Progress reports

Report by the Secretariat

GLOBAL IMMUNIZATION VISION AND STRATEGY: Progress report and strategic direction for the 'Decade of Vaccines'

I. INTRODUCTION

This report includes a summary of the progress report on the Global Immunization Vision and Strategy (GIVS) to the Executive Board (EB 128/9) and proposes the strategic direction to achieve vaccine and immunization goals during the next "Decade of Vaccines" (DoV) 2011-2020. The WHA is invited to provide guidance for the finalization of the DoV strategy and action plan.

II. GLOBAL IMMUNIZATION PROGRESS

Routine immunization

By 2009, 109 of 193 Member States had achieved and maintained DPT3 coverage at or above 90% for the previous three years, and an additional 13 attained this level more recently. However, the failure to achieve the set targets in the remaining countries has resulted in over 23 million children failing to receive the required doses of primary immunization in 2009. In addition, only 48 countries reported that all their districts had achieved the DTP3 coverage target of 80%. A recent analysis has shown that lack of services due to system weaknesses, low public awareness or fears and misconceptions about vaccines were responsible for a large proportion of children failing to access immunization services or complete their immunization schedule. The increased use of outreach services, integrated delivery of a package of interventions including immunization through Child Health Days/Weeks, and advocacy and public awareness through Regional Immunization Weeks are some of the strategies undertaken to improve community demand for vaccines and delivery of services.

Accelerated disease control initiatives

In 2010, the implementation of the new polio strategic plan requested by resolution WHA61.15 resulted in 82% decline in polio cases in 2010 compared to the same period in 2009 (232 cases in

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1 By 2010 or earlier, countries will reach at least 90% national vaccination coverage and at least 80% vaccination coverage in every district or equivalent administrative unit.

2 Over half of these children, i.e. 11.8 million, live in two countries, namely India and Nigeria.
2010 compared with 1,255 cases in 2009, as of February 2011), including a 95% reduction in reported cases in both Nigeria (21 cases compared with 387 cases) and India (42 cases compared with 741 cases). Afghanistan has reduced case numbers by 35% (25 cases compared with 37 cases) compared to 2009. Outbreaks in West Africa and the Horn of Africa are close to being interrupted. However, challenges remain in Pakistan, where the devastating floods have complicated implementation of the strategy and facilitated the spread of poliovirus, and in Angola, the Democratic Republic of the Congo, and Chad, where poliovirus transmission is still not under control. Emergency action plans for these countries have been developed by national governments and partners with the aim of rapidly bringing transmission under control.

A report on progress towards achievement of measles control was provided to the sixty-third World Health Assembly (A63/18). Measles supplementary immunization activities (SIAs) continue to provide a platform for delivery of other child interventions; 32 millions doses of Vitamin A, and 19 million doses of deworming medicine were distributed through measles SIAs in 2010. Dedicated funding and support are urgently needed to prevent large outbreaks of measles, like those being seen in countries in Africa that had earlier achieved mortality reduction targets, and accelerate progress towards the achievements of the 2015 measles goals proposed in the report to the sixty-third World Health Assembly.  

Further reducing child mortality with new vaccines

The introduction of *Haemophilus influenzae* type b (Hib) vaccine in developing countries has gained traction in spite of initial delays, with 158 countries having introduced this vaccine. However, only 48% of the 2009 global birth cohort currently lives in a country with nationwide availability of Hib vaccine, as some large population countries such as China, India, Indonesia and Nigeria, have yet to introduce this vaccine as part of their national programmes.

The recent launch of the Advance Market Commitment (AMC), through the GAVI Alliance has accelerated the introduction of the pneumococcal conjugate vaccine (PCV) in the poorest countries. The vaccine has been introduced in 5 low income countries and another 11 countries are planning to introduce the vaccine in 2011. An increasing number of countries are also expected to introduce rotavirus vaccines starting in 2011. Large scale immunization campaigns with a meningococcal A conjugate vaccine, produced in India through technology transfer facilitated by PATH and WHO and financially supported by the Bill & Melinda Gates Foundation, were initiated in Burkina Faso, Mali and Niger in September 2010. Financial support for procuring this vaccine, which was made available at a price of less than US$ 0.50 per dose, for the preventive campaigns was provided by the GAVI Alliance. Human papilloma virus vaccines are used at national scale only in 26 high income countries.

Recognizing that new vaccines do not address the entirety of major public health problems such as pneumonia, diarrhoea, and cervical cancer, more comprehensive disease prevention and control strategies are being elaborated where vaccination is just one element of a more comprehensive strategy to "Protect, Prevent, and Treat" against these killer diseases.

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1 Data available at http://www.polioeradication.org/Dataandmonitoring/Poliothisweek.aspx
2 A63/18: Global eradication of measles. Proposed interim milestones: measles routine immunization coverage >90% nationally and >80% in every district; measles incidence of <5 cases/1 000 000 population; and measles mortality reduction of 95% compared with 2000 levels
Despite recent successes in the introduction of new vaccines, high vaccine prices, weak systems and inadequate management processes remain a challenge to sustained use of these vaccines in many developing countries. Media reports, misinterpretation of data and misinformation related to adverse events following vaccination have led to delayed introduction or even suspension of the use of new vaccines in several countries. Several new initiatives to address these challenges have been initiated and are described in the following sections.

Surveillance and monitoring

From the inception of the Expanded Programme on Immunization (EPI) in 1974, disease surveillance and programme monitoring have been stressed as a core component. However, both need further strengthening and expansion in order to measure progress towards achieving disease control goals and facilitate the introduction of new vaccines.

Building on the successful networks for surveillance of poliomyelitis and measles, WHO is now coordinating a network of sentinel sites that is conducting surveillance of invasive bacterial diseases and rotavirus diarrhoea; this network now covers 46 low-income countries and aims to include high and middle income countries into the fold, so that standardized case-based reports available from all countries may be synthesized into a comprehensive review. Work is needed in developing countries to promote greater local ownership of surveillance sites and use of the data for decision-making. Similarly, the improved quality and accuracy of routine coverage and vaccine stock and distribution data and their regular analyses have to be prioritized in national immunization programmes.

Countries are also being supported to establish mechanisms to detect and respond to adverse events following immunization and to communicate with the public in a credible and transparent manner and to allay fears and maintain trust in the programme.

Vaccine development and production in developing countries

WHO continues to advise United Nations agencies on the acceptability of vaccines considered for purchase, thereby providing assurance that they comply with WHO standards for quality and safety. In 2009, 10 vaccines or vaccine combinations from 26 manufacturers were prequalified, including products from seven countries with emerging economies.5

In order to increase the manufacturing base to include manufacturers in developing countries and facilitate adequate supply of vaccines at affordable prices, two centres of excellence have been established to support technology transfer and provide access to know-how on adjuvants and formulation, at the Netherlands Vaccine Institute, and the University of Lausanne, Switzerland, respectively. Support was provided to 9 emerging manufacturers to develop and produce influenza vaccines.

Financial sustainability of immunization programmes

Ownership by countries is crucial to the long-term sustainability of immunization programmes. The proportion of government funding allocated immunization programmes moderately increased in the

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5 Brazil, Bulgaria, Cuba, India, Indonesia, Russian Federation and Senegal
period from 2000 to 2008 and a growing number of countries have a budget line item for immunization. Preliminary data from a recent analysis of national multi-year plans for immunization shows that the annual expenditure on immunization for low-income countries increased from an average of US$ 6.00 per live birth (LB) in 2000 to US $25.00/LB in 2008 and is likely to increase further to US $ 64.00/LB in order to accommodate PCV and rotavirus vaccines. In order to make this sustainable, greater efforts would be required to achieve affordable vaccine prices and promote greater investments in immunization programmes, both by the countries themselves as well as by their development partners. Establishment of pooled procurement mechanisms to achieve more favourable prices is being explored in some regions.

**III GIVS FRAMEWORK (lessons learned)**

GIVS was launched in 2006 as the first-ever 10-year Framework to fully realize the potential of immunization in controlling morbidity and mortality from vaccine preventable diseases. By 2010, GIVS had succeeded as a rallying point globally and was adopted by many countries as an overarching strategic framework for immunization. The global framework was used to develop regional immunization strategies and by many countries to develop comprehensive multi-year national plans for immunization. Several companion documents and action plans were developed by WHO and UNICEF in collaboration with other partner agencies to implement the strategies in the framework.

Some of the successful outcomes of GIVS include i) the development of new recommendations for routine immunization that include new vaccines and goes beyond the traditional infant age group to include children, adolescents and adults; ii) increased use of new vaccines in the developing countries, particularly with support from the GAVI Alliance; iii) the launch of the synergistic approaches to pneumonia, diarrhoea and cervical cancer control, where vaccination formed one of a package of interventions and iv) the establishment of a sentinel site surveillance networks for invasive bacterial diseases and rotavirus diarrhoea as a platform for surveillance for diseases targeted by new vaccines.

The GIVS framework has some limitations, including: i) insufficient engagement of country level policy-makers, civil society organization and professional societies in its development ; ii) lack of clear benchmarks and processes for monitoring and evaluation; and iii) inadequate follow up actions to realize the vision of a world in which immunization was valued.

The experience gained from the first five years of GIVS can be applied to build on the achievements to date, to remedy the noted limitations of the GIVS framework and overcome obstacles to its implementation, and develop an even more ambitious vision for the coming decade.

**IV. THE DECADE OF VACCINES, 2011-2020: A COMPREHENSIVE VENTURE TO ADVANCE IMMUNIZATION**

The Decade of Vaccines (DoV) envisions a world where children, families, and communities enjoy lives free of the fear of vaccine preventable diseases. The goal of the DoV is to extend the full benefits of immunization to all people, regardless of where they live. This goal reflects the perspective that access to safe and effective vaccines is a human right that is not currently enjoyed by all people, particularly in low and middle income countries.

Achieving this goal will require full engagement of the diverse stakeholders needed to facilitate vaccine discovery, development and delivery, including industry, researchers, policy makers, the
private sector and civil society, philanthropy, donor governments, and health workers in the
countries where most vaccine-preventable diseases occur today.

The DoV builds on, learns the lessons from, and extends the fundaments and time period of the
GIVS framework. WHO, UNICEF, the Bill & Melinda Gates Foundation and other partners are
beginning a 12-month DoV Collaboration process to develop a draft Global Vaccine Action Plan for
review by the sixty-fifth World Health Assembly. Such a plan should enable greater coordination
across all stakeholder groups, outline the steps necessary to achieve the vision and goals outlined
above, and identify critical gaps that must be addressed to realize the potential of vaccines by 2020
and beyond. It will comprise four essential components:

1. Establishing and sustaining broad public and political support for the use of vaccines and the
financing of immunization services.

2. Strengthening the equitable delivery of immunization services to achieve universal coverage
of safe and effective vaccines by 2020 in order to prevent, control, eliminate or eradicate
vaccine-preventable diseases.

3. Cultivating a robust scientific enterprise to produce innovation in the discovery and
development of new and improved vaccines and associated technologies for high priority
disease targets.

4. Creating the right market incentives to ensure an adequate and reliable supply of affordable
vaccines.

Delivering Immunization in the Next Decade

This section further elaborates on the DoV Collaboration 'Delivery' workstream, based on initial
discussions carried out with stakeholders and country representatives, under the joint coordination
of WHO and UNICEF. This work stream recognizes the centrality of demand-driven, country-led
approaches and action, based on equity, responsibility and accountability in a spirit of self-reliance
and gradual self-sufficiency to achieve commonly shared global immunization goals.

The overall goal is, throughout the life course, to achieve equity in the delivery of effective and safe
immunization along with other essential health care interventions, in order to prevent, protect,
eliminate or eradicate diseases.

The DoV Delivery Strategy proposes five overarching objectives:

Objective 1: Achieve equity in the use of vaccines: reaching every community with vaccination
through complementary delivery methods that engage all appropriate health service providers in the
public, private and non-governmental sectors; include all persons at risk and not just children,
ensuring that the poorest and least-served are reached; building demand for the wider use of new
vaccines; and strengthening the efforts to eradicate polio, and eliminate measles and maternal and
neonatal tetanus.

Objective 2: Uphold immunization as a human right: creating, increasing and sustaining
community trust in immunization and awareness of this right; and focusing on underserved and
marginalized communities by shifting the current emphasis on “Reaching Every District” to
“Reaching Every Community”.

**Objective 3: Seek synergies with other programmes and re-establish immunization as a key component of primary health care:** putting increased emphasis on disease burden reduction; encompassing the multiplicity of interventions needed to achieve this reduction with vaccines as an entry point or a complement to other interventions; and participating in collaborative efforts to renovate and strengthen overall health systems.

**Objective 4: Develop immunization systems able to meet the challenges posed by the ambitious new goals:** improving systems and tools for generating evidence, monitoring programme performance and use of data for action; training, deploying and supporting adequate human resources for programme management and implementation; and building, maintaining and sustaining regular immunization procurement, delivery and effective supply systems.

**Objective 5: Bolster national self reliance and partnerships:** Strengthening structures and processes for countries to develop immunization policy, strategies, and best practices; promoting greater ownership, political commitment, accountability and self-reliance of immunization programmes; enabling formation of collaborative endeavours and engaging actors with a variety of expertise across different sectors; achieving sustainable immunization financing and sound financial management; and establishing national structures and enforcing processes for accountability.

**V. NEXT STEPS**

The DoV Collaboration through its secretariat will ensure oversight and coordination of the planning effort through working groups corresponding to each of the proposed four DoV Collaboration components. The process for developing the Global Vaccine Action Plan will include extensive consultations with Member States and also engage with a variety of stakeholders, including civil society organization, professional societies and the private sector and will provide an opportunity to develop cost estimates for implementation of the action plan.

The World Health Assembly is invited to take note of the progress report, provide guidance on the process outlined above and request that a comprehensive Global Vaccine Action Plan for the next decade be presented at its 65th session.