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Building on Polio: Improving Access and Strengthening EPI

Report of the Eighth Meeting of the Technical Consultative Group on Vaccine Preventable Diseases in SEAR
New Delhi, 22-25 October 2001

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CONTENTS

Annexes

1. INTRODUCTION

The Eighth Technical Consultative Group on Vaccine Preventable Diseases in SEAR was held in New Delhi, India from 22 - 25 October 2001. The purpose of the meeting was to review and advise SEAR countries on:

(1) Revitalization of the expanded programme on immunization (EPI), (especially for the priority diseases - polio, measles, MNT);

(2) Progress in polio eradication since the last TCG meeting and the multi-year strategic plan of action;

(3) Issues of critical importance to strengthen immunization services, including communications, data for decision making, vaccine management, and service delivery, and

(4) Innovations in SEAR in introducing new vaccines and developing a Regional Vaccine Policy.

The TCG members present were Dr R N Basu, Vice-Chairperson; Dr Walter Dowdle, Rapporteur; Dr A Ramalingeswara Rao, and Dr Stephen L Cochi.

His Excellency Dr C P Thakur, Minister of Health and Family Welfare, Government of India inaugurated the session. Mr A R.Nanda Secretary, Ministry of Health and Family Welfare, Government of India delivered the welcome address. Dr Uton Muchtar Rafei, Regional Director, WHO/SEARO spoke on behalf of WHO and Ms Maria Calivis, Country Director, UNICEF/India, on behalf of UNICEF. Dr. R N Basu, Acting Chairperson SEAR/TCG delivered a vote of thanks. (See Annexes 1 and 2 for list of participants and agenda.)

2. GENERAL SUMMARY

SEAR has reached a strategic crossroads in immunization progress. Polio eradication remains the top priority for the coming year, but, as eradication nears, the Region has begun to apply the lessons from polio to revitalize EPI and reduce the burden from all vaccine preventable childhood diseases. The success of polio eradication will be measured ultimately not only by a polio-free world, but by the increased capacity of national health systems.

Strategies for revitalizing EPI include increased access to services and increased demand and acceptance for immunizations in the community, requiring improved planning, communication, monitoring, and supervision at all levels. The polio eradication initiative serves as a model for the control of vaccine preventable diseases. The key elements of polio eradication are applicable to all priority EPI diseases, that is, complete and timely reporting, case investigation, laboratory confirmation, and detailed data analysis to monitor progress and target action. Reliable vaccine demand-forecasting capacities, transparent procurement, access to quality supplies, effective cold chains, stock controls, efficient logistics, and immunization safety are essential components. Effective communications, advocacy, and social mobilization are crucial for generating demand and sustaining financial support for a revitalized EPI.

The newly formed SEA Regional Working Group for Immunization and the Task Force on Regional Vaccine Policy represent important steps in providing technical assistance in the Region and towards the development of a regional vaccine policy. Many other approaches, new ideas, and strategies will be required to successfully revitalize EPI. Among them will be a renewed commitment to strengthening and forming new partnerships with other related international agencies and national health programmes in the Region. The collective infrastructures of SEAR Member countries have never been stronger than at this strategic crossroads in immunization. Now is the time to commit to making age-appropriate immunizations available for all children in the Region.

3. REVITALIZING THE EXPANDED PROGRAMMEME ON IMMUNIZATION (EPI)

EPI was the focus of international and national attention in the late 1980s' and early 1990s' under the Universal Childhood Immunization campaign, with outstanding success. As EPI became more closely integrated with other maternal and child health services, it focused attention towards health sector reform and decentralization as priority activities. The challenges now facing the Region are to reinvigorate EPI within the broader context of comprehensive services, increase access to unreached children, and decrease the number and proportion of children who drop out before completing all age appropriate immunizations.

The SEAR goal is to achieve coverage with EPI vaccines, DTP, OPV, measles and BCG, of at least 80% of children in all districts. However, the TCG reminds Member States that this is a management goal. The real goal is to provide all of children in the Region with age-appropriate immunizations.

In 2000, over 80% of districts in Sri Lanka, Bangladesh and Myanmar reported DPT3 coverage over 80%. Bhutan reported 75% of districts with 80% DPT3 coverage, a drop from the 85% of districts the previous year. Similarly, Indonesia reported 78% of districts achieved 80% coverage in 2000, a drop from 90% of districts reporting 80% coverage in 1999. In 1999, Thailand and Maldives provided evidence of achieving over 80% of districts with more than 80% DPT3 coverage. In several countries, however, surveys indicated that the actual coverage was lower than reported (Annex 3).

The TCG endorses the five key SEAR objectives to achieve the overriding goal of reducing the burden of vaccine preventable disease:

(1) To develop a Regional vaccine policy by June 2002 and national policies by 2005;

(2) To increase Regional vaccine self-sufficiency by achieving EPI vaccine self-sufficiency in all countries by 2005;

(3) To strengthen national capacity to ensure vaccine quality by establishing functioning National Regulatory Authorities in all countries by 2003;

(4) To strengthen human and institutional resources through training and support of immunization staff by all countries by 2005, and

(5) To strengthen the operational provision of services by developing and maintaining sustainable immunization programmes by 2005.

4. STRENGTHENING IMMUNIZATION SYSTEMS FOR VACCINE PEVENTABLE DISEASES

The strategies and lessons learned from polio eradication can equally add value to the control of other EPI diseases, particularly service delivery, vaccine management and injection safety, data for decision-making, and improved communication.

4.1 Service Delivery

The TCG notes that reported immunization DPT3 coverage varies greatly among the countries of the region, from 65% to 100%, often with great disparity between different administrative units in countries. The roots of poor routine immunization services may be economic instability, poor management, or recent health sector reform, all of which may disproportionately affect poor people living in densely populated as well as those living in the remote and hard to reach areas. Traditional national immunization programmes in many countries have been slow to respond to changes in health systems and social conditions. Strategies for revitalizing EPI include providing increased access to services and increasing the demand for and acceptance of immunization by the community. Improved planning, communication, monitoring, and supervision are crucial for improving immunization coverage. Components of the polio eradication initiative are amenable to rapid strengthening of routine immunization, including detailed logistic planning, social mobilization, and AFP surveillance, which can be used to identify communities with low routine immunization.

Recommendations

(1) Countries of the Region should utilize the experience gained in polio eradication to improve EPI immunization delivery systems through identifying areas with low coverage and responding with detailed micro-planning, social mobilization, partnership building, logistic support, and monitoring.

(2) Countries of the Region should pay special attention to data collection, analysis and use of information for action. Areas with high drop-out rates should be identified, reasons for the drop-out should be found, and corrective measures taken.

(3) Countries of the Region should review immunization service delivery in districts with low routine immunization coverage to identify available resources and operational gaps. Findings of the review should be used to tailor district plans of action to reach under served and unreached populations. Poor performing/high-risk areas may need intensive technical and financial assistance.

(4) Countries should develop a 2-3 year action plan for capacity building among mid-level managers at the national and state

levels. Such plans should aim to protect core functions of EPI including procurement of vaccine and supplies in the face of health sector reforms through strengthening decision making, management and planning capacity of state and district level managers, including advocacy skills for funding allocations at district levels.

4.2 Vaccine Management and Immunization Safety

Ensuring adequate supplies of quality vaccines, administered safely, continues to pose challenges for the Region. The SEAR polio eradication initiative has challenged immunization systems and provided opportunities to strengthen vaccine management in all stages from production to end-use. The initiative has demonstrated that an efficient management system requires a robust demand-forecasting capacity with access to reliable data on vaccine use, transparent procurement systems, access to quality suppliers, fully functioning cold chains, stock controls, and efficient logistics. The vaccine management system forms the backbone of the immunization programme, with immunization safety being a crucial component. Immunization safety requires assurance of quality through a vaccine regulatory mechanism, effective surveillance for adverse events, and safe injections, including reduction of risks to the community from improperly disposed injection equipment.

The TCG notes that as recommended by the Regional Immunization Safety Workshop held in Colombo in November 2000, efforts are underway to improve immunization safety in the Region through a gradual shift to auto-disable (AD) syringes, better injection techniques, and environmentally safe syringe and needle disposals.

Recommendations

(1) Countries should strengthen national vaccine procurement systems and forecasting through a process of assessment, training, and monitoring. The vaccine management assessment tool newly developed by WHO should be field tested by SEARO in collaboration with Member Countries and tailored for use in the Region.

(2) Countries should develop a specific, measurable plan of action for EPI that includes conducting an assessment of safe injection practices,

adopting benchmark indicators, establishing a national safe injection policy that applies to curative and preventive services, as well as establishing a national health care waste management policy with guidelines for implementation.

(3) Countries introducing AD syringes are encouraged to do cost analysis to identify options for sustained procurement of ADs once GAVI funds cease.

(4) Countries should include training on use and safe disposal of ADs in all training modules for mid level management. Training should be provided to vaccinators just prior to implementation. in the Region should work towards increasing the capacity to meet regional demand for production of AD syringes that meet WHO specifications.

(5) India, Myanmar, Nepal and Indonesia should develop and implement two-year plans of action to strengthen vaccine National Regulatory Authorities based on recently concluded assessments in each of these countries. All countries in the Region should have functional NRAs by 2003.

(6) All countries of the Region should conduct temperature assessments and consider cold store certification as components of an overall plan to strengthen cold-chain systems and vaccine management.

4.3 Data for Decision Making

The TCG commends SEAR for its recognition of the polio eradication initiative as a model for using data effectively to control other vaccine preventable diseases. Complete and timely reporting, case investigation, laboratory confirmation, and detailed data analysis to monitor progress and target action are programme components applicable to all priority EPI diseases. In addition, the polio surveillance medical officer (SMO) network has proved to be a strong force at the field level with potential for galvanizing vaccine-preventable disease surveillance and assisting the government to improve quality and coverage of EPI immunizations. Because the AFP surveillance infrastructure may be required well beyond certification, it will continue to provide opportunities to integrate and strengthen surveillance for all five vaccine preventable diseases, polio, measles, tetanus, pertussis and diphtheria. Bangladesh has expanded its AFP surveillance to include measles and NT surveillance. Indonesia, Thailand, Myanmar and Sri Lanka have already included measles and NT surveillance with AFP surveillance as well as providing laboratory confirmation for measles outbreaks.

Recommendations

(1) Countries (including those with an SMO network) that have been polio-free for >1 year with adequate AFP surveillance (non-polio AFP rate >1/100000 and adequate stools >80%), should consider gradually expanding AFP surveillance activities to include measles and neonatal tetanus surveillance in selected areas. Establishing nationwide enhanced surveillance should be the long-term objective.

(2) Countries that already have an integrated surveillance system should continue to improve the quality of surveillance data to be able to define the local epidemiology of neonatal tetanus and measles with the objective of targeting TT immunization activities and forecasting and preventing measles outbreaks.

(3) Countries should encourage the analysis of surveillance data at the province, district, and sub-district levels for priority setting, forecasting outbreaks and implementing appropriate corrective action. Data from these levels should be reported to the national level for programme monitoring and evaluation.

(4) Countries should conduct regular reviews and analyses of data including surveillance, immunization coverage, and vaccine accessibility and utilization data using programme indicators to monitor progress. Feedback should be provided to the district and sub-district level for corrective action and to the public to provide information about the programme.

(5) By June 2002, VAB/SEARO should make available a list of clear indicators for monitoring immunization programmes aimed at achieving the region-wide goal of 80% coverage levels in all districts.

4.4 Communication

The TCG is pleased to learn that work has been initiated on its recommendation of May 2001 that a Regional Plan of Action should be drafted for communication, advocacy, and social mobilization. These key activities in polio eradication will continue to be crucial to ensure high immunization levels well after eradication has been achieved. Such activities are also crucial for re-vitalizing EPI through placing immunization back on political agendas, generating demand for EPI vaccines, and sustaining financial support.

The TCG commends Rotary, USAID, UNICEF, and WHO for their strong support of social mobilization and communications for polio eradication, especially in currently endemic areas.

The TCG looks forward to the inclusion of EPI advocacy on the agendas of Interagency Coordinating Committees. The involvement of policy makers/planners, administrators, the media, the private health sector, and other stakeholders is essential for successful planning and implementation of immunization services. Effective communication strategies result from "knowing the audience" through information derived from surveillance, surveys, KAPS and pre-tested Information, Education and Communication (IEC) materials. Each communication and social mobilization strategy is tailored to meet local needs, but the basic elements apply to all countries of the Region.

Recommendations:

In collaboration with SEARO, EAPRO, and ROSA, Member States should develop

(1) Communication plans that include annual plans of action for polio eradication and EPI for the years 2002 through 2005.

(2) Innovative training methods to assist mid-level managers and service providers to acquire the essential inter-personal communication skills to assure successful immunizations.

(3) Member States, along with SEARO, EAPRO, and ROSA, should deploy adequate material and appropriate professional resources to manage and coordinate effective immunization communication activities.

(4) SEARO, EAPRO, and ROSA should develop a plan of action with Member Countries to increase their communication capacities, including adaptation and dissemination of such communication tools as rapid assessment kits, checklists and Question and Answers (Q&As) for monitors.

(5) SEARO should, in partnership with Member States and UNICEF, explore declaration of an upcoming year as the "Regional Year of Immunization".

(6) SEARO should develop the capacity to respond rapidly to urgent information needs of Member Countries, including Q&As, position statements, and model material for the news media.

(7) Member States should involve local leaders, vaccinators, mobilizers, and NGOs for social mobilization and communication efforts at the community level, with strong emphasis on interpersonal communication backed by mass media and IEC.

5. ACCELERATED DISEASE CONTROL

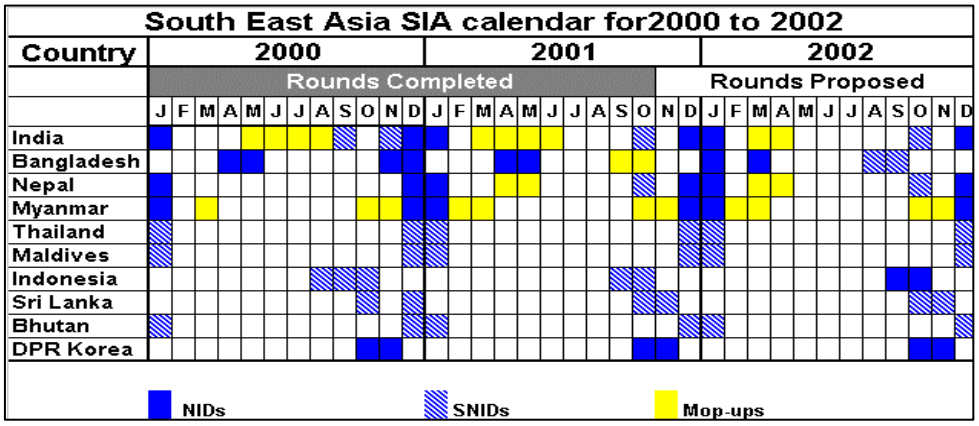
SEAR has set goals for 2005 for 3 priority EPI diseases. These are: (1) to certify the Region as polio-free, (2) to halve the annual number of measles deaths relative to 1999, and (3) to eliminate maternal and neonatal tetanus (<1 case of NNT/1000 live births) in every district of every country of the Region.

5.1 Polio Eradication Progress

The TCG congratulates Bhutan, DPR Korea, Indonesia, Maldives, Sri Lanka and Thailand for being polio-free for more than three years. Myanmar and Bangladesh and Nepal have been polio-free since detection of the last case in February, August and November 2000 respectively. Endemic polio transmission in 2001 has been limited to reservoirs within the states of Uttar Pradesh and Bihar in northern India. (Table 4 Annex 3 provides the summary of eradication activities.)

As of week 42, 21 October 2001, India reported 129 confirmed polio cases with 102 in Uttar Pradesh, 17 in Bihar, and 10 from other states. Outside of Uttar Pradesh and Bihar, two cases occurred in one district of Punjab, three in Haryana, two in Maharashtra, and one each in Delhi, Uttaranchal, and Jharkhand. These cases are virologically linked to Uttar Pradesh and Bihar and probably represent "importations" from UP and Bihar. The geographic extent of virus decreased from 314 "infected" districts in 1998, 192 in 1999, 89 in 2000 to 39 in 2001 (as on 13 October).

The TCG commends India for its vigorous response through extensive mop-up operations and endorses the provisional SEAR calendar for comprehensive immunization activities in 2000-2001 and planned for the remainder of 2001-2002 (Fig 1).



The TCG notes the continued improvement in SEAR surveillance quality to certification standard levels on a regional basis. The annualized non-polio AFP rate for the Region in 2000 was 1.35 per 100000 children below 15 years of age, with 82% of AFP cases having two adequate stools. Bangladesh, Bhutan and Myanmar achieved the global target non-polio AFP rate (> = 1 per 100000) joining India, Nepal, Sri Lanka and Thailand. AFP detection dramatically improved in DPR Korea.

Surveillance indicators declined from previous levels in Indonesia, attributed to multidimensional crises. However, surveillance is expected to improve in 2002, with implementation of a plan to establish a network of 40 surveillance medical officers. Further improvement of AFP surveillance in the Region is anticipated following the surveillance reviews in Nepal, India, DPR Korea and Bangladesh in 2001 and reviews planned in 2002 for Myanmar and Indonesia.

The TCG commends the SEAR Polio Laboratory Network for its continued progress. Sixteen of the 17 laboratories are now fully accredited. The laboratory in DPR Korea will be reviewed by March 2002. The rapidity of performing and reporting ITD and sequencing results by the laboratory network is better than ever before, and permits a timely immunization response throughout the Region.

The TCG commends the Region for the SEAR Polio Strategic Plan, 2002-2005 and endorses the basic strategy. Comments from TCG members have been incorporated into the Plan that will be available by December 2001.

Recommendations

(1) DPR Korea should join the other countries of the Region in switching to the virological classification scheme (retrospectively effective in January 2001) contingent upon independent confirmation of results by a Regional Reference Laboratory until national laboratory accreditation is achieved.

(2) DPR Korea and Indonesia should conduct an NID in 2002 and follow the SEAR strategic Plan for the years thereafter. The remaining countries of the Region should continue implementation of the proposed supplemental immunization activities as indicated in Table 1.

(3) The single-most important challenge in SEAR should be to interrupt transmission in north India, particular in Bihar and UP. To do so requires:

- Ensuring high-quality supplementary immunization
- Sustaining health worker motivation and government support
- Achieving strong and effective social mobilization
- Ensuring adequate micro-planning, training and supervision
- Maintaining donor funding to meet resource requirements
- Improving routine EPI without losing sight of polio priority

5.2 Measles Mortality Reduction

Reported measles cases in the Region declined dramatically after introduction of measles vaccines in the 1960s, but measles continues to be a major cause of illness and death. In 2000, 37030 cases were reported, but the actual incidence is estimated to be much higher because of underreporting.

The TCG is pleased that the Region is using the opportunity of AFP surveillance to strengthen measles surveillance and better target immunization activities, and congratulates Thailand and Sri Lanka on their progress towards measles control.

The TCG notes that a joint WHO/UNICEF Regional Plan of Action for measles control is under development with specific strategies guided by the polio eradication status of each country. Bhutan, DPR Korea, Maldives,

Indonesia, Sri Lanka and Thailand will concentrate on measles outbreak prevention. Polio endemic or recently endemic countries such as Bangladesh, India, Myanmar and Nepal will target measles mortality reduction with emphasis on increased immunization activities to reach children not reached by the current routine EPI programmes. In the latter group of countries, intensification of measles activities will be considered in areas where polio eradication is satisfactorily completed. The TCG commends the SEAR countries on their progress and looks forward to the Regional Plan being completed by January 2002. It further endorses the goal of the Regional Plan for each country to develop its own country-specific action plan.

5.3 Maternal and Neonatal Tetanus (MNT) Elimination

The TCG commends Indonesia and Myanmar on their innovative approaches to identifying areas at high risk for MNT. Five countries in the Region (Bhutan, DPR Korea, Maldives, Sri Lanka and Thailand) are considered to have reached the elimination goal of less than one case per 1000 live births in every district. The reported coverage of pregnant women in the Region with two doses of TT has been around 80% since 1990. The government of Nepal has developed a joint WHO-UNICEF plan of action to eliminate neonatal tetanus. Bangladesh, India, Indonesia, Myanmar, and Nepal have all started to implement supplemental immunization activities (SIA) in high-risk areas. MNT activities will need to be coordinated with MCH activities, such as coordination of immunization activities with antenatal care and clean delivery activities. The TCG reaffirms that SIA in high-risk areas is the most appropriate way to achieve MNT elimination status. Indonesia has implemented school-based immunization as a component of its MNT strategy.

The TCG looks forward to the completion of the Regional Plan by January 2002 and subsequent development of action plans by each SEAR country.

6. INNOVATIONS

To assist Member States in addressing technical and policy issues in the introduction of new vaccines, SEAR has created two innovative advisory bodies.

6.1 SEA Regional Working Group for Immunization

The purpose of the Working Group is to facilitate and coordinate vaccine technical assistance for the Region. All countries have comprehensive EPI programmes that generally follow WHO-recommended schedules for BCG, OPV, DPT, TT, and measles. Thailand also includes Japanese encephalitis vaccine and two doses of MMR in the routine EPI. Sri Lanka has introduced measles-rubella (MR) vaccine at three years of age. Four countries (Bhutan, Indonesia, Maldives and Thailand) include hepatitis B vaccine as part of their routine programme. The remaining countries are in the process of applying for GAVI support to introduce this vaccine, with assistance of the Working Group.

The TCG commends the Working Group for their efforts to assist member Countries in developing and implementing GAVI applications and in other technical measures to strengthen their immunization systems. The TCG looks forward to periodic reports from the Working Group.

6.2 Task Force on Regional Vaccine Policy

The TCG commends the Task Force for its progress towards developing a regional vaccine policy as recommended by the Southeast Asia Region Advisory Committee for Health Research in April 1999. A comprehensive policy for the Region is essential to ensure a coordinated assessment of regional vaccine needs, provide criteria for introduction of new vaccines, assess options to attain national self-sufficiency for current and new vaccines, support and direct global and bi-lateral inputs, provide guidance on vaccine research and development priorities, and support the implementation of immunization programmes. When completed, the policy will provide a much-needed framework for decision-making and priority development at the national and regional levels and serve as an advocacy tool for government commitment and cooperation between countries.

The TCG endorses the objectives of the Task Force to develop a framework to provide Member States with sound criteria for making decisions on the introduction of new vaccines into the national EPI system.

Annex 1

PROGRAMME

Monday, 22 October 2001

0900-1000 hrs	Inauguration	
1030-1040 hrs	Introductions and Administrative Information (Plenary)1	
1040-1110 hrs	Regional Strategic Plan for Immunization and Objectives of TCG (Plenary)	B. Burkholder
1115 -1600 hrs	***Programme Communication***	
	Plenary Session:	
	• Routine Immunization, opportunities and challenges	
	• Advocacy for Immunization	
	• Introduction to working groups	
	Group 1	
	Advocacy and policy making	
	Group 2	
	Participation and demand generation	
	Group 3	
	Capacity building, institutional support	
	Regional Working Group	A. Adish Lynda Yi
	• Review 3rd quarter meeting minutes	
	• GAVI applications in SEAR – Update	
	• Workplan for 4th quarter	
	• October 3-4 TFCC core group meeting report	
	• JE status in SEAR	
	• General discussion	
	• RWG meeting summary & recommendations	

	Task Force on Regional Vaccine Policy	B. Burkholder V. Ganesh
	Discussion on progress and next steps	
	Group discussion continued	
1630-1800 hrs	Plenary Session	
	Contd…Task Force on Regional Vaccine Policy	

Tuesday, 23 October 2001

0830-1030 hrs	***Accelerated Disease Control***	
	Polio Eradication (Plenary)	
	Global Update	Chris Maher
	Status of Polio Eradication in India	India
	Status of Polio Eradication in DPRK	DPRK
	Discussion	
	Regional Update/Regional Strategic Plan	A. Thapa
	Discussion	
1100-1300 hrs	Measles Mortality Reduction (Plenary)	
	Global update/global policy	Julian Bilous
	Status of measles control in Thailand	Thailand
	Status of measles control in Sri Lanka	Sri Lanka
	Discussion	
	Regional update/Regional Strategic Plan	VAB
	Discussion	
1430-1600 hrs	MNT elimination (Plenary)	
	Global/regional update	J. Vandelaer
	MNT survey in Indonesia	Indonesia
	MNT campaigns/assessment in Myanmar	Myanmar
	Discussion	
1630-1800 hrs	***Strengthening Immunization Systems (Plenary)***	
	Strategic Framework: Reaching the Unreached	J. Bilous
	Discussion	
	Introduction of Working Groups	B. Burkholder

Wednesday, 24 October 2001

0830-1030 hrs	***Vaccine Management System and Immunization Safety***	(V. Ganesh S.SPanner S.Guichard)
	Overview of vaccine management issues	S. .Guichard
	Use of data for vaccine management	Sri Lanka
	Challenges in strengthening cold chain system	India
	Update on cold chain technology	S. Spanner
	Discussion	
	Data for Decision Making	K. Banerjee N. Dougherty
	Regional overview of issues	K. Banerjee
	Integrated surveillance of VPD	Thailand
	Measles and NT with AFP surveillance	Bangladesh's experience
	Discussion on VPD surveillance	
	Service Delivery	R. Hossaini L. Yi
	Regional overview of issues	R. Hossaini
	Experience of decentralization:	Indonesia
	Health & Population Sector Programme and Essential Service Package,	Bangladesh
	Discussion on delivery strategies	
1100-1300 hrs	***Vaccine management assessment and National Vaccine procurement assessment***	J. Milstien
	Use of Temp. study and cold store certification as tools to strengthen cold chain system	S. Spanner
	Discussion	
	Regional overview of immunisation & vaccine safety - Concepts and issues	V. Ganesh
	Use of indicators for monitoring programme progress	N. Dougherty

	Discussion	
	Immunization Registry	
	Monitoring Immunization coverage,	L. Frenkel
	Discussion	Experience of Maldives
	Sustainable outreach Immunization services:	Nepal
	Multi-antigen campaigns	Bhutan
	Discussion on delivery strategies	
1400-1530 hrs	***Options for safe disposal of waste***	SEARO
	Injection Safety Assessment	Nepal
	Discussion	
	Recommendations and wrap up	
	Potential problems with reporting routine coverage and WHO/UNICEF estimates of routine coverage.	T. Burton
	Discussion	
	Discussion, Recommendations & wrap up	
	Making best use of available resources, Plans to increase delivery of EPI:	UNICEF: L. Yi
	Discussion on regional needs & Priority	
	Discussion, Recommendations & wrap up	
1600-1800 hrs	***Strengthening Immunization Systems and Communication: Working Group Reports (Plenary)***	
	Data for decision making	
	• Service delivery	
	• Vaccine management and immunisation safety	
	Communication	
	Discussion	

0830-1230 hrs	***Innovations (Plenary)***	L. Yi
	Introduction to the Regional Working Group/Report	A. Adish
	Overview of other vaccine preventable diseases	P. Abeykoon
	Discussion	
	Introduction to the Regional Vaccine Policy	
1100-1130 hrs	Financing Immunization Programmes	J. Milstien
1130-1145 hrs	Strategies for Introduction of New Vaccines	J. Wenger
1145-1230 hrs	Discussion	
0130-1530 hrs	***Interagency Coordination Committee (Icc)***	
	Resource Requirement & Mobilization, Advocacy	J. Gabriel Tezier
	Discussion	
	Parallel meeting of TCG	
	Members to finalize TCG	
	Report.	
1600-1730 hrs	TCG : Final Conclusions and Recommendations (Plenary)	
1730 hrs	Close	

Annexe 2

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ANNEX 3
INCIDENCE AND COVERAGE DATA FOR VACCINE PREVENTABLE DISEASES IN SEAR 1999 - 2000

Table 1. *Immunization Coverage Data*

Reported and Survey Results, SEAR 2000											
	BCG		**DTP3**		**OPV3**		**Measles**		**TT2**		**FI**
	Survey	**Reported**	**Survey**	**Reported**	**Survey**	**Reported**	**Survey**	**Reported**	**Survey**	**Reported**	
Bangladesh[1]	96	94	81	91	81	90	71	89	89	89	69
Bhutan	N.A	94	NA	89	NA	90	N.A.	N.A.	N.A.	94	N.A
DPR Korea[2]	82	82	96	81	98	91	92	92	84	84	N.A
India[3]	68	103	55*	94	61*	95	50	89	60	80	38
Indonesia	N.A	69	N.A	65	N.A.	66	N.A.	65	N.A.	73	N.A.
Maldives	N.A	99	NA	98	N.A.	98	N.A.	99	N.A	100	N.A.
Myanmar	N.A	88	N.A.	82	N.A.	86	N.A.	84	N.A.	81	N.A.
Nepal[4]	87	97	65	80	74	80	82	87	N.A	57	55
Sri Lanka	N.A.	102	N.A.	103	N.A.	103	N.A.	99	N.A.	99	N.A.
Thailand[5]	99	94	97	90	97	90	94	87	90	79	92
SEAR		98		90		91		89		81	

NA - data not available

F.I. - Fully Immunized children, survey data

1 Survey Source : WHO 30 cluster coverage evaluation survey conducted by MOH WHO, 2000

2 Survey Source : MICS conducted by Govt. of DPR Korea CBS, MOPH in year 2000

3 Survey Source : MICS conducted by MOH, UNICEF in year 2000. * MICS survey data for DPT3 and OPV3 adjusted up for recall bias

4 Survey Source : BCHIME survey conducted by CSO/NPC/UNICEF in year 2000

5 Survey Source : Immunization coverage survey conducted by MOH in year 1999

All Data reported to WHO through WHO-UNICEF Joint reporting form, April 2001

Table 2 : *Reported Cases Of EPI Target Diseases, In SEA Region, 1999-2000*

	Poliomyelitis(wild)		Measles		Diphtheria		Neonatal Tetanus		Pertussis	
	1999	2000	1999	2000	1999	2000	1999	2000	1999	2000
Bangladesh	322	1	5666	5098	58	21	479	376	520	252
Bhutan	NA	0	NA	418	NA	1	NA	6	NA	18
DPR Korea	NA	0	NA	NA	0	NA	0	NA	50	304
India	2806	265	21013	22236	1786	3094	610	1674	610	27851
Indonesia	0	0	4767	3344	114	23	54	466	287	142
Maldives	NA	0	NA	20	NA	NA	NA	NA	NA	NA
Myanmar	NA	2	NA	861	NA	17	NA	41	NA	55
Nepal	NA	4	NA	9397	NA	268	NA	134	NA	6021
Sri Lanka	0	0	2417	16527	0	0	8	1	112	194
Thailand	0	0	3167	4074	52	15	25	17	43	93
SEARO	3128	272	37030	61975	2010	3439	1176	2715	1622	34930
NA – data not available										

Source: Country reports to WHO through WHO-UNICEF Joint reporting form, April 2001

Table 3. *Proportion of districts with DPT3 coverage below 80%*

Country	Total Number of Districts (2000)	Districts With Coverage Less Than 80 % 1999		Districts With Coverage Less Than 80 % 2000	
		Number	%	Number	%
Bangladesh	64	8	9	10	16
Bhutan	20	3	15	5	25
DPR Korea	213	64	30	0	0
India	575	ND	ND	ND	ND
Indonesia	313	31	10	70	22
Maldives	20	ND	ND	ND	ND
Myanmar	324	132	41	53	16
Nepal	75	ND	ND	ND	ND
Sri Lanka	25	2	8	1	4
Thailand	926	ND	ND	ND	ND

Source: Country reports to WHO through WHO-UNICEF Joint reporting form, April 2001

Table 4. *The Poliomyelitis Eradication Initiative in SEAR, 1994-2001*

Country	Year of 1st NIDs	Total Rounds	Last NID Round **	Last case of Polio	Sero-types
Bangladesh	1995	18*	May 2001	Aug 2000	P1
Bhutan	1995	2	Feb 1995	1983	Not known
DPR Korea	1997	8	Oct 1997	1996	P1
India	1995	14*	Jan 2001	Sep 2001	P1
Indonesia	1995	6	Oct 1997	1995	P1+p3
Maldives	1996	8	Jan 1998	1994	Not known
Myanmar	1996	12	Jan 2001	Feb 2000	P1
Nepal	1996	10*	Jan 2001	Nov 2000	P3
Sri Lanka	1995	8	Nov 1999	Nov 1993	P1
Thailand	1994	10	Jan 1999	Apr 1997	P1

* Intensified and additional rounds from the fall and winter of 1999

** All countries have continued to conduct NID or SNIDs or Mop-ups, except for Indonesia, who conducted small-scale multi-antigen SNIDs in 1999 and 2000, with more rounds planned for 2001.

Annexe 4

COMMUNICATION WORKING GROUP RECOMMENDATIONS

Defining the Role and Priority Actions for Communication In Immunization In SEAR 2002-2005

Background

While most countries in the Region had initiated immunization programmes in the late 70s or early 80s, real programme acceleration started with the global Universal Child Immunization movement. This global support coupled with a clearly defined target (90% coverage by the year 1990), was instrumental in increasing national coverage levels sharply. By mid 1990s however, immunization coverage in most countries stagnated or started to decline.

(1) Factors contributing to the decline of immunization coverage include: international donor fatigue, health sector reforms and decentralization (without building adequate capacity at lower levels to cope/deliver these changes), decline in financial support, weakening of supervision, monitoring, reporting and accountability systems.

(2) In order to effectively re-establish immunization services as a Public Good (its benefit goes far beyond individuals), and make effective use of the current global movement for immunization, there is an urgent need to involve policy makers/planners, administrators, the media, the private health sector, and other stakeholders, in the planning and implementation of immunization services.

(3) Monitoring of the communication activities, and their outcome, is rarely carried out to the desired levels. The communication component of immunization suffers from a lack of systematic/scientific planning, assessment, analysis and follow-up action.

(4) Provision of quality immunization services should develop in parallel with the generation of demand. Too often, poor quality of services coupled with indifferent or even hostile attitudes of health workers, become the major hindering factor in achieving good coverage for routine immunization.

(5) One of the objectives of social mobilization strategies is to build up a sustainable network of people to enhance consistency of outreach to all areas including urban population, media-dark areas and under-served communities. A key task of this network, is to also, to rapidly disseminate accurate information to counter rumours, myths and other threats to the programme.

(6) Much has been said and written about the importance of communication and social mobilization in policy development, intersectoral cooperation, community mobilization and participation in support of immunization. However, adequate attention is seldom given to this important component of the programme. The IEC departments are very often seriously under-staffed, poorly trained and have inadequate funding. Additionally, they are often sidelined during the planning and implementation of immunization activities.

(7) Wild poliovirus transmission continues in very limited areas of India. Cases are mostly among children under two years of age in certain communities. The communication and social mobilization strategies should be tailored to meet the specific needs of these communities. The current joint MOHFW, UNICEF and WHO social mobilization initiative in these high risk areas was appreciated by the communication working group.

(8) A strong, research-based communication component is critical for polio eradication in areas with wild poliovirus transmission and improving routine immunization. There is a growing need, to reflect on lessons learned from polio eradication, for developing appropriate communication strategies for other VPDs.

(9) Communication strategy development and mass media placements should be based on available information derived from surveillance, surveys, KAPS and audience research. Effort should be made to generate these data when not available. Additionally, to improve efficacy of communication messages and materials, the IEC materials must be targeted and adequately pre-tested.

Recommendations

(1) For India in particular, UNICEF, Rotary and WHO should continue to support Government of India's social mobilization and communication plan in polio-endemic districts. Activities should include use of local leaders, vaccinators, mobilizers and NGOs from the same communities, and much stronger interpersonal communication backed up by mass media and IEC.

(2) Member States, WHO and UNICEF are encouraged to declare one year as the "Regional Year of Immunization". SEARO and ROSA should prepare a concept note on "Regional Year of Immunization" by the first quarter of 2002 to be shared with Member States and partners.

(3) Member States should develop communication plans of action for polio eradication and routine immunization for 2002 to 2005, along with detailed annual action plans. SEARO and ROSA should provide financial and hands-on technical support for development of these plans. Member States should report to the next TCG the progress on preparation of POAs.

(4) Member States should plan and conduct ongoing political advocacy by using the Interagency Coordinating Committees (ICC). The ICC role and coalition should be broadened to address all vaccine preventable diseases. SEARO should develop and share guidelines for ICC operation with member states.

(5) Adequate and professional human resources must be deployed at key positions, with appropriate resources, to manage and coordinate effective programme communication activities. Member States, SEARO and ROSA should assign communication focal points for immunization.

(6) There is an urgent need for training, empowering and motivating vaccinators and supervisors. This activity should include developing more effective methods for imparting training, as well as improving interpersonal communication skills of service-providers. The mid-level managers' training should include a strong communication component. SEARO and ROSA should proactively support MLM training.

(7) SEARO and ROSA should plan for a regional communication workshop in 2002. They should adapt and disseminate available communication tools such as rapid assessment kit, checklist and Q&As for monitors to be used for preparation of the regional workshop.

(8) In order to respond to urgent communication needs, SEARO should establish a rapid response capacity that would include Q&As, position statement on controversial issues, model press and other support material as requested from countries.