Second South-East Asia Regional Technical Advisory Group on Immunization (SEAR ITAG) Meeting

A Brief Report
2-3 March 2011, New Delhi, India
## Contents

<table>
<thead>
<tr>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction</td>
</tr>
<tr>
<td>2. Background</td>
</tr>
<tr>
<td>3. Regional immunization policy</td>
</tr>
<tr>
<td>4. Framework for increasing and sustaining immunization coverage in SEAR</td>
</tr>
<tr>
<td>5. Strategy for global/regional immunization weeks</td>
</tr>
<tr>
<td>6. Strengthening national committees on immunization practices</td>
</tr>
<tr>
<td>7. Achieving polio eradication</td>
</tr>
<tr>
<td>8. VPD surveillance in SEAR</td>
</tr>
<tr>
<td>9. Pandemic preparedness, influenza vaccine production and deployment</td>
</tr>
<tr>
<td>10. Moving from measles mortality reduction to elimination in SEAR</td>
</tr>
<tr>
<td>11. Introducing rubella vaccine in national immunization programmes: options for SEAR countries</td>
</tr>
<tr>
<td>12. Progress in new vaccine introduction and strategic framework for introducing new vaccines in SEAR</td>
</tr>
<tr>
<td>13. MNT elimination in SEAR: progress and plans to achieve elimination by 2015</td>
</tr>
<tr>
<td>14. NRA capacity building and status in implementing vaccine safety post-marketing surveillance</td>
</tr>
<tr>
<td>15. Health system strengthening in relation to increasing routine immunization coverage</td>
</tr>
</tbody>
</table>
Annexes

1. List of participants.................................................................21
2. Programme..............................................................................23
1. **Introduction**

The second meeting of the World Health Organization’s South-East Asia Regional Technical Advisory Group on Immunization (SEAR-ITAG) was convened from 2-3 March 2011 in New Delhi, India. The terms of reference for the meeting were:

1. To provide policy guidance on issues relevant to immunization programmes in the South-East Asia Region; and
2. To provide a forum for discussion on immunization goals and strategies for the Region and ways to accelerate efforts to achieve immunization-related Millennium Development Goals.

The ITAG members present were: Professor Lalitha Mendis, Dr. Jacob John, Dr. Supamit Chunsuttiwat, Dr. Nyoman Kandun, Dr. A. M. Zakir Hussain, Dr. Lalit Kant., Dr. M. H. Maskey, Dr. N. K. Arora, Dr. Triono Soendoro and Dr. Khin Pyone Kyi. Dr. Brent Burholder regretted. Other participants included representatives from WHO-HQ, SEARO, and WHO country level staff.

On behalf of the Regional Director, Dr Samlee Plianbangchang, Dr. Monir Islam, Director, Family Health and Research, WHO-SEAR, opened the meeting. Professor Lalitha Mendis was appointed as Chair, Dr. Supamit Chunsuttiwat as rapporteur and Dr. Patrick O’Connor as co-rapporteur.

2. **Background**

Under the broad framework of the WHO/UNICEF Global Immunization Vision and Strategies (GIVS), the South-East Asia Region is being guided by the Immunization and Vaccine Development (IVD) Strategic Plan for 2010-2012. The Plan has set specific immunization goals and provides general strategic direction for the Regional Office and Member States.
At its first meeting in 2008, the ITAG was tasked with making specific technical recommendations on key policy and strategic issues regarding polio elimination, measles control, routine immunization, surveillance, vaccine safety, and introduction of new vaccines. Since the last ITAG meeting, many of the recommendations became out-dated. Consequently, one of the administrative recommendations from this meeting was for regular ITAG meetings.

**Recommendation:**

- The ITAG recommends meeting on a regular basis (annually) in March to review progress on implementation of ITAG recommendations.

- The ITAG recommends establishing sub-groups to review and make recommendations on specific issues such as health resource management and vaccine introduction (rubella, hepatitis B and typhoid) with each sub-group consisting of an ITAG member as a focal point, WHO staff as secretariat and invited experts from relevant areas.

The ITAG recommends that national EPI managers (or their representatives) be invited to attend and participate in future ITAG meetings to enhance the discussion and implementation of the ITAG recommendations.

3. **Regional immunization policy**

Since 2003, the EPI programme in countries of the SEA Region has undergone many changes. During this period, new vaccines and new combinations of established vaccines as well as new technologies have been introduced to improve vaccine efficacy and injection safety. In addition, the prices of vaccines have decreased, the epidemiology of vaccine preventable diseases has changed, expectations of the community for vaccine safety have increased and intensified campaigns have been conducted to achieve set targets and the Millennium Development Goals by 2015.

Taking these developments into consideration WHO-SEARO felt the need to revise the Regional Vaccine Policy (2003) to reflect the recent
advances and the changing epidemiological trends and to address the needs expressed by the Member States on programmatic aspects of Immunization. The draft regional immunization policy presented to the ITAG aims to take advantage of the lessons learnt and to move countries of the Region towards vaccine security with quality products along with greater visibility and mobilization of scientists and governments to address research priorities in the prevention of tropical diseases.

**Recommendations:**

- The ITAG recommends that the regional immunization policy could:
  - Focus more on programmatic issues that include the need for integration of surveillance, sustainability of new vaccines, public-private partnerships for immunization services and human resource development.
  - Reframe the policy to address challenges in terms of inputs, processes and outputs.
  - Implement recommendations of Strategic Advisory Group of Experts (SAGE) on immunization for the introduction of new vaccines highlighting the need for countries to ensure high public acceptance and long-term sustainability.

4. **Framework for increasing and sustaining immunization coverage in SEAR**

Countries in the Region have faced major challenges in achieving the GIVS goals of reaching at least 90% national DTP3 coverage and at least 80% coverage in every district by 2010 and sustained through 2015. According to the 2009 WHO/UNICEF estimates, seven countries in SEAR (Bangladesh, Bhutan, DPR Korea, Maldives, Myanmar, Sri Lanka, and Thailand) have achieved at least 90% national DTP3 coverage. However, four countries (India, Indonesia, Nepal and Timor-Leste) have yet to achieve 90% coverage at national level. The absolute number of under-immunized children is a matter of concern, particularly in the larger countries.
Countries with a large number of under-immunized children should assess the reasons and develop a clear plan of action to scale-up routine immunization. The reason for persistently low coverage varies by country. There are common issues across countries: poor infrastructure, inadequate number of immunization staff, complications of high staff turnover, challenges in accessing hard-to-reach children, and limited availability and/or analysis of data to guide programme management. Many of these issues are compounded by a critical lack of training programmes for EPI managers in the Region. Innovative strategies to link immunization with delivery of other health services, particularly for outreach programmes, are especially encouraged. Essential to all of these efforts is high-level advocacy to ensure policy commitment and visibility of immunization programmes. The ITAG is aware that the need to incorporate new antigens into national programmes has increased the complexity of EPI schedules as well as programme management.

**Recommendations:**

The ITAG recommends that:

- All countries in the Region engage in standardized, high-level advocacy with senior political leaders in order to obtain political commitment for immunization programmes so that technical interventions can be fully implemented.

- Countries in the Region with immunization coverage deficiencies receive support from WHO to identify major issues preventing adequate and equitable immunization coverage. This process should be guided by district-based assessments of VPD surveillance and immunization coverage.

- WHO should create a checklist and analytical framework for countries to conduct self-assessments that help prioritize steps for increasing immunization coverage recognizing that the steps maybe different based on high, medium or low immunization coverage.
5. **Strategy for global/regional immunization weeks**

**Recommendation:**

- The ITAG recommends developing and implementing a plan for advocacy for routine immunization in 2012 ensuring that it is coordinated with regional immunization partners and other WHO Regions.

6. **Strengthening national committees on immunization practices**

ITAG recognizes the importance of strengthening national capacity for making evidence-based policy decisions. While this requirement applies to all immunization programme decisions, this capacity assumes added urgency as governments are faced with multiple options in adopting new vaccines.

While the membership composition of the national committees on immunization practices (NCIP) varies among countries, the key to the success of such groups is to maintain technical credibility and the capacity to provide independent advice to national programmes. Long-term sustainability will be maximized if governments assume ownership and agree to fund NCIP operations. The ITAG appreciates the supportive role that IVD has made in the formation and development of NCIPs in the Region and encourages continued technical assistance as required.

**Recommendations:**

- The ITAG supports creating links between regional and country level advisory bodies to ensure that their roles include both immunization policy and practices.

- The ITAG recommends that NCIPs review their composition and function regularly. NCIPs should consider broadening their membership. The composition of these advisory bodies may include voting and non-voting members such as core, liaison, ex-official, observers and invitees to address specific issues. In order
to ensure transparency of these bodies, the chairperson should be an independent expert.

- The ITAG recommends that WHO should support the capacity building of NCIPs to include forums for information and experience sharing as well as developing a mechanism to follow-up the NCIP recommendations.

7. Achieving polio eradication

India is the only country in the Region with endemic transmission of wild poliovirus (WPV). As a result of concerted efforts made during the past 12-24 months, the number of polio cases in India has declined significantly. Only 42 polio cases (18 WPV1 and 24 WPV3) were detected in India during 2010 compared to 741 polio cases (79 WPV1, 661 WPV3 and 1 WPV1+3) detected in 2009. Within India, polio transmission has remained endemic in focal areas of only two of the 35 states and union territories – UP and Bihar. The endemic state of UP has not reported any WPV1 case since November 2009 – the longest period ever since surveillance was initiated in 1997 in India.

Nepal was the only other country in the Region that had active circulation of WPV in 2010. Six WPV1 cases were detected in 2010 in two districts of Nepal that share a border with Bihar, India. The last case was reported on 30 August 2010. These cases were from two separate importations of wild poliovirus from India.

The major risks to eradication of WPV1 in India are:

- Continuation of WPV1 transmission in the high-risk areas of UP and Bihar, especially in western UP and the Kosi River area of Bihar.

- Re-introduction of WPV1 in UP or Bihar from neighbouring Nepal or West Bengal through extensive migration and population movements.

- Continuation of transmission in West Bengal with further spread to other parts of the country.
The programme in India has been addressing challenges in polio eradication through four broad strategies:

- **107 high-risk block initiative** is a multi-pronged approach developed to address the challenges in the 107 high-risk blocks in western Uttar Pradesh and central Bihar. These blocks have a history of recurrent and persistent transmission of poliovirus. The strategy calls for rapid improvements in sanitation, availability of clean water, hygienic practices and prevention/control of diarrhoea.

- **Migrant populations** are playing an important role in the persistence and spread of polio. The vaccination of migratory populations, both in the two endemic states as well as in the states which host large numbers of migratory labour and nomadic populations is a priority of the programme.

- **Introduction of bivalent oral polio vaccine (bOPV)** has provided the programme with an additional tool for epidemiologic-based SIAs and mop-ups. The vaccine (bOPV), which protects against both WPV1 and WPV3 has been able to sustain the progress against WPV1 while curtailing the transmission of WPV3. Rapid, large-scale mop-ups are being conducted with mOPV or bOPV in response to the detection of any WPV.

- **Research** in India covers a wide range of activities that include trials of polio vaccines and surveys to assess antibodies against polioviruses among children in the highest risk areas. The findings of these studies are being extensively used in India and other countries to guide programmatic decisions that will have a direct impact on the achievement of polio eradication. India is committed to continue further research to understand the dynamics of poliovirus transmission and efficacy of the various vaccines even better to ultimately overcome the remaining challenges to polio eradication in the country.

The response to the six polio cases in Nepal in 2010 was focused on supplementary immunization activities (SIAs) and enhancing AFP surveillance. In addition to the NIDs conducted in April and May, the country conducted eight SIAs between June and November. SMOs from other areas of Nepal and international consultants were deployed to the
Terai districts to help with micro-planning, monitoring and evaluation of the SNIDs. As of March 2011, Nepal has been polio-free for six months.

In polio-free countries, there are three major challenges/actions:

- Maintain high levels of immunity against polio mainly through high **routine immunization** (OPV3) coverage and the limited number of supplementary immunization activities (SIAs) with a focus on: border areas with India, migrant/refugee populations, slum/underserved populations, highly dense urban areas, areas with previous imported cases, and conflict-affected and inaccessible areas.

- Sustain uniform, high quality AFP surveillance in all districts through regular sub-national analysis based on the standard AFP surveillance indicators (non-polio AFP rate and adequate stool collection rate) especially in the high-risk areas as listed above.

- Make updated plans for timely and adequate response to importations in order to prevent local circulation getting established.

**Recommendations:**

- The ITAG reiterates that maintaining high immunity against the poliovirus through routine immunization is important for achieving polio eradication in the Region.

- The ITAG recommends that all countries in the Region consider developing a plan to address issues related to the transition from polio-endemic to polio-free status.

- The ITAG congratulates India for the substantial progress made towards polio eradication in 2010 and encourages the Government of India to ensure that financial support and political commitment remain high in order to eliminate the final chains of transmission in 2011.

- The ITAG congratulates Nepal for the tremendous effort made in controlling the wild polio outbreak in 2010 and achieving six month polio-free status in March 2011. The ITAG encourages
the Government of Nepal to continue its commitment to polio eradication by funding the National Immunization Days (NIDs).

- The ITAG recognizes the high commitment of the remaining Member-States in the Region to polio eradication by remaining polio-free.

- The ITAG recommends that Bhutan, DPR Korea, Maldives, Thailand and Timor-Leste not having achieved the minimum targets for AFP surveillance indicators should review their strategies and address any challenges.

- The ITAG recommends that countries in the Region should consider protective NIDs until the Region is polio free, particularly in countries with large populations bordering India (Bangladesh, Myanmar and Nepal).

8. VPD surveillance in SEAR

Effective vaccine-preventable disease (VPD) surveillance is essential for guiding immunization strategies and activities, monitoring programme performance, and allocating resources. In line with the guiding principles of the Global Immunization Vision and Strategy - GIVS (2006-2015) to pursue policies and strategies based on evidence and best practices, the SEA Region is encouraging Member States to ensure that by 2015 or earlier, all countries will have developed the capacity at all levels to conduct case-based surveillance of vaccine-preventable diseases, supported by laboratory confirmation where necessary. Since 2005 substantial progress has been made in accelerating and integrating surveillance of VPDs and adverse events following immunization (AEFI) with existing AFP surveillance systems in the Region.

AFP surveillance: The polio eradication programme in SEAR continues to be a model for using data effectively to support surveillance and control of other vaccine-preventable diseases. The polio Surveillance Medical Officer (SMO) network in Bangladesh, India, Myanmar, Nepal and the Surveillance Officer (SO) structure in provinces in Indonesia have proven to be an essential component of effective AFP surveillance for polio eradication.
When any AFP case crosses an international border, the surveillance system of the countries notifies IVD-SEARO. To meet the requirements of International Health Regulations, case details, specimen results, 60-day follow-up notification, and final diagnoses are followed and shared with respective countries. Since 2005, SEARO has tracked 402 AFP cases crossing international borders. Seven of these cases resulted in the detection of wild poliovirus. IVD-SEARO maintains a database of all cross-border cases to assure adequate follow-up of stool results and to map travel routes.

Measles and other VPD surveillance: Four countries in the Region (Nepal, Bangladesh, Indonesia and Myanmar) are submitting measles case-based data\(^1\) on a monthly basis from their integrated VPD surveillance systems. Since 2009, to measure progress towards measles elimination, SEAR data tools were modified to capture information on suspected measles cases, outbreaks and classification of outbreaks.

Laboratory network: The SEAR laboratory network consists of 17 polio, 21 measles and 14 JE laboratories that support field surveillance. Laboratory and field data are merged electronically to give the final “picture” of the vaccine-preventable diseases in the Region. Integrating VPD surveillance and laboratory network under one umbrella has provided programme managers epidemiologic-based information for decision making.

Reporting: Member States submit weekly reports for AFP and monthly reports for measles, rubella, encephalitis (JE), neonatal tetanus (NNT), diphtheria, pertussis and AEFI. For 2009, all Member States except India submitted the annual WHO/UNICEF Joint Reporting Form (JRF) and the Annual EPI Reporting Form (AERF). The JRF and SEARO AERF remain the primary tools for collecting annual VPD, immunization coverage, and other EPI-related data, which is used at the global and regional levels for programme planning, resource mobilization, and evaluating programme activities. IVD-SEARO uses the data to develop the regional and country-specific EPI Fact Sheets.

\(^1\) Line lists from routine and/or outbreaks with core variables as outlined in the “Measles and Rubella surveillance and outbreak investigation guidelines – SEAR”.

Page 10
Surveillance reviews: In 2010, an international AFP/EPI surveillance review was completed in Nepal. India conducted four internal AFP surveillance reviews with a follow-up review in Timor-Leste. In 2011, EPI/AFP surveillance reviews are planned in Bhutan and Bangladesh with follow-up reviews in Nepal and Myanmar.

**Recommendations:**

The ITAG recommends:

- Further expansion of case-based measles surveillance for countries that have successfully completed catch-up and follow-up campaigns or countries that have evaluated coverage of >90% for two doses of measles containing vaccine. Measles case-based surveillance should achieve all indicators of sensitivity at national and sub-national levels and be integrated with government surveillance systems.\(^2\)

- Greater government support for the SMO/SO networks with long-term plans for sustainability and integration of the SMO network with existing disease priorities and plan for a gradual assimilation into government health care systems.

- WHO should continue providing technical support for expanding and integrating VPD surveillance at the country level.

- The EPI programme manager’s meeting be used as an opportunity to discuss country priorities/strategies and follow-up on the progress of VPD surveillance strengthening.

- Regional guidelines for AES surveillance be developed with Japanese encephalitis as a priority.

- Mechanisms at the national level be coordinated to merge laboratory and epidemiologic surveillance data.

- The ITAG endorses the proposed 2011 comprehensive EPI/VPD surveillance reviews planned for Bangladesh and Bhutan and the follow-up review planned for Myanmar and Nepal.

---

\(^2\) Monitoring progress towards measles elimination. WER, No 49, 3 December 2010.
9. Pandemic preparedness, influenza vaccine production and deployment

The H1N1 pandemic in 2009 demonstrated that there is significant expertise and capacity within the Region to respond to pandemic influenza. Lessons learned from this experience guided several regional meetings and resulted in identifying opportunities for strengthening regional and national preparedness and response capacity. Regional tools for assessment of response to pandemic H1N1 (2009) were prepared and plans are underway to review implementation by Member States. SEARO will continue to play a vital role in supporting Member States in up-dating, revising and implementing national pandemic preparedness and response plans; sharing country experiences, lessons learned and best practices; and identifying future steps towards pandemic preparedness and response.

Despite being one of the most densely populated areas of the world and having three vaccine manufacturing countries (India, Indonesia and Thailand), the Region currently has limited capacity for production of influenza vaccine. There are many opportunities for developing partnerships to introduce new technologies for vaccine manufacturing, and build on existing partnerships for regional vaccine and essential medicine production. As regional vaccine manufacturing capacity develops, technical assistance to Member States will be essential for developing national plans that reflect rational, sustainable and cost-effective new vaccine introduction.

Recommendations:

The ITAG recommends:

- Countries be encouraged to assess disease burden, conduct risk assessments and determine cost-benefits/effectiveness of seasonal influenza immunization and surveillance (including laboratory support).

- Documenting the lessons learned from the pandemic preparedness in 2009/2010 to guide future responses.
National pandemic response plans should include vaccine deployment plans and that countries should maintain active participation in the global influenza surveillance network.

10. Moving from measles mortality reduction to elimination in SEAR

Between 2000 and 2008, measles mortality decreased by 78% globally (from 733000 to 164000). Progress, however, has not been uniform across regions. During the same period, the South-East Asia Region achieved a mortality reduction of only 46% (from 234000 to 126000). There is potential for the Region to do substantially better by implementing WHO/UNICEF recommended strategies for reduction of measles mortality.

SEARO held a regional consultation on measles in August 2009 where it was agreed that measles elimination by 2020 was technically, biologically and programmatically feasible for all countries in the Region. In 2010, the Sixty-third session of the Regional Committee for WHO South-East Asia recommended that Member States should consider adopting interim goals towards measles elimination to be achieved by 2015 (as approved by the Sixty-third World Health Assembly).³

The interim goals are:

➢ To exceed 90% coverage with the first dose of measles-containing vaccine nationally, and exceed 80% vaccination coverage in every district or equivalent administrative unit.

➢ To reduce annual measles incidence to less than five cases per million and maintain that level.

➢ To reduce measles mortality by 95% or more in comparison with 2000 estimates.

All WHO regions, except South-East Asia, have set a measles elimination goal with target dates between 2012 and 2020. The Strategic Advisory Group of Experts (SAGE) in November 2010 concluded that measles can and should be eradicated and that eradication of measles

³ Global eradication of measles. Report by the Secretariat. Sixty-third World Health Assembly. A63/18
represents unique disease control and developmental opportunities, and should be carried out in the context of strengthening routine immunization programmes.\(^4\)

The ITAG noted that since its last meeting in 2008 there has been significant progress in the Region:

- India started implementing plans to immunize 134 million children (9 months to 10 years) in 14 states through catch-up campaigns between 2010 and 2013. In the remaining 21 states, an annual cohort of 10 million children from 1-2 years would be targeted every year with a second dose of measles vaccine in routine immunization. This is a significant step in India and will help achieve the interim goals towards measles elimination within the Region and globally.

- In 2009 and 2010, Bangladesh, Indonesia and Timor-Leste completed successful mass vaccination campaigns immunizing 23 million children; in India the catch-up campaigns have so far immunized more than 9 million children.

- In 2011, Indonesia and Myanmar plan to immunize approximately 18 million children through SIA.

- Coverage with the first dose of measles vaccine in routine immunization in the Region has remained stagnant at 76% between 2008 and 2009. In 2009, five countries in the Region (Bhutan, DPR Korea, Maldives, Sri Lanka and Thailand) had achieved more than 90% coverage with the first dose of routine measles vaccination nationally. Three of these five countries (DPR Korea, Maldives and Sri Lanka) achieved and sustained >80% MCV1 coverage in all districts in 2009 (as reported in WHO/UNICEF Joint Reporting Format).

- Eight countries in the Region (Bangladesh, Bhutan, DPR Korea, Maldives, Myanmar, Nepal, Sri Lanka and Timor-Leste) are implementing case-based measles surveillance. In Indonesia case-based measles surveillance is in an evolving stage. India has an outbreak surveillance system and Thailand conducts

\(^4\) Meeting of the Strategic Advisory Group of Experts on Immunization, November 2010: summary, conclusions and recommendations.
aggregate surveillance for suspected measles cases across the country through routine reporting. However, sensitivity of measles surveillance for all countries of the Region has not reached levels specified by WHO.5

- Measles surveillance is supported by a regional measles/rubella laboratory network of 20 national laboratories and one regional reference laboratory for serological confirmation of measles and rubella. All but one of the laboratories has been accredited by WHO.

The ITAG was encouraged to note that national governments are committing increasing resources to measles control efforts. India, Indonesia and Myanmar are planning to conduct mass immunization campaigns in 2011 and have committed resources supporting the operational costs of the campaign in part (Indonesia and Myanmar) or in whole (India). The ITAG was concerned that globally measles control activities are suffering due to lack of donor funding and that in the South-East Asia Region there is a funding gap of at least USD 15 million for 2011.

**Recommendations:**

The ITAG recognizes that there has been significant progress towards achieving reduction in measles mortality in the Region. The South-East Asia Region should draft a new regional plan for measles control for 2011-2015. This plan should incorporate a definitive roadmap towards achieving the interim milestones for measles elimination as endorsed by the Sixty-third session of the Regional Committee for South-East Asia.

- The ITAG recognizes that the Government of India (GOI) should be encouraged to complete the measles catch-up campaigns in all the remaining districts of the high-burden states and introduce MCV2 in the routine immunization programme of the remaining states.

- The ITAG further encourages GOI to continue efforts to establish and maintain systemic laboratory-supported measles surveillance, particularly in states that are conducting measles

---

5 Monitoring progress towards measles elimination. Weekly epidemiological record, No. 49, 3 December 2010. Available at: http://www.who.int/wer
catch-up vaccination campaigns, in order to measure the impact of the accelerated measles control activities.

- The ITAG recommends that measles mortality reduction should appropriately remain the immediate priority in India; however, it recognizes the pivotal role India plays in reducing the measles burden in SEAR and achieving any regional elimination targets. The ITAG encourages GOI to undertake national and state-by-state epidemiologic and programmatic analyses that will help the country develop the rationale and roadmap for participation in a regional measles elimination initiative.

11. **Introducing rubella vaccine in national immunization programmes: options for SEAR countries**

Four countries (Bhutan, Maldives, Sri Lanka and Thailand) in the Region have introduced rubella-containing vaccine (RCV) into their routine immunization programmes. Two additional countries (Bangladesh and Nepal) are planning to introduce rubella vaccine through mass campaigns and routine immunization in the next 12-24 months.

Laboratory-supported measles surveillance is generating evidence that there is rubella transmission in the Region. Since successfully completing mass measles campaigns, both Bangladesh and Nepal have confirmed that most fever and rash outbreaks are now due to rubella.

Some countries in the Region (Bhutan, Maldives, Nepal, Sri Lanka and Thailand) have been able to generate evidence of Congenital Rubella Syndrome (CRS) burden and/or risk through a combination of sentinel site surveillance, surveys of cause of disability and serological surveys in women of reproductive age. However, robust data on CRS is lacking in most countries in the Region.

The ITAG is cognizant that a rubella working group from the SAGE is preparing an update to the rubella vaccine position paper and would consider it prudent to await SAGE recommendations.
Recommendations:

- The ITAG encourages countries in the Region to initiate/establish rubella and CRS burden to inform both technical and financial sustainability of immunization introduction. Appropriate surveillance strategies should be in place including laboratory support to integrate rubella into existing disease notification systems.

- The ITAG encourages countries that have evidence of rubella transmission to consider the introduction of rubella containing vaccine. Rubella control should be integrated with existing measles control initiatives and immunization strategies (i.e., catch-up and follow-up campaigns). The new rubella vaccine position paper is expected to facilitate the decision-making process. The Regional Office should assist GAVI-eligible Member States to take advantage of GAVI support for RCV.

12. Progress in new vaccine introduction and strategic framework for introducing new vaccines in SEAR

One of the major challenges to the introduction of new vaccines and technology is sustainability. Even for routine vaccines such as DPT and TT, most countries are dependent on donor assistance to maintain their EPI programme; adding new vaccines will substantially increase vaccine and operational costs. One potential avenue of increasing the supply (and hopefully lowering costs) is to increase the capacity of vaccine manufacturers. The ITAG notes the promise that the multiple vaccine producers in the Region could provide.

Programme and management issues regarding improvements in routine immunization are further highlighted in the introduction of a new vaccine. Existing gaps in the cold chain and logistics, which continue to be a major challenge in most countries can be exacerbated by the demands of the new vaccines. Countries are urged to carefully consider these demands when planning for additions to the EPI system.
**Recommendation:**

- The ITAG appreciates progress made in developing the strategic framework for new vaccines and will review for endorsement after further refinement.

13. **MNT elimination in SEAR: progress and plans to achieve elimination by 2015**

The Region is being validated for maternal and neonatal tetanus (MNT) elimination. In Myanmar, validation was completed in 2010 whereas in the case of Indonesia, only the first phase of validation has been completed. Two regions in Indonesia, several states in India and Timor-Leste are the remaining areas of the region where the validation is still to be completed.

**Recommendations:**

- The ITAG congratulates all the countries in the Region that have completed MNT elimination validation, and encourages them to monitor their MNT elimination status through frequent reviews and audits.

- The ITAG recommends that Timor-Leste, the two regions of Indonesia and the remaining states of India develop a plan to complete the MNT elimination validation process by 2015.

14. **NRA capacity building and status in implementing vaccine safety post-marketing surveillance**

In order to ensure access to vaccines of assured quality, national immunization programmes should procure their vaccine either from a WHO prequalified source or from a country that has a functional National Regulatory Authority (NRA). An independent and functional NRA is essential to ensure quality, safety and efficacy of vaccines and the required regulatory functions. Four SEAR countries currently have functioning NRAs: India, Indonesia, Thailand and Sri Lanka. Given the critical role that
regional manufacturers are playing in providing national, regional, and global vaccine supply ensuring functional NRAs should be a top priority.

Adverse Events Following Immunization (AEFI): There has been extensive progress made over the past 12-24 months to improve regional capacity for AEFI surveillance and capacity building for national AEFI committees. Although AEFI surveillance systems are operational throughout the Region, they appear to vary widely in their sensitivity and in their ability to effectively address events as they occur. Additional attention should be given to increasing national AEFI capacity considering the implications for national EPI programmes.

Recommendations:

- The ITAG recommends that countries support their NRAs to enable them to address the oversight of quality and safety of all vaccines particularly with regard to the introduction of new vaccines.
- The ITAG recommends that countries ensure transparency and independence in all the administrative, financial and technical functions of the NRAs.
- The ITAG recommends that countries establish and/or strengthen post-marketing surveillance and AEFI committees.
- The ITAG recognizes the potential role of vaccine manufacturers in supporting the development of NRA systems; however, this support should be contingent on addressing any potential conflict of interest.

15. Health system strengthening in relation to increasing routine immunization coverage

The challenges to the health systems in the Member States in the SEA Region include low health budget allocations and high out-of-pocket expenditure resulting in high catastrophic expenditure and impoverishment. There is a shortage of health workforce in Bangladesh, Bhutan, India, Indonesia, Myanmar and Nepal resulting in inefficient service delivery.
There are common bottlenecks for programme improvement and therefore health system strengthening using the primary health care approach has been identified as a key intervention. Risk analysis approach is used to identify and decide priority sub-national areas at the state/province and district levels for health system strengthening in relation to immunization.

**Recommendation:**

- The ITAG recommends that GAVI funding for health systems strengthening be used to improve immunization services.
Annex 1

List of participants

ITAG Members

Professor Lalitha Mendis
Director
Post Graduate Institute of Medicine
University of Colombo
Colombo 7

Dr Jacob John
Professor (retired)
439 Civil Supplies
Godown Lane
Kamalakshipuram Vellore, TN 632002

Dr Supamit Chunsuttiwat
Senior Medical Officer
Ministry of Public Health
Department of Disease Control
Thailand

Dr Nyoman Kandun
Director General of Disease Control & Environment Health
Jakarta, Indonesia

Dr Lalit Kant
Senior Deputy Director General
Indian Council of Medical Research
New Delhi, India

Dr N K Arora
Director, INCLEN
All India Institute of Medical Sciences
New Delhi, India

Dr Khin Pyone Kyi
House no 74 B
Inya Road
Kamayut Township
Yangon –Myanmar

WHO-HQ

Mr Chris Wolf
Scientist
Strategic Implementation
Oversight and Monitoring

Dr Rudolf Richard Eggers
Medical Officer
EPI Expanded Programme on Immunization Plus

WHO Field Staff

Dr Serguei Diorditsa
Medical Officer – EPI
World Health Organization
Dhaka, Bangladesh

Dr Hamid Syed Jaffari
Project Manager
NPSP/New Delhi

Dr Steve Sosler
Deputy Project Manager (UIP)
NPSP/New Delhi

Dr Bardan Jung Rana
Medical Officer – EPI
World Health Organization
Jakarta, Indonesia

Dr Vinod Bura
Medical Officer – EPI
World Health Organization
Yangon, Myanmar

Dr William Schluter
Medical Officer – EPI
World Health Organization
Kathmandu, Nepal

WHO-SEARO Secretariat

Dr Monirul Islam
Director Family Health & Research and Ag IVD

Dr Nihal Abeysinghe
Regional Advisor – Vaccine Preventable Diseases (VPD)

Dr Patrick O’Connor
Regional Advisor – Polio & Surveillance
A Brief Report

Mr Stephane Guichard
Technical Officer – Vaccine Safety & Quality (VSQ)

Dr Nalini Ramamurty
Virologist (VIR)

Dr Jayantha Liyanage
Medical Officer – Immunization System Strengthening (ISS)

Mr Luis Homero Hernandez
Resource Mobilization (RMI)

Ms Uttara Aggarwal
Technical Officer – IVD (TOI)

Dr Madhav Ram Balakrishnan
TIP – Surveillance

Dr Anil Kumar Chawla
TIP – Strengthening Quality & Health Systems

Dr Anindya S. Bose
TIP – Measles Control

Dr Aparna Singh Shah
TIP – Laboratory Expert Microbiology

Dr Oommen John
Consultant- Measles Aerosol

Dr Zakir Hussain
TIP-Environmental Health & Climate Change (EHC)

Ms Chitra Salil
Admin.Clerk
Annex 2

Programme

02 March 2011

08.30-09.00 Registration
09.00-09.30 Opening ceremony
  • Welcome – Dr Monir Islam
  • Introduction of SEAR ITAG Members
  • Regional Director’s opening address (delivered by Acting Regional Director)
  • Administrative announcements Dr Nihal Abeysinghe
09.30-09.35 Opening remarks by the Chair of SEAR ITAG and appointing a Rapporteur
09.35-09.45 Review of the implementation status of 2008 SEAR ITAG meeting recommendations – Dr Nihal Abeysinghe
09.45-10.00 Global progress on immunization: from GIVS to Decade of Vaccines [DoV]- Dr Rudi Eggers
10.30-11.00 Regional immunization policy- Dr Nihal Abeysinghe
11.10-11.15 Discussion
11.15-11.45 Framework on increasing and sustaining immunization coverage in SEAR - Dr Jayantha Liyanage
11.45-12.00 Strategy of Global/Regional immunization weeks Dr Rudi Eggers
12.00-12.15 Discussion
01.15-01.30  Strengthening National Committees on Immunization Practices-
Dr Nihal abeyesinghe

01.30-01.45  Discussion

01.45-02.15  Achieving regional polio eradication- Dr Patrick O’Connor

02.15-02.30  Discussion

02.15-02.45  VPD Surveillance in SEAR- Dr Madhav Ram

02.45-03.00  Discussion

03.30-04.00  Pandemic Preparedness: Influenza vaccine production,
deployment and immunization strategies- Dr Jayantha Liyanage

04.00-04.15  Discussion

03 March 2011

09.00-09.30  Moving from measles mortality reduction to elimination in SEAR -
Dr Anindya Bose

09.30-09.45  Discussion

09.45-10.0  Introducing rubella vaccine in national immunization Programmes:
options for SEAR countries-Dr Anindya Bose

10.10-10.15  Discussion

10.45-11.15  Progress in New vaccines introduction-Dr Nihal Abeysinghe

11.15-11.30  Strategic framework for introducing new vaccines in SEAR-
Dr Nihal Abeysinghe

11.30-11.45  Discussion
The WHO-SEAR Technical Consultative Group (TCG) on Polio Eradication and Vaccine-Preventable Diseases was established in 1994. The TCG was an advisory body providing guidance to WHO on immunization matters. In 2008 the terms of reference for the TCG, as well as its memberships were revised and it became the South-East Asia Regional Technical Advisory Group (SEAR ITAG). The ITAG consists of experts from various technical areas related to immunization and vaccine development.

This publication is the report of the Second Meeting of the South-East Asia Regional Technical Advisory Group on Immunization (SEAR ITAG) held from 2-3 March 2011 in New Delhi, India. This report includes a review of the progress made in strengthening routine immunization, polio eradication, measles control, introduction of new vaccines, injection safety etc. It provides recommendations for the consideration of Member States of the WHO South-East Asia Region in their efforts to achieve the World Health Assembly endorsed Global Immunization Vision and Strategy (GIVS) goals.