3 GUARANTEE ACCESS TO QUALITY HEALTH AND PROMOTE WELFARE FOR ALL

3.b Support research and development of vaccines and medicines for communicable and non-communicable diseases, which mainly affect developing countries, provide access to essential medicines and vaccines at affordable prices, in accordance with the Doha Declaration, which affirms the right of developing countries to make full use of the provisions of the TRIPS agreement on flexibilities to protect public health and, in particular, to provide access to medicines for all

3.b.1 Percentage of the target population covered by all vaccines included in the national program

target population covered by all vaccines included in the national program as a percentage

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Percentage of the target population covered by all vaccines included in the national program is the Proportion that represents the number of children under 1 year of age who received all doses of vaccines according to the vaccination schedule, in relation to the target group. All fully vaccinated children are registered after having their individual cards stamped with “complete vaccination” which implies that the child received anti polio antigens 0 and BCG at birth; 3 doses of Polio and 3 doses of DPT-HepB-Hib and 3 doses of PCV 10, at 2.3 and 4 months respectively and 2 doses of VORH at 2 and 3 months; and anti-measles at 9 months of age.

Percentage

Within the scope of the implementation of activities that contribute to the reduction of infant and juvenile mortality, it is intended to measure the degree of coverage of the Extended Vaccination Program (PAV), in terms of administration of all the vaccines defined for each child before 1 ° year of life. The proportion of children who received all doses of the basic vaccination schedule within the first year of life is proportional to the success that the PAV program aims for.

Vaccination is the first line of defense against various infectious diseases and is the most successful and cost-effective public health intervention to reduce child mortality and improve child health.

An unvaccinated child can face serious illnesses, including potentially untreatable illnesses that can prove to be deadly.

The rationale for selecting a set of vaccines reflects the ability of immunization programs to deliver vaccines throughout the life cycle and to adapt new vaccines.

Given that the HPV vaccine is relatively new and the vaccination schedule varies from country to country, coverage estimates will be made for girls vaccinated at age 15 and, at the moment, data are limited to very few countries, therefore, reports will start later.

Percentage of children aged 12-23 months who received specific vaccines at a certain time before the interview (according to the vaccination card or mother's statement).

You are considered to have taken all basic vaccines if your child has received at least:

- One dose of BCG vaccine (Bacillus Calmette Guérin), which protects against tuberculosis,
- Three doses of pentavalent vaccine, which protects against diphtheria, pertussis (whooping cough), tetanus, hepatitis B and Haemophilus influenza,
- Three doses of polio vaccine,
- One dose of the measles vaccine,
- Three doses of the PCV vaccine, which protects against pneumonia.

Sample: Children aged 12-23 months.

Vaccination cards were an important tool that constituted the best indicator that the child received all the recommended vaccines within his chronological calendar. Seventy-four percent of children had a vaccination card

The indicator is comparable to the international level

Available in:
http://www.who.int/immunization/monitoring_surveillance/routine/coverage/en/index4.html
https://www.unicef.org/immunization/

The field typist, together with the team controller, reviewed the questionnaires and then typed them in the Census and Survey Process (CsPro) version 4.1.002, special edition. This process of typing in the field allowed the detection of inconsistencies or omissions in the questionnaires, as well as the correction of them even on the ground, with the presence of the team in the conglomerate.

During the data collection activities, several levels of quality control were applied. The first level consisted of identifying the AEs by checking the reference maps or sketches, followed by confirming the AE at the central level, using data sent from computers equipped with a GPS system and online in the field. The first level of quality control helped to identify the central point of each enumeration area with a margin of error of ten meters from the center of the enumeration area. The second level of quality control consisted of checking the questionnaires by the team's controller and the field typist, after filling in the questioner, checking for inconsistencies and following the filters through the programming done in the CsPro program in the field and double typing process typing and critical analysis at the central level (central typing).

Throughout the data processing process, standard DHS Program procedures for CAFE6 surveys were applied. The introduction of CAFE at IMASIDA 2015 ensured that the questionnaires started to be edited in the field, using a portable computer. After completing the questionnaires on paper and completing all interviews in the household, the interviewers and health technicians delivered the questionnaires to the field typist.

In the process of entering all the questionnaires, the field digitizer sent the data to the central level, through the Internet File Transmission System (IFSS). In parallel with the data transfer via IFSS, each field team sent all paper questionnaires to the central level (INS). At the central level, a team of receptionists and typists took care of receiving the questionnaires on paper and started the second round of typing and correcting inconsistencies. These tasks were performed by three receptionists and twelve central typists. In the end, all questionnaires were entered twice.

The verification of data inconsistencies was made by comparing the first entry (made in the field) and the second entry (made at the central level). It was an ongoing process, which allowed all inconsistencies to be corrected. In addition to checking for inconsistencies, critical typing of all questionnaires completed in the 307 AEs was also carried out. This process consisted of a thorough review of inconsistencies produced by the data entry program (CsPro).

Based on the CsPro at the central server level, weekly reports were produced that served as a check for consistency in the answers to the questionnaire questions. Emphasis was placed on verifying inconsistencies in questions related to dates, time intervals and ages, with reference to the secondary edition manual adapted for Mozambique, which contains possible solutions to the identified errors or inconsistencies.

Survey of Indicators on Immunization, Malaria and HIV / AIDS in Mozambique (IMASIDA) 2015

Data collection took place between 8 June and 20 September 2015, the fieldwork was carried out by 25 teams.

The design of the sample consists of three stages. *In the first* , the sample was stratified by province and urban / rural area and then 307 primary sampling units (UPA) were selected, through systematic selection of equal probability. *In the second step* , an enumeration area (AE) was selected from each of the 307 primary sampling units with probability proportional to the size of the AEs, resulting in a selection of 134 AEs in urban areas and 173 AEs in rural areas. *In the third stage* , all households (PA) were listed in each of the 307 AEs.

The listing was conducted systematically, using files specially designed for the purpose. The complete list of households was used to select the 24 households eligible for interviews in each EA. Based on this procedure, 7,368 households were selected for the survey.

four questionnaires were used: one to interview households, one individual for 15-59 year old women, one individual for 15-59 year old men and another biometric for 15-59 year old men and women.

During the survey, 7,368 households were selected, of which 7,342 were present and 7,169 agreed to conduct the household interview, which resulted in a 98% response rate.

Data available in 2015. Disaggregated by province, mother's education level, education level and wealth quintile

2022

2022

National Institute of Health in coordination with MISAU

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Under Law 7/96, which defines the general bases of the National Statistical System, the National Statistics Institute (INE), according to the Order published in the Boletim da República No. 39/2000, Series I, of 27 September 2000, officially delegates the Directorate of Planning and Cooperation (DPC), of the Ministry of Health, the publication and dissemination of the official statistical information of the Health Sector, in Mozambique.

Ministry of Health (MISAU), National Statistics Institute (INE), and ICF, 2015. Survey of Indicators of Immunization, Malaria and HIV / AIDS in Mozambique 2015. Maputo, Mozambique. Rockville, Maryland, USA: INS, INE, and ICF.

3.8.1 Coverage of essential health services (defined as average coverage of essential services based on screening interventions that include reproductive, maternal, newborn and

child health, infectious diseases, non-communicable diseases and the ability to and access services, among the general and most disadvantaged population)