICEF recommended forms. The firms are required to produce the necessary pharmaceutical related documents in order to qualify for the international bids. Prior to calling for bids, the recommended firm negotiates with the National Drug Regulatory Authority (NDRA) of the Ministry of Health. Competent officials based on the competitive price, pack size of vaccines, shelf life, possession of necessary documents and route of shipment make the selection of vaccine.
Section 3 - Past Costing and Financing

3.1 - Overview of past program costs

The total program cost over the years (pre-VF year 2001 and VF year 2003) are given in table 10:

Table 10: Costing table for Bhutan for the years 2001 and 2003

<table>
<thead>
<tr>
<th></th>
<th>2001</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total spending</td>
<td>$1,031,657</td>
<td>$836,585</td>
</tr>
<tr>
<td>% Gov. funding</td>
<td>52%</td>
<td>67%</td>
</tr>
<tr>
<td>Cost per DTP3 child</td>
<td>$38.68</td>
<td>$38.66</td>
</tr>
<tr>
<td>Total spending (% total health expenditures)</td>
<td>5%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Routine immunization spending has increased between 2001 and 2003. Campaigns conducted in 2001 and 2002 incurred substantial expenditure: about 30% of total spending on immunization. Transport cost reflection appears low because most of it is a shared cost. Personnel expenses is by far the largest cost driver. Much of the expenditure is incurred on travel and per diem because of the nature of the country’s difficult terrain and thinly scattered population. These require covering long distances on foot and riding pony particularly in attempts to reach the far-flung communities. The cost per DTP3 child is roughly estimated to be about US$39 per child. The amount of importance the Government allocates to the EPI programme can be seen from the fact that the government is the largest contributor from 52% of the total cost activities in 2001 to 67% in the year 2003. The high spending in the year 2001 reflects the polio campaign conducted which accounts for US$293,615.

As per WHO standards, any country having hepatitis B virus rate higher than 2% should integrate HepB vaccine within existing EPI programme. Sero-survey study conducted in 1994/95 found that the HepB prevalence rate was 5%, and therefore, DTP-HepB was introduced in September 2003 through GAVI support. Since it is a new vaccine being introduced recently, the cost impact is not yet fully accounted.
Table 11: Past Cost by category for the years 2001 and 2003

Table 12: Past costing by category

<table>
<thead>
<tr>
<th>Category</th>
<th>2001</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional Vaccines</td>
<td>0.0618</td>
<td>0.0557</td>
</tr>
<tr>
<td>New &amp; Underused vaccines</td>
<td>0.0187</td>
<td>0.0505</td>
</tr>
<tr>
<td>Personnel</td>
<td>0.3833</td>
<td>0.4025</td>
</tr>
<tr>
<td>Other routine recurrent costs</td>
<td>0.0582</td>
<td>0.0931</td>
</tr>
<tr>
<td>Vehicles</td>
<td>0.0148</td>
<td>0.0232</td>
</tr>
<tr>
<td>Cold chain</td>
<td>0.0422</td>
<td>0.0445</td>
</tr>
<tr>
<td>Polio campaigns</td>
<td>0.2936</td>
<td>-</td>
</tr>
<tr>
<td>Other optional information</td>
<td>0.1449</td>
<td>0.1509</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1.0175</strong></td>
<td><strong>0.8204</strong></td>
</tr>
</tbody>
</table>

3.2 Overview of Past Program Cost Indicators

The cost per DPT3 child is around $39. The growth rate in program costs is 16% between 2002 and 2003 (with GAVI). In 2001 and 2002, campaign represented 30% of total spending on immunization. The total spending on immunization, as a percentage of GDP is less than 0.2% while total spending on immunization as a % of total expenditure on health is between 4-5%.
3.3 Overview of Past Program Financing

Government financing for EPI has increased between 2002 and 2003 while UNICEF financing has decreased during the same period as a result of campaigns (see table 13). DANIDA fund is now directed towards budget support to the Ministry of Health.

Table 13: Past Program Financing

<table>
<thead>
<tr>
<th>Secure Funding</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>US$</td>
<td>US$</td>
<td>US$</td>
</tr>
<tr>
<td>Government</td>
<td>$538,968</td>
<td>$535,118</td>
<td>$563,667</td>
</tr>
<tr>
<td>GAVI - Vaccine Fund</td>
<td>$ -</td>
<td>$ -</td>
<td>$57,219</td>
</tr>
<tr>
<td>UNICEF</td>
<td>$139,214</td>
<td>$35,745</td>
<td>$40,043</td>
</tr>
<tr>
<td>WHO</td>
<td>$184,175</td>
<td>$68,586</td>
<td>$100,139</td>
</tr>
<tr>
<td>JICA (UNICEF)</td>
<td>$128,481</td>
<td>$124,840</td>
<td>$62,394</td>
</tr>
<tr>
<td>DANIDA</td>
<td>$20,778</td>
<td>$12,229</td>
<td>$ -</td>
</tr>
</tbody>
</table>

3.4 Overview of Past Program Financing Indicators

The government financing for immunization represents about 50%. UNICEF is the largest multilateral donor especially in 2001, 2002 with the polio campaigns. WHO and JICA (UNICEF) are among the traditional partners in the immunization programme in Bhutan. The DANIDA support to the programmes directly has been stopped and is now emphasizing on budget support to the Health sector as a whole.

Table 14: Trend in Past Financing by Source (US$ Millions)
Section 4 - Future Resource Requirements, Financing and Gaps

Considering the present partners and the national government’s involvement in the EPI programme, there is expected to be a minimal gap in the funding for the programme. With the end of the GAVI support towards 2007, it is expected that the Bhutan Health Trust fund would play a major role in the EPI activities. The present gap analysis in percentage for Bhutan is 8% and in the year 2013 it is expected to fall to 2%, considering both the probable funding and the secure funding. Plans to reduce the gap in terms of reducing vaccine wastage, improving monitoring and supervision and human resource capacity building have been formulated and would help in the overall strategy to reduce the gaps in financing.
Section 5 - FS Strategies

5.1 Mobilizing more resources

5.1.1 Advocacy

As of today, the procurement of vaccines and vaccine equipment is wholly dependent on donor funding. The external funding support granted, based on the basis of program performance and the country needs have been quite consistent over the years. However, there has been increasing pressure from the donor partners for increased government share of the budget allocation for the immunization programs. To this end, the program will look to create an EPI budget head, and PPD in MoH will pursue the matter with the MoF. Until the time the Royal Government has adequate revenue from export of power and tourism, it is important to solicit continued funding support for the program from the traditional donors and potential new partners as well. High level advocacy will be carried out to obtain commitment from bilateral agencies for continued funding support.

5.1.2 Bhutan Health Trust Fund

The Bhutan Health Trust Fund (BHTF) has been created with the noble objective of providing basic health care free of cost to the Bhutanese citizens at all times. This is in keeping with the desire of His Majesty the King. The BHTF, once fully operational, is expected to pay for essential drugs and vaccines.

5.1.3 Strengthening PCM

The PCM is basically a public-private partnership through which issues of immunization service is addressed. This mechanism is fairly new, and it needs much strengthening to give meaning by way of convening regular interactive meetings, inviting new partners and keeping the members constantly informed of the developments in immunization service. The program will ensure that important policy and programmatic matters, particularly EPI financing and sustainability issues, are put up to PCM for deliberation and/or endorsement.
5.2 Increasing Efficiency of Existing Resources

5.2.1 Facility based Micro-Plans

Dzongkhag health authorities have already been instructed to prepare BHU based micro-plans so that targeted interventions can be undertaken in low coverage areas. The micro-plans will prioritise outreach services and the frequency of sessions at specific locations. Intervention efforts based on micro-plans will enable the health staff for optimal utilization of their efforts and supplies. At the central program level, understanding the dzongkhag wise micro-plans will facilitate the program in effective resource allocation to the dzongkhags, thereby reducing wastage both in terms of supplies and efforts. It will also help to guide the central and regional program personnel in focusing on the areas of monitoring and supervision.

5.2.2 Wastage Reduction Strategy

In view of the exceptionally high wastage rate in Bhutan due to the rugged terrain and sparsely scattered population, WHO open vial policy has been adopted since December 2003. After training of health workers as per WHO standard procedure, Multi dose Open Vial policy is implemented throughout the country at the fixed clinics only for DPT, OPV & TT vaccines. The program ensures that this policy is implemented in all the health facilities. Bhutan will also explore procuring vaccine vial with lesser doses especially for far-flung outreach clinics with minimal attendance and or minimal catchment areas.

5.2.3 Coverage Target and Forecasting

Having realized the inconsistency in estimating target population the program will henceforth work closely with the Dzongkhag health sector and obtain actual pregnancy and birth reports on regular basis. Special emphasis will be given to covering un-reached population groups like nomadic people who are seasonal migrators, business people, laborers and marginalized urban families. The use of National EPI/MLM guidelines will be enforced in all health centres for enabling accurate target setting and vaccine forecasting.
5.2.4 Cold Chain Inventory and Replacement Plan

The cold chain inventory is maintained by the national cold store in-charges under the direct supervision of the Drugs Vaccines & Equipments Division (DVED), Department of Medical Services (DoMS). With regard to the cold chain replacement plan, there is no standard plan developed so far. The replacement is presently being done as per the need. With the past experience of the cold chain equipment maintenance, the life span of various cold chain equipments is now known, and hence it is feasible to prepare the replacement plan for the cold chain equipment (see table 16).

<table>
<thead>
<tr>
<th>S.No.</th>
<th>Cold chain equipments</th>
<th>Replacement plan</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Refrigerated Van</td>
<td>5 years</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Refrigerator</td>
<td>7 Years</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Cold Box</td>
<td>10 years</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Vaccine carrier</td>
<td>10 Years</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Ice Packs</td>
<td>7 Years</td>
<td></td>
</tr>
</tbody>
</table>

5.2.5 Standard operation procedures for cold chain and vaccine management

Bhutan has a comprehensive National EPI Service Manual developed in 2002. The standard operational procedures (SOP) on cold chain and vaccines management are described in detail in the manual. Operational procedures prescribed for the cold chain covers the cold chain system, vaccine storage, equipment and its maintenance, and monitoring of temperature during immunization sessions. Operational procedures prescribed for management of vaccine also covers vaccine stability & sensitivity, potency, stock record, essential actions, storage, distribution, wastage, prevention of freezing, multi dose vial policy, reconstitution & administration, vaccine vial monitor & standard indenting and reporting forms and formats. This manual serves as a guiding tool in the field and is accessible in all the health centers and health workers in the country.

5.2.6 Improving monitoring and supervision

The Dzongkhag Medical Officer (DMO) and District Health Supervisory Officer (DHSO) are fully responsible and accountable for planning and implementation of the immunization services in their dzongkhags. They will supervise and monitor routinely the EPI activities in the health centers within the dzongkhag. Their main focus will be on ensuring the cold chain maintenance system and effective coverage of the immunization service. The regional cold store in-charges will also be responsible in monitoring and supervision of the vaccine supply and cold chain maintenance in the dzongkhags under their jurisdiction. The Vaccine Preventable Disease Program (VPDP) at the center will monitor immunization program activities particularly the cold chain maintenance and vaccine supply & management system from the regional cold store up to the dzongkhag head quarter level.
5.3 Improving the Reliability of Resources

The Policy and Planning Division (PPD), MoH, will advocate for the creation of a budget head for immunization service, and pursue the matter with the MoF, commencing from the 2005-2006 fiscal year. It is also expected that when Tala Project gets commissioned, the budget head could pay for the combo vaccines currently supported by GAVI.

JICA’s support to the immunization program is currently through UNICEF. In order to improve the reliability of its continued support, the program will make JICA’s input much more visible in the government and as well as in the communities at large through available media focus. High-level advocacy will be carried out in an effort to garner enhanced JICA support for the immunization program.
Section 6 - Stakeholders Comments

Dialogue with the traditional collaborating partners could not get any funding commitment as far as the secured funding for immunization services are concerned. The reason being that they too have no budget for a definite time period as the fund is usually obtained on an annual request basis. From the discussions thus far, it appears that the traditional partners will continue supporting the EPI program and not withdraw their support abruptly. It can therefore, be construed that they would not downgrade their support for the next few years, and that their assistance can safely be understood as probable funding for the next few years. Other stakeholders expressed their interest and willingness to support the program, but short of making any commitment in terms of actual funding commitment. Bhutan Chamber of Commerce & Industries (BCCI) represented in PCM by its General Secretary, has already made a substantial contribution to the BHTF.