Task Force on Immunization (TFI) in Africa
15th Annual meeting

Meeting Report

Antananarivo, Madagascar
11-14 December 2007
TFI RECOMMENDATIONS

Overview

1. TFI recommends that:
WHO HQ disseminates the feedback obtained from the consultations in the African region to categorize vaccine preventable diseases.

Routine immunization performance

TFI notes with appreciation the progress made by member states during the last year in improving immunization coverage. However, the TFI is concerned that only 15 countries (33%) have attained ≥90% DTP3 coverage at the national level as foreseen by GIVS.

2. TFI recommends that:
   - At least 65% of countries in the African region attain DTP3 coverage of 90% at national level and at least 80% coverage in all districts in 2008.

RED Strategy

Considering the contribution that the RED approach has made towards improving immunization coverage rates, the TFI endorses the recent In-depth Evaluation of the RED approach in the African Region. However, the TFI notices with concern that the complete package of the five components of the RED approach are not implemented in every district. Moreover, TFI notes the weak routine immunization coverage in Angola, Chad, Equatorial Guinea, Niger and Nigeria.

In view of the above,

3. TFI recommends that WHO and partners:
   - Revise RED guidelines to include innovative strategies to assist countries to reach all districts with the five RED approach components and provide indicators to monitor implementation.
   - Actively promote moving beyond “reach every district” to reach every village in order to be able to target every child.
   - Support Angola, Chad, Equatorial Guinea, Niger and Nigeria to increase routine immunization coverage.

Progress in polio eradication efforts

Considering the persistent circulation of WPV in Angola, Chad, DR Congo and Niger due to the sub-optimal implementation of recommended outbreak response strategies,

4. TFI recommends that:
   - These countries, with support from WHO and partners, should fully implement the 2007 ACPE recommendations to ensure the highest quality of response activities.

Communication for polio eradication

5. TFI recommends that:
   - WHO, UNICEF and partners should support countries to intensify their communication activities and to develop communication indicators to be systematically used in polio eradication activities in all countries. Progress towards achieving these indicators should be presented at the 2008 TFI meeting.
Data quality
Given the importance of the quality of data for the planning, implementation and evaluation of vaccine preventable disease eradication and control efforts in the African region,

6. TFI recommends that:
   - Countries should reinforce the existing mechanisms for data verification and make greater use of independent monitoring.
   - WHO/AFRO and partners should undertake an in-depth analysis of the quality of reported data and make suggestions for their improvement. Results should be presented at the next 2008 TFI meeting.

New Vaccines
In view of the increasing number of new vaccines that are or will be available to the African region,

7. TFI recommends that:
   - WHO/AFRO and partners continue to support countries to make informed decisions on the introduction of new vaccines.
   - Innovative strategies should be developed to support non GAVI eligible countries for the introduction of new vaccines.
   - WHO/AFRO and partners should develop innovative mechanisms to reduce the costs of HPV vaccine and support countries to accelerate its introduction.

GAVI support

8. TFI recommends that:
   - WHO/AFRO should approach GAVI and their partners to consider extending the period of country support beyond the 2015 deadline.

Meningitis
TFI reiterates its strong support for the rapid full development of a meningococcal conjugate vaccine that will provide long lasting protection, including in children, against the threat of epidemic meningitis.

This vaccine, used along with the polysaccharide vaccine, has the potential to eliminate meningitis outbreaks in Africa.

9. TFI requests GAVI to commit the required financial support to facilitate timely widespread introduction of the vaccine in the African meningitis belt.

Integration

10. TFI recommends that:
    - WHO/AFRO and partners should continue to do relevant operational research related to the delivery of integrated interventions, and to evaluate the effectiveness and programmatic implications of integrated activities.
    - Training should be based on needs expressed by health personnel and lessons learned during supportive supervision.
**Capacity building**
Within the context of health systems strengthening and to effectively introduce new vaccines,

11. TFI recommends:
   - That training institutions, countries and partners should increase efforts to deliver integrated pre and in-service training on consensus child health/child survival packages. These efforts should also build individual and institutional capacity to participate in vaccine research and development activities.

**Revolving Fund**

12. TFI notes progress has been made towards the implementation of the Revolving Fund recommendation made during the 14th TFI. The TFI reiterates this recommendation and urges WHO/AFRO to evaluate the feasibility of the establishment of an African Revolving Fund for vaccine procurement.

**Measles**

13. TFI recommends that:
   - The African region should convene the measles TAG in order to review the measles mortality reduction goals and the eventuality of a regional elimination programme.

**Neo-natal tetanus**

14. The TFI recognizes the progress which has been made with the elimination of NNT in the region and requests country immunization and reproductive health programmes to work closely together to ensure appropriate community based surveillance and clean delivery practices.

**Yellow Fever**

15. The TFI recognizes the work begun with the implementation of the Yellow Fever Initiative and encourages them to fully implement the 14th TFI recommendation related to yellow fever.

**VPD surveillance**
Recognizing the need to maximize the use of available resources for the different disease surveillance activities, including that for new vaccines,

16. TFI recommends that:
   - WHO/AFRO develops a comprehensive framework to guide countries on how best to integrate their surveillance networks.

**Nigeria**
The TFI recognizes the progress that Nigeria has made in improving the quality of implementation of Polio Eradication strategies and the resultant decline in the wild poliovirus incidence. To build on this progress and achieve interruption of wild poliovirus transmission,

17. TFI recommends that:
   - Every effort should be made to reduce the proportion of children who have never been vaccinated in the highest risk states to < 10% by March 2008.
The 15th Annual Meeting on the Task Force on Immunization in Africa and the 14th Annual Meeting of the Africa Regional Inter-Coordination Committee (ARICC) held in Antananarivo, Madagascar were officially opened by the H.E. the Prime Minister of Madagascar in the presence of Dr. Luis Gomes Sambo, Regional Director of WHO/AFRO.

In his opening remarks, TFI Chairperson Professor Peter Ndumbe used host-country Madagascar’s national action plan (MAP) as an example of sound government leadership by recognizing that good health and healthy people are the foundation on which other development objectives will be attained. He further noted the impressive results that have been achieved to date in Africa to improve routine immunization coverage, eradicate polio and reduce measles morbidity and mortality.

Tempering his praise for these achievements, Professor Ndumbe cautioned that gains have been obtained through substantial foreign assistance and questioned the sustainability of progress given the fragility of existing health systems and inadequate resources allocated by governments to such initiatives. Furthermore, he challenged member states to increase national resources allocated for health projects and the human resources necessary to implement them.

Dr. Sambo, Regional Director of WHO/AFRO, noted the following progress:

- Routine immunization coverage continues to increase in Africa. DTP3 coverage, which was 47% in 1993, has climbed to 82% at the end of 2006 and 17 countries have reported coverage of > 90%.
- Measles mortality is estimated to have decreased by 91% between 2000 and 2006 in the African region;
- Whereas 39 African countries were polio-endemic in 1994, only one endemic country and 4 with imported cases existed at the end of November 2007. In addition, the number of WPVt1 cases has decreased by 90% in the past 12 months and 41 of 46 countries have attained certification level surveillance standards.

However, Dr. Sambo noted that challenges still exist for vaccination programmes in Africa and that all are directly related to achieving MDG 4. He drew the attention of participants to the crucial stage of polio eradication efforts and exhorted member states to honor their commitment to interrupt WPV transmission by December 2008. In addition, he stated that measles mortality reduction efforts must continue and that countries should augment efforts to achieve 90% routine vaccination coverage at the national level. He thanked the TFI for their important role in advancing the agenda of immunizations and control on vaccine preventable diseases in Africa.
PLENARY PRESENTATIONS

A. OVERVIEW
IMPLEMENTATION STATUS OF 2006 TFI RECOMMENDATIONS

Dr D. Nshimirimana – Director ad interim DDC/WHO - AFRO

Background

There were a total of 22 recommendations:

- 6 on Routine EPI, New Vaccines and Immunization systems support,
- 6 recommendations on Polio Eradication Initiative,
- 5 recommendations related to the accelerated disease control initiatives,
- 2 on Integration,
- 3 on Funding and Resource mobilization

Summary:

16 recommendations were of on-going nature of interventions, while 6 recommendations were time limited – within 2007. 15 recommendations; (68%) were fully achieved and 7 recommendations; (32%) partially achieved / ongoing. The recommendations fully achieved included:

- WHO/AFRO should ensure that Central African countries are working toward improving routine immunization coverage and are supported to implement RED strategies: DPT3 coverage has improved in all countries in C Africa except Chad;
- WHO AFRO should finalize and disseminate to countries the integration framework, guidelines and tools: English and French versions have been disseminated to countries;
- WHO/AFRO should develop an inventory of recent and ongoing studies in the Region related to diseases preventable from new vaccines (Hib, pneumococcal, HPV, rotavirus, etc): studies are ongoing in 53 sites (including sentinel surveillance sites) for the various disease areas;
- In view of the demonstrated safety and efficacy, Hib conjugate vaccines should be included in all routine infant immunization programmes in the African Region: 31 of the 36 GAVI eligible countries have been approved for Hib containing vaccine (as of 30 Oct);
- Countries should rapidly respond to importations and sustain campaigns until confirmation of interruption of imported virus: 4 countries (Angola, Chad, DRC and Niger) experienced WPV importation and responded with at least 2 rounds of SIAs;
- The Government of Nigeria should establish a 24-months SIA plan, with substantial provision for “mop-ups” to facilitate partner and government resource mobilization and allocation;
- All Countries in the Region should make efforts to comply with the 2009 MNT Elimination Goal: All countries except 4 have updated MNTE plans. With availability of funding support for MNTE, activities are being scaled up;
- In view of the fact that there may not be adequate vaccine in the event of a major meningitis epidemic, WHO/AFRO should make every effort to secure adequate vaccine stocks. Countries in the meningitis belt should develop preparedness plans: High level advocacy has been done with ECOWAS, African Development Bank, manufacturers and partners and countries in the belt have developed preparedness plans.

Amongst those on-going in nature or partially achieved are:

- Countries with OPV3 routine immunization below 80% should implement at least one annual SIA using the appropriate OPV as a safeguard to limit spread of importation should this occur:
only countries that are considered at risk and with less than 80% OPV3 coverage implemented SIAs (Angola, Congo, Cameroon, Nigeria, Namibia, Chad, DRC, Ethiopia, South Africa and Namibia);

- WHO/AFRO should evaluate the establishment of a revolving fund for vaccine procurement: Assessments of vaccine procurement systems were conducted in 3 self-procuring countries and a summary report prepared on 6 country assessments.

VACCINES AND IMMUNIZATION: GLOBAL PROGRESS HIGHLIGHTS

Dr J.M. Okwo-Bele, Director, IVB/HQ

Background:

- The GIVS overall goal:
  - Protect more people against more diseases by expanding the reach of immunization to every eligible person,
  - 2015 Target for children: to achieve 2/3 reduction of childhood morbidity and mortality due to VPDs by 2015 compared to 2000 levels.
- The projected change in <5 mortality due to VPDs is slow with current pace of progress with coverage improvements. However, there is a 60%-70% reduction in rate if coverage is scaled up to 90% and widespread use of new vaccines.

Summary:

- Critical to sustain the gains in immunization coverage are monitoring and surveillance (Use of data to guide programme),
- Continued efforts are needed to fully implement current strategies and to maintain synergies with polio eradication activities,
- Hib vaccine has been introduced in 116 countries (60%) and planned in 2008 in 28 additional countries (15%),
- 26 countries have expressed interest in introducing Pneumo vaccines by October 2007,
- Global and regional coverage estimates for infants, 2006 BCG, DTP3, MCV, HepB3 and Hib3:
- New Vaccines Introduction Strategic areas of improvements
  - Decision-making Processes: Integrated Strategies / Independent Advisory Groups
  - High level Political Support: L/T & Predictable (Co-)Financing
  - Management and System strengthening: Multi-year planning and budgeting, Cross-cutting areas (i.e. Cold chain and Disease surveillance)
  - Global supply of assured quality vaccines

MEETING OF THE STRATEGIC ADVISORY GROUP OF EXPERTS ON IMMUNIZATION (SAGE): KEY CONCLUSIONS AND RECOMMENDATIONS

Dr J.M. Ndiaye, SAGE member

Topics covered during November 2007 meeting:

- Reports (IVB Director, Regional Offices, GAVI and other committees)
- Pneumococcal conjugate Target Product Profile (TPP)
- Polio eradication
- Typhoid fever vaccines
- Categorization of vaccine preventable diseases
- Influenza pandemic vaccines (HN51) and WHO vaccine stockpile
- Position paper on rabies
- Use of polysaccharide pneumococcal vaccine
- Immunization safety – Cross-departmental report

Summary:

- SAGE acknowledges good progress in programme implementation
- SAGE requests WHO:
  - to develop a revised immunization schedule for SAGE to review in 2008
  - to develop a more detailed analysis and description of children who are not reached with immunization services
- Target Product Profile (TPP) for pneumococcal conjugate vaccines for GAVI/AMC
  - Eligible vaccines should cover at least 60% of invasive disease isolates and include serotypes 1, 5 and 14;
  - Immunogenicity to follow WHO criteria and vaccines schedule – no more than 3 does in 1st year of life;
  - Vaccine to be compatible for integration into national immunization schedules;
  - Mono- or low multi-dose form – liquid formulations only;
  - Storage, packaging and labelling as per WHO guidelines;
  - vaccines to be pre-qualified;
- WHO Categorization of Vaccine-Preventable Diseases
  - Categorize vaccine-preventable diseases by public health priority: Diseases with vaccines currently available (but not routinely recommended/widely used) or available in the near-term (2012);
  - Provide guidance to Member States, partners, and industry for which diseases to prioritize activities.
- Potential uses of WHO H5N1 vaccine stockpile and H5N1 vaccine: recommendations
  - WHO to continue urgent development of H5N1 vaccine stockpile (procurement, management, governance, regulatory procedures) and address its sustainability;
  - National pandemic preparedness plans – to be updated to enable countries to receive and efficiently deploy H5N1 vaccine
REGIONAL IMMUNIZATION UPDATE

Dr Balcha Masresha, Regional Advisor a.i, IVD/DDC/AFRO

Background:

- Objectives and targets of EPI Regional Strategic Plan 2006 – 2009.

Summary:

- Routine immunization performance in AFR:
  - The reported DPT3 coverage in 2006 was 82% and Measles coverage 84%;
  - 15 countries reached a DPT3 coverage ≥ 90% and 14 countries ≥ 80% DPT3 coverage in 80% or more districts;
  - 11 countries maintained at national level for at least 3 years a DPT3 coverage ≥ 90%
- New vaccine introduction
  - 32 countries approved for Hib containing vaccines;
  - 13 countries approved for HSS (287,432,000 USD);
  - 18 countries expressed interest in introducing pneumococcal vaccine.
- Polio Eradication Initiative:
  - 311 WPV in 5 countries (as of Nov 28 2007) vs 1189 WPV in 2006 in 9 countries;
  - Two epidemiological areas of WPV circulation remain in 2007: Nigeria-Niger-Chad and Angola-DRC
  - Ethiopia - polio free since Nov. 2006
- Accelerated Disease Control
  - There is an estimated 91% reduction in Measles mortality (All ages) in the AFR during the period 2000-2006
  - Yellow fever control: Activities scaled up following the support from IFFim. 22 countries with YF vaccine in EPI: 9 countries: ≥ 80% coverage.
• Capacity Building:
  o Regional Consensus Workshop on integrated training packages on child health: contents, processes & POA 2007-2010
  o First Regional vaccinology course
  o 1 inter-country MLM course for Lusophone countries and 7 in-country MLM courses: 164 participants

• Vaccine Management & Procurement:
  o Pre-service logistics training: Funding proposal formally presented to the EU
  o Cold chain assessments & planning: for 14 countries applying to GAVI new vaccine support and Vaccine procurement assessments in 3 more countries;
  o Workshop on debt relief & immunization.

• Vaccine Regulation:
  o NRA Strengthening: 200 NRA staff & Ethics Committee members trained in 2 years. Senegal NRA evaluated for YF vaccine pre-qualification;
  o African Vaccine Regulatory Forum (AVAREF): 2nd Meeting held with participants from 19 countries. Joint reviews & joint inspections of clinical trials.

Challenges for 2008

• Increasing DPT3 coverage to > 90% from around 80% and sustaining high coverage for the traditional EPI antigens while new vaccines are being introduced,
• Interrupting WPV transmission in Nigeria and Responding adequately to WPV importations into countries with low population immunity;
• Mobilizing additional funds from within countries;
• Sustaining political commitment for polio eradication considering other pressing priorities;
• Achieving and/or sustaining certification level AFP surveillance at sub-national levels.

Priorities for 2008:

• Implement high quality SIAs in Nigeria and countries reporting WPV in 2007;
• Support all countries to achieve and sustain certification level surveillance at sub-national levels;
• Early detection and timely response to WPV importations;
• Continue to use established polio infrastructure to support routine EPI;
• Scale up TT SIAs & validate elimination in 8 countries;
• Support countries to update their training curricula on child health to include recent developments in immunization;
• Feasibility study on establishment of a group procurement & revolving fund mechanism in AFR.

B. ROUTINE IMMUNIZATION

ROUTINE IMMUNIZATION PERFORMANCE AND NEW VACCINE UPDATES

Dr Rose Macauley, IVD/DDC/AFRO

Background: Priorities for 2007

• In 2007, countries in central Africa and the Big 4, particularly Nigeria and Angola were particularly supported,
• Countries were also supported to scale up the implementation of all 5 components of the RED approach and to improve their monitoring systems and the quality of routine immunization data,
• The GAVI application process was strengthened and the introduction of new vaccines continued to be supported.
Summary

- Routine immunization coverage has improved in the Africa Region:
  - DPT3 Coverage increased from 73% in 2005 to 82% in 2006,
  - 15 of the 46 countries reported 90% or more DPT3 coverage in 2006,
  - 14 countries have attained >80% DPT3 coverage in 80% of districts or more,
  - 11 countries had maintained 90% DPT3 at national level for at least 3 years.
- RED approach was scaled up in all countries:
  - The number of districts implementing RED approach has significantly increased in the big 4 countries,
- Routine monitoring and data quality have improved through DQS: in 2006-2007, 28 countries have being received orientation and/or assisted in introducing DQS.
- New vaccines introduction:
  - All GAVI-eligible countries in AFR have been approved and/or introduced HepB vaccine,
  - 32/36 of GAVI eligible countries in AFR have been approved for support for Hib containing vaccine,
  - 18 countries have expressed interest introducing Pneumococcal vaccine
- Surveillance of new vaccines:
  - African rotavirus surveillance network established in 9 countries,
  - 26 countries have trained and participate in the PBM Surveillance Network.

Challenges:

- How to sustain the coverage gains while new vaccines are being introduced?
- Countries are beginning to stagnant around 80% DPT3 coverage, how to accelerate the achievement of >90% coverage?
- Given the number of new vaccines in the pipeline, how can countries be supported on acceptability and sustainability of these new vaccines as well as the traditional antigens?

Perspectives for 2008:

- Support countries to accelerate improvement in immunization coverage,
- With the success of the forum for decision-makers, WHO and partners to host similar forum for the newer vaccines to help member states make informed decision about introduction of newer vaccines.

REACHING EVERY DISTRICT (RED) IMPLEMENTATION EVALUATION, NINE AFRICAN COUNTRIES, 2007

Margaret Watkins, US Centers for Disease Control and Prevention

Background:

- Immunization coverage stagnated/declined in 1990s: AFR accounted for 11 of the global 33.4 million unimmunized children in 2002,
- RED strategy was develop in 2002 to redress losses and improve vaccination coverage,
- Contribute to global goals:
  - MDG: Reduce child mortality by 2/3 by 2015
  - GIVS: 90% coverage nationally, 80% all districts by 2010.
- 2005: rapid assessment of RED in 5 countries concluded RED success contingent on funds for training, micro planning and intensified outreach and supervision
- 2006: TFI recommended a more comprehensive evaluation
Summary:

- Overall goal of the in-depth RED Evaluation in 2007 were to review implementation status in a sample of AFR countries and to determine progress towards improving immunization services
- Methods:
  - Desk review of district data in 27 countries with 9 countries selected for the final evaluation,
  - 68 districts, 133 health facilities visited using a structured interviews with 3 questionnaires,
  - Constitution of teams: At least 1 WHO international and/or UNICEF staff and at least 1 international partner agency representative with national evaluators.
- Limitations of the evaluation:
  - Non-random selection of countries, districts, health facilities,
  - No comparison districts,
  - In-depth exploration of some components not possible (interviews with community reps, etc),
  - Some elements of evaluation based on reports from district and facility staff.
- RED introduction and scale up, 2002-2006:

**RED Introduction and Scale-up, 2002-2006**

<table>
<thead>
<tr>
<th>Year</th>
<th>% RED Districts</th>
<th>No. of Districts</th>
<th>% of Total Districts</th>
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<td>2002</td>
<td>5%</td>
<td>44</td>
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<tr>
<td>2003</td>
<td>19%</td>
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<td>36%</td>
</tr>
<tr>
<td>2006</td>
<td>90%</td>
<td>1077</td>
<td>75%</td>
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</tbody>
</table>

Source: 2002-2006 district dataset for all countries

- Key findings:
  - Workplans available in most districts and facilities and catchment area maps in >2/3 of facilities,
  - Staff report increase in outreach since RED and to most staff: RED = outreach. Outreach activities are commonly linked to other interventions,
  - Supervision visits are integrated with supervision for other health services,
  - More links with community reported than before,
  - Data and monitoring tools were found in most districts and health facilities, most up-to-date. However, interpretation and use could be improved,
Other key findings:
- Integration: Linking with other maternal-child health interventions common in facilities and outreach activities,
- Financing: Variety of funding sources to introduce RED.
- RED has expanded; progress has been made and intensified efforts are needed to fully implement the RED strategy.

Recommendations:
- Ensure funding, training, technical support
- Systematically assess stockouts
- Ensure adequate planning for supervision, improved feedback methods (e.g., on-the-job training), resources for transport, allowances
- Identify and address barriers for outreach to all populations
- Evaluate and strengthen community links
- Improve quality, analysis and use of immunization data

ROUTINE STRENGTHENING THROUGH DIFFERENT APPROACHES: MADAGASCAR

Dr B. Randriamanalina, EPI/MoH/Madagascar

Background:
- Difficulty of reaching annually the coverage standard of > 80% for all antigens
- Difficulty in maintaining at <15% the drop-out rate between DTC-HepB1-3,
- Difficulty in regularly covering 45% of the population located beyond 10 Kms of the CSB
- Challenges:
  - To annually reach the vaccine coverage of at least 80% for all EPI antigens
  - To reduce the drop-out rate DTC-HepB1-DTC-HepB3 to less than 15%

Summary:
- Approaches for strengthening routine immunization coverage:
Traditional strategies:
- Strengthening of the organization and improvement of the immunization services,
- Scaling up of active search of missed children with the participation of community volunteers,
- Monitoring of the drop-out rate,
- Implementation of RED approach.

Innovative strategies:
- Rapid Result Initiative (RRI) or EPI of 100 days,
- Maximization of local and national opportunities to provide immunization services,
- Mother and child health week: 2x/year

Enabling factors for innovative strategies implementation:
- Inter-agency coordination committee for mother and child survival activities
- EPI data management system computerized,
- Active partnership (regular discussions, joint planning of activities),
- Monitoring and evaluation of interventions,
- Capacity building.

Challenges during implementation:
- High turn-over of trained staff,
- Lack of motivation from health workers,
- Insufficient coordination and supervision of activities,
- Interference of other programme activities

Lessons learnt:
- The RED approach has facilitated the upgrading of staff skills and strengthened relations between health workers and the community,
- The peer review approach has consolidated the solidarity between districts,
- The mother and child health week has strengthened the integration of child survival activities.

Trends of DPT3/DPT-HepB3 coverage between 2002-2006

![Graph showing trends of DPT3/DPT-HepB3 coverage between 2002-2006]
C. POLIO ERADICATION

Global Polio Update and Post Polio Eradication Era
Dr. Bruce Aylward, Polio Eradication Initiative, WHO/HQ

Background: Key events since 2006 TF1
- Director General’s Urgent Polio Stakeholder Consultation (28 February 2007).
- Advisory Committee on Polio Eradication (ACPE; 28 November 2007).
- Increased political support for intensified effort in key countries.

Summary
- Scale-up of new tools and tactics:
  - Expanded use of monovalent oral polio vaccine 1 and 3.
  - Revised laboratory algorithm implemented globally.
  - Synchronized campaigns in Pakistan and Afghanistan.
  - Immunization Plus Days (IPDs) implemented in Nigeria.
  - Use of international outbreak response standards in re-infected countries.
  - OPV required for international travel, most notably in Saudi Arabia.

Scale-up of New Tactics

- Major ACPE issues:
  - Need to fully exploit mOPV1 and mOPV3.
  - Emergency international mission to re-infected countries if transmission continues > 6 months.
  - Response time reduced to < 50 days for re-infected countries.
  - Sub-national levels must achieve and maintain > 2.0 non-polio AFP rates.
  - Financing PEI activities, 2008-2012:
Timeline – Target dates:

- 2008: Interruption of type 1 polio virus.
- 2012: Certification of all WHO regions.
- 2013: Cessation of all routine OPV use.

Recommended issues for TFI consideration

- Reaching missed children in northern Nigeria, especially Kano, Katsina and Jigawa.
- Quality of outbreak response activities, especially in Chad, DR Congo and Angola.
- Sub-national AFP surveillance quality.

Polio Eradication Efforts in the African Region – Overview
Dr. Sam Okiror, IVD WHO/AFRO

Background

- Two epidemiological areas or WPV circulation remain: Nigeria-Niger-Chad and Angola-DR Congo.
- There was significant reduction (75%) in the number of wild poliovirus in the region in 2007 (311 cases) compared to 1189 for the same period in 2006. There has also been a decline in the number of countries with transmission in 2007 (5 countries) compared to 9 countries in 2006.
- The number of WPV infected districts has decreased by 42%, from 266 infected districts in 2006 to 173 in 2007.
- Active transmission (detected within the last 6 months) arising from virus importation in 4 countries: Angola (circulation since 2005), Chad (circulation since 2003), DR Congo (circulation since February 2006) and Niger (repeated importations).

* Assumes new private sector funding and level US funding for 2008 and for 2008-9, designated funding for India of US$ 170 million and 150 million, respectively.
Summary

Supplemental immunization activities (SIAs):
- All infected countries implemented at least 4 rounds of national or sub-national SIAs.
- Greater than 70 million children < 5 years old vaccinated of estimated 75 million target.
- Independent monitoring data indicates that 5-23% of targeted children are missed.

AFP surveillance:
- 42 of 46 countries have met certification level surveillance in 2006 and 2007.
- 30 of 46 countries are meeting operational NP-AFP case detection rate of at least 2.0 per 100,000 children below 15 years.
- Guinea Bissau, Algeria and Malawi have not achieved certification level surveillance indicators for the past 3 years.

Status of polio certification:
- From 2004-2007, 21 of 23 countries presenting documentation to the ARCC were accepted.
- 8 countries to present in October 2008: Benin, Burkina Faso, Eritrea, Liberia, Madagascar, Mali, Mozambique and Namibia.

Challenges for 2008
- Interrupt WPV transmission in Nigeria and other infected countries.
- Respond adequately to importations in countries with low population immunity.
- Achieve and maintain 2.0 per 100,000 non-polio AFP rate at sub-national level.
- Consolidate the new accelerated laboratory testing algorithm.
- Sustain political commitment for polio eradication.
Priorities for 2008

- Improve population immunity through supporting routine immunization delivery.
- Implement high quality SIA rounds in all infected countries until interruption is achieved.
- Respond timely and adequately to any wild poliovirus importations.
- Monitor the operational non-polio AFP target of > 2.0 per 100,000 at sub-national level and address gaps.
- Consolidate implementation of the new polio lab algorithm to support timely response.
- Continue certification activities as planned.

Recommended issues for TFI consideration

- Are the proposed priorities sufficient to lead the programme to stopping transmission in all currently infected countries?
- The mainstay of surveillance is the current infrastructure established and sustained mainly through polio funding, how will this be sustained beyond polio eradication?

Nigeria: Progress in Polio Eradication Initiative
Ministry of Health, Nigeria

Background

- All 37 states met the 2 AFP core indicators from January through September 2007 as compared to the same time period in 2006 when only 30 of 37 met both indicators.
- 242 cases of WPV (type 1=92; type 3=150) have been reported in 23 states compared to 1054 cases in 18 states in 2006.

Summary

- WPV epidemiology:
  - Significant decline in total polio cases (80% reduction in total cases and 90% reduction in WPV1 cases compared to same period in 2006).
  - Significant reduction of infected LGAs (districts).
  - Significant reduction in circulating genetic lineages.
- Innovations to improve SIAs:
  - Expansion of immunizations in Koranic schools.
  - Youth-street mobilization activities.
  - Introduction of mOPV3
  - Female Koranic School teachers involvement
  - High Risk Operational Planning.
  - Appropriate mix of mOPV1 & 3 according to WPV type epidemiology.
- Remaining risks and challenges:
  - Trend and reasons for non-vaccination.
**Priority activities for 2008**

- **SIAs:**
  - 4 monovalent rounds during low transmission period between Jan to May 2008, 2 national and 2 sub-national.
  - Intensification and expansion of innovations from 2007.
  - Strengthen High Risk Operational Planning & intensify supervision in targeted areas with high proportion of zero doses non-polio AFP.
  - Improve logistics of teams for hard to reach areas.
  - Synchronized implementation between ward, LGA, states and international borders.

- **Onset of cVDPV in February 2007 had required intensification of immunization activities using trivalent OPV during September IPDs and October LIDs.**

- **Weak sub-national routine immunization:** Geographical correlation of routine OPV3 coverage and polio cases, Jan - Sept 2007.
- Continue appropriate mix of mono-valent types and tOPV according to emerging WPV epidemiology
  - Mop-ups:
    - Continue mop-ups for importation in polio free areas.
  - Routine immunization:
    - Accelerating tOPV3 coverage with expanded REW, LIDs, CHWs
  - AFP surveillance:
    - Intensify active surveillance and peer reviews in weaker states

Polio Outbreaks: Angola, Chad and DR Congo
Dr. Joseph Caboré, IST Central Africa, WHO/AFRO

Background
- 4 countries with 18 WPV cases in 2006.
- 3 countries with 62 WPV (Angola: 8 cases; Chad: 14 cases; and DR Congo: 40 cases) cases in 2007.

Summary
- WPV epidemiology:
  - DR Congo: Four importation events, probably from Angola and one chain of transmission is still active.
  - Angola: Three importation events from Northern India with all three transmission chains still active.
  - Chad: Three chains of ongoing transmission arising from importations Nigeria and between Chad and Sudan. First cases detected in 2007 genetically linked to cluster dating back 17 months with detection indicating surveillance gaps.
  - Immunization status of < 5 year old AFP cases in 2007:
Poor quality SIAs noted in all 3 countries.

Surveillance performance:
- Evidence of surveillance gaps and undetected virus transmission in Angola, Chad and DR Congo.
- Continued poor surveillance performance in Cameroon along Nigerian border calls into question their ability to rapidly detect WPV transmission.

Actions taken
- External surveillance and administrative reviews. (Angola and DR Congo).
- Expanded TAG meeting (Angola, DRC, and Namibia).
- Additional technical support (STCs, WHO staff for Chad, Angola, DRC).
- Synchronized SIAs in addition to national SIAs.
- Support to improve transportation and logistics (DR Congo and Angola).
- Joint WHO/UNICEF mission to Chad.
- Refresher training (Angola & Chad).

Challenges
- How to improve surveillance performance at the sub-national level (Angola and Chad)?
- How to ensure that SIA microplans are of high quality and implemented (DR Congo)?
- How to improve access to difficult to reach areas (Chad and DR Congo)?
- How to ensure that house-to-house vaccination is systematically conducted during SIAs (Chad)?

Way forward
- Chad:
  - High level advocacy mission (AFRO/HQ) to be undertaken ASAP.
  - Four high quality SIAs to be conducted in 2008.
  - SIAs in the Lake Chad region to be synchronized with Cameroon, Niger and Nigeria.
  - SIAs in eastern Chad to be synchronized with Sudan.
  - RED approach to be strengthened.
  - Health staff capacity levels strengthened to better implement surveillance activities.
  - Social mobilization plan to be developed.
- DR Congo:
  - 2 high quality SIAs to be conducted in the first half of 2008.
  - Cross-border activities with Congo-Brazza and CAR to be implemented.
  - Social mobilization plan to be developed and implemented.
- Angola:
  - 2 high quality SIAs to be conducted.
  - Implement cross border activities with DR Congo.
  - Fully implement TAG and surveillance review recommendations.
**Issues for TFI consideration**

- Are the actions taken and the proposed activities adequate to interrupt WPV transmission in Chad, Angola and DR Congo?
- Are the actions taken and the proposed activities good enough to detect, in a timely manner, any WPV importation?

**Communication for Polio Eradication: challenges, interventions in 2007 and perspectives in 2008**

Mr. Paryss Kouta, UNICEF/WCARO

**Background**

- Two epidemiologic zones considered:
  - Nigeria, Niger and Chad
  - Angola, Namibia and DR Congo

**Summary**

- Nigeria – challenges:
  - > 10% of targeted children and missed during SIAs of which 50% is due to non-compliance.
- Nigeria – key interventions:
  - Child-to-child outreach approaches.
  - New education modules for educators, health personnel and community mobilizers.
  - Continued implementation of recommendations from June 2007 communication review and TAG.
- Nigeria – perspectives for 2008:
  - Intensify key interventions begun in 2007 and make planning communication activities more data driven.
  - Conduct MLM/IPC package and conduct IPC training in all states for RI and SIAs.
  - Address cVDPV in context of final push to eradication.
  - Document and share regularly recent efforts to eradicate Polio in Nigeria.
- Niger – challenges:
  - Inter personal communication and supervision difficult to systematize in hard-to-reach populations living in remote areas.
  - Insecurity in certain zones limits ability of community mobilizers to work properly at the household level.
  - Persistent non complaisance issues in certain zones.
- Niger – key interventions:
  - Intense communication interventions/involvement of Islamic women associations as community mobilizers.
  - Advocacy at the borders with Nigeria (Zinder and Maradi) and good involvement of political leaders and other key decision makers.
- Involvement of the Sultan de Zinder in social mobilization activities during the NIDs.
- Synchronization of polio social mobilization with Nigeria.

**Niger – perspectives for 2008:**
- Develop more data-driven and result-based communication with a monitoring and evaluation system in the high risk zones.
- Re-design communication strategies in the high risk zones, with better involvement of local leaders.
- Develop a quality cross-border communication micro-plan with Nigeria and systematically implement.
- Involving more community members in communication micro planning as well as implementation in high risk zones.

**Namibia – challenges:**
- Language barrier (English, Portuguese, and different local dialects) with communities from neighboring countries.
- Radio spots must be translated to ensure the consistency and understanding of messages.
- Lengthy approval process for messages and IEC materials
- Synchronized launches of SIAs.

**Namibia – key interventions:**
- Full involvement of bilingual officers in both UNICEF and WHO with good knowledge of local conditions.
- Use of WHO and UNICEF offices in the two countries to facilitate communication between Angolan and Namibian governments.
- Utilization of communication staff in UNICEF Angola to guide the communication process, design the IEC materials and train key actors at the borders.
- Key common speakers and common messages agreed ahead of time.

**Namibia – perspectives for 2008:**
- Planning and social mobilization for cross-border teams to begin at least 3 months in advance.
- Agree on 1-2 key messages that include encouraging mothers and care takers to continue with routine immunization.
- Promote greater use of local radio and key personalities to broadcast messages.

**Angola – challenges:**
- Incorporate messages surrounding routine immunization into social mobilization and mass media strategy to better target hard to reach children and confront social mobilizers’ fatigue.

**Angola – key interventions:**
- Better communication during National Immunization Days.
- More local messages during National Immunization Days synchronized with DRC and Namibia.
- Development of an effective communication strategy for routine.

**Angola – perspectives for 2008:**
- Initiate the implementation of an integrated communication strategy for routine immunization.
Reinforce and better systematize communication to contribute in the reduction of the missed children and non compliance rates.

**Conclusions**
- The use of Community Dialogues appears to be a must to reduce non-compliance in hard to reach children/high risk areas.
- Communication planning/Cross borders activities should start at the time when Immunisation campaigns are planned for.
- Systematic and regular communication interventions should be strengthened for RI and “In between” Polio campaigns.
- More communication Data Driven, Human Right Based, Community Focused/Oriented in the region.
- Effective Communication strategy in support with MDGs/Child Survival integrated interventions to be developed in Afro region.

**Polio Eradication Summary**

**Key discussion points**
- How can we reduce the number of susceptible children especially in the areas of poor performing surveillance;
- There is the need for surveillance review in Nigeria in 2008;
- Concerns about SIAs data quality in Nigeria;
- Plans to improve communication indicators and harmonize tools;
- Need to have more information on Algeria during the next TAG;
- Should consider logistics in the discussions around IPV use post cessation of OPV;
- There is the need for countries to have legislation in the context of polio eradication;
- Angola has not had WHO surveillance focal person at the national level since the contract of the FP ended in March 2007.

**D. Immunization Systems: Immunization Financing and Systems Strengthening**

**DEBT RELIEF INITIATIVES: AN OPPORTUNITY FOR SCALING UP HEALTH AND IMMUNIZATION FINANCING IN AFRICA**

M. Dicko, IVD/DDC/AFRO

**Background:**
- During the December 2006 meeting, the TFI recommended that: “WHO/AFRO should enhance its resource mobilization capacity by supporting countries to explore the possibility of allocating debt relief funding for immunization.”
- Why look at debt relief?
  - Get a better understanding of available debt relief resources and mechanisms of channelling to the health sector,
Inform staff from Governments and partner agencies working at regional and country level,
Provide support to national authorities (especially MOH) in beneficiary countries.

Summary:

- Three types of debt relief initiatives:
  - Heavily Indebted Poor Countries (HIPC) Initiative,
  - Multilateral Debt Relief Initiative (MDRI),
  - Different Bilateral Debt Relief Initiatives.
- Debt relief funds could potentially be an additional source of health system and immunization financing:
  - Debt relief funds are predictable and availability over a medium to long period of time (up to 40 years),
  - National authorities are fully responsible for the allocation of debt relief funds,
  - Focus is on poverty reducing expenditures and MDGs.
- Allocation of HIPC resources in 2004:

<table>
<thead>
<tr>
<th>2004</th>
<th>Cameroon</th>
<th>Mauritania</th>
<th>Madagascar</th>
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<tbody>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
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<tr>
<td>Total HIPC 2004 (US$ million)</td>
<td>164</td>
<td>38</td>
<td>22</td>
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</table>

**HEALTH**

| % HIPC for health | 21.3% | 19.7% | 33.3% |
| HIPC for health (US$ million) | 35    | 8     | 7     |
| Gov HE 2005 (US$ million) | 215   | 59    | 97    |
| 16% | 13% | 8% |

**IMMUNIZATION**

| % HIPC Health for EPI | 6%   | 12%  | 8%   |
| HIPC EPI (US$ million) | 2.1  | 0.9  | 0.6  |

- Debt relief resources could have contributed to boost immunization:
STATUS OF IMPLEMENTATION OF 2006 TFI RECOMMENDATION ON THE REVOLVING FUND

M. Dicko, IVD/DDC/AFRO

Background:

At its December 2006 meeting the TFI recommended “WHO/AFRO should evaluate the establishment of a revolving fund for vaccine procurement, in view of the experience of PAHO and the Vaccine Independence Initiative in West Africa, and the costs of introduction of new vaccines.”

Summary:

What is a Revolving Fund (RF)?

- The RF is a financial mechanism that utilizes:
  - A centralized unit to procure products for MCs,
  - And a common fund to prepay purchases authorized by members who reimburse later.
- The capital sum of money required to enable the fund to function depends on:
  - Volume & value of purchases,
  - Number of members,
  - Fees charged on the cost of purchases.
- Vaccine Procurement in the AFR : Procurement Sources (JRF 2006):
- Status of Vaccine Procurement in the AFR: Main Features
  - Active role of UNICEF Supply Division,
  - Budget line item for vaccines present in 39 countries,
  - Importance of external funding: Only 12 countries pay 100% of their vaccines. Increasing role of GAVI in vaccine financing,
  - Limited capacity of NRAs with limited experience of the central medical stores on vaccines,
  - No previous experience in pooled procurement & revolving fund,
  - Variety of situations and capacities.

- Vaccine Independence Initiative (VII) in Central and Western Africa:
  - Initiated in 1992 by UNICEF to help 8 then 12 countries,
  - Guarantee funds from donors enable UNICEF to prepay vaccines and countries reimburse in local currencies,
  - In 1996, EU put in place ARIVA project to support VII implementation.

- PAHO Key Features & Lessons Learnt:
  - PAHO pooled procurement & RF Mechanism created in 1979 for >35 MCs with a capital > USD 30 m. Key Aspects of the Fund: Central contracting + RF;
  - Strong Political Support, Involvement of MCs in the decision making, Clear & strict entry, participation and exit criteria, Transparency in the procurement process;
  - Technical and Programmatic support for MC with strict payment Rules;
  - Sustainable operational funding;
  - Mechanism for vaccine quality assurance and control.

Priorities for 2008:
- Establishment of a Working Group in AFRO for studies & activities:
  - Feasibility study of establishing a revolving fund incl. a full risk/benefit analysis,
  - Initiation of pooled procurement between SADC countries,
  - Development of a Communication Strategy,
Establishment of an active collaboration with PAHO,
Assessment & training of Central Medical Stores of Central & West Africa mix-procuring countries.
• Establishment of a High-level Steering Committee to guide, orient & approve Working Group.

NATIONAL REGULATORY AUTHORITIES (NRAS): PROGRESS IN VACCINE REGULATION IN THE AFRICAN REGION

M. Dicko, IVD/DDC/AFRO

Background:
The WHO Goal is to ensure that “100%” of vaccines used in all national immunization programmes are of assured quality.

Summary:
• NRAs present status in AFR: 32 countries have functional NRAs, with 19 dealing with vaccines. 26 countries have developed Institutional Development Plans (IDPs), on which 14 have been approved by the Ministry of health.
• New challenges for regulation of new vaccines:
  • Now more pressure on Developing Countries using vaccines,
  • Less on Industrialized Countries producing vaccines,
  • Countries have insufficient expertise and experience to assess data and applications.
• Clinical trials for new vaccines are being run in any country, no matter the expertise/weight of their NRA (Quality of the trials must be guaranteed).
• Vaccine Regulation Activities conducted in 2007:
  • NRA Strengthening: Follow up of Institutional Development Plans (IDPs), about 200 trainees on vaccine regulation since 2006 and M&E of Senegal NRA for pre-qualification of YF vaccine;
  • NRAs & NECs from Burkina Faso, The Gambia, Ghana, Ethiopia and Mali conducted an inspection of GCP of clinical trial of meningocal conjugate vaccine at the Centre for Vaccine Development (CVD), Bamako, Jan 2007;
  • African Vaccine Regulatory Forum (AVAREF): second meeting held in Ouagadougou with 19 countries (Sept 07).

Priorities for 2008:
• Technical Assistance & Planning:
  • Follow up visits in at least 10 countries to assess IDP implementation,
  • Development & implementation of IDPs in 10 additional countries,
  • M&E of Senegal NRA to perform regulatory oversight on YF vaccine production.
• Capacity building in countries:
  • Strengthening capacity to authorize & inspect clinical trials,
  • Strengthening capacity in licensing & marketing authorization of new vaccines including fast track mechanisms,
  • Support the African Vaccine Regulatory Forum.
GAVI HEALTH SYSTEMS STRENGTHENING IN THE AFRICAN REGION

P. Tumusiime, DSD/AFRO.

Background:

- Significant GAVI alliance investment between 2000 and 2005:
  - Strengthening immunisation services,
  - Introducing new and under-used vaccines,
  - Strengthening injection safety.
- Country studies on barriers to immunization in 2004 followed by a decision for GAVI to support HSS by December 2005.

Summary:

- The objective of GAVI HSS is to achieve and sustain increased immunization coverage, through strengthening the capacity of the health system to provide immunization and other health services (with a focus on child and maternal health),
- GAVI HSS focus is on removing health system bottlenecks to immunization and other child and maternal health services,
- At least 15 out of 36 countries eligible for GAVI HSS support in the African Region have had their proposals approved for funding,
- In the recent proposal review by the GAVI Independent Review Committee (IRC), 7 of the 13 successful proposals came from the African Region,
- GAVI HSS Experience in the Region: lessons learned:
  - Technical support where the expert works with a national team is easier and more productive with an added value of capacity building (ETH, BRD);
  - Agencies need to continuously improve their technical capacity (quantity and quality) to respond promptly and appropriately to country requests;
  - Agency bureaucracy may work against agency intentions: e.g. with regard to recruitment of consultants; involvement of the regional focal points.

Challenges for GAVI HSS support:

- Leveraging GAVI HSS support with other existing support for strengthening national health systems;
- Reaching an optimum level of collaboration between ISS and HSS both at country and higher levels (Regional and sub-regional);
- Effective implementation of the approved HSS proposals;
- Monitoring implementation of the GAVI HSS approved proposal activities (what, how and when).

GAVI SUPPORT TO CIVIL SOCIETY ORGANISATIONS (CSOs)

Dr M. S. Essengue Elouma, GAVI Alliance Secretariat

Background:

- CSOs by definition include NGOs, community-based groups / or partnerships, professional associations, academic and technical institutions working on immunisation, child health and health system strengthening;
- Areas of Activity:
  - delivering immunisation or child health care packages,
- technical assistance,
- monitoring/evaluating immunisation or child health programmes,
- community mobilization,
- Advocacy, child health rights, or operational research.

- Level of Activities: National, local, regional or international in structure and scope
- Length of Operation: Organisations that have been working in the relevant areas for at least three years.

Summary:

- GAVI CSO support type A:
  - Support to strengthen the coordination and representation of CSOs,
  - All GAVI eligible countries can applied,
  - Lump sum available based on birth cohort,
  - No deadline for submission, Form: 3 pages.

- GAVI CSO support type b:
  - Support to facilitate implementation of HSS support,
  - 10 pilot countries (including Ghana, Burundi, Ethiopia, DRC, and Mozambique in AFR)
  - Funding based on number of children not immunized with DTP3,
  - Same deadline for submission as for HSS proposals (next 7 March 08).

CSO Proposal Development process:

- GAVI Assessment of CSO Proposals Type A
  - Has the proposal been developed through an inclusive and participatory process with necessary stakeholders?
  - Is there a good description of the CSO mapping exercise?
  - Is there a good description of the level of CSO involvement prior to the support?
  - Is the process of involving the CSOs in the relevant health coordinating structures clearly defined?
Is the issue of securing continuing representation of CSOs in HSSC, ICC, or equivalent structures addressed?

Has the proposal been endorsed by chair of the HSCC?

GAVI VACCINE INVESTMENT STRATEGIES

Dr. J. Heldrup, GAVI Alliance Secretariat

Background:

- Current ‘implicit’ vaccine investment strategy:
  - Vaccine investments have been comprehensively evaluated as individual opportunities have arisen, not as part of a strategic plan across vaccines,
  - The Alliance has generally operated within a relatively short-term planning horizon (5 years in phase 1),
  - The Alliance has placed an emphasis on encouraging countries to reach financial self-sufficiency in their immunization programs over time,
  - To support its vaccine priorities, the Alliance has invested in a wide range of later-stage activities, though explicitly deciding not to focus on R&D.

Summary:

- Vaccines to be considered (Disease prioritization):
  - 15 Diseases for which vaccines are currently licensed and available (but not routinely recommended or widely used): Cervical cancer (Human Papillomavirus infection), Cholera, Hepatitis A, Influenza (seasonal), Japanese encephalitis, Meningococcal disease (groups ACYW135), Meningococcal disease (group B), Mumps, Pneumococcal disease, Rabies, Rotaviral enteritis, Rubella, Typhoid fever, Varicella and Yellow Fever.
  - 3 Diseases for which vaccines may be available (licensed) by 2012: Dengue Hepatitis E, Malaria.

- Policy objectives for the new strategy:
  - Long-Term Vaccine Investment Strategy to enable further reductions in introduction timeframes,
  - Strategic plan across new vaccines,
  - Maximize health impact/cost-effectiveness,
  - All else equal, prioritize near-term and more likely impact,
  - Invest in value-added activities where Alliance has comparative advantage (but, not in R&D),
  - Invest in vaccines that balance interests of countries with a global perspective,
  - Make time-limited investments in vaccines for which countries can become self-sustainable.
Process and timeline in vaccines investment strategies:

**Approach vaccines investment strategies:**

- **Diagnostic/analysis**
  - Mortality, morbidity, alternatives, cost-effectiveness, epidemic/pandemic potential,
  - Work with broad set of stakeholders,
  - What activities can GAVI support for each vaccine?

- Country consultations will gather country input on priorities
  - 10 country visits,
  - Pre-WHA meeting to look at outputs of review committee,

- Independent review committee will consider data gathered and input from consultations to recommend final strategic approach.

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**E. INTEGRATION TRACK**

**Child Survival in the African Region: Update on Implementation**
Dr. S. Muziki, CAH WHO/AFRO

**Background**

- AFR under-five mortality rates dropped only from 185 to 166 deaths per 1 000 live births from 1990 to 2006.
- 27% of under 5 deaths in the Africa region are neonatal.
- Worldwide, up to 50% of neonatal deaths are in the first 24 hours and 75% are in the first week – 3 million deaths.
Millennium Development Goal 4 can only be achieved if neonatal deaths are addressed and this necessitates both maternal and child health interventions.

Summary

Coverage of key child survival intervention in the Africa region (2005)

15 countries have developed integrated maternal, newborn and child health strategic plans using the joint regional CS strategy as a framework (Angola, Benin, Burkina Faso, Liberia, Malawi, Mali, Mozambique, Niger, Nigeria, Senegal, Sierra Leone, Tanzania, Uganda, Zambia and Zimbabwe).

Efforts continue to build capacity levels of health staff, develop partnerships and mobilize resources.

Challenges

Low coverage of effective health and nutrition interventions due to system-wide supply and demand obstacles.

Poor coordination of interventions and health system performance in term of policies including social protection of the poor, legislation, resource allocation, and capacity development.

Existing commitments made and reaffirmed by world leaders at various summits are sufficient to meet the goals; however time is running out to make the needed practical investments.

At the midway point of 2007, these commitments must be urgently translated into practical plans with systematic follow-up.

Conclusion

Current national and partner efforts are insufficient to attain MDGs 4 and 5.

The way forward is to integrate and scale up essential MDG-related health interventions for high coverage and health systems strengthening.

Improving how we measure these efforts is integral to these efforts.
Scaling up child survival interventions
Bob Davis, Regional Advisor EPI UNICEF/ESARO

Background
- Every minute 8 children < 5 years old die, 2 of them are newborns.
- Reaching MDG 4 will require high coverage of key newborn and child interventions.
- We have coverage of over 60 percent for TT, complementary feeding in infants, vitamin A administration, and measles vaccination, however, coverage levels for ORT, treatment of pneumonia and malaria prevention (ITNs) and treatment, lag behind.

Summary
- Child health days and weeks, offering multiple child survival and other health interventions have been implemented in numerous African countries.
- Country level results demonstrate that such activities can achieve and sustain high coverage of interventions such as vitamin A and deworming, as well as overcome health system constraints.

Ethiopia DPT3 administrative coverage and Enhanced Outreach Services, 2006

Niger: higher OPV coverage when associated with LLINs, December round:
Challenges

- How do we ensure the availability of funding to support the delivery of additional interventions?
- How best to ensure the capacity of immunization workers to deliver additional interventions?
- How to establish integrated monitoring systems to better track progress of integrated interventions?

Providing integrated interventions through “Periodic Intensified Activities”: country experiences
Dr. Stephen Sosler, IVD – IST Central Africa WHO/AFRO

Background

- Recommendations from 2004 and 2005 TFI meetings to promote the integration of additional child survival activities with immunization services.
- AFRO documentation of integration experiences:
  - Structured documentation outline shared with countries.
  - Experiences of Ethiopia, Ghana, Kenya, Madagascar, Uganda and Zambia shared.

Summary

- Periodic Intensified Activities:
  - Implemented 1 or 2 times per year.
  - Follow an integrated SIA model or aligned with routine EPI services.
- Core package of services determined at the national level however, additional interventions included at sub-national level determined by local needs, available funds, financial and human resources.

- Package of interventions, selected countries 2006-2007:

<table>
<thead>
<tr>
<th>Intervention</th>
<th>ETH</th>
<th>GHA</th>
<th>KEN</th>
<th>MAD</th>
<th>UGA</th>
<th>ZAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vitamin A</td>
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<td>x</td>
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<td>x</td>
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<td>Routine EPI (0-11m)</td>
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</table>
Expanded role of ICC beyond immunization activities as the national level coordination for integrated activities comprising multiple interventions.

Sub-national planning and organization:
- Implementation of regional level ICCs (ETH).
- Activity is budgeted into district health plans (UGA).
- Broad-based district level coordination body for improved planning, advocacy and social mobilization efforts.
- Plans and additional resources necessary to access hard to reach populations at times devised and budgeted for at the district level.

Ugandan example of financing and resource mobilization:
- Child Days Plus activities are expected to be part of district annual work plans and budgets.
- Financial assistance obtained from local partners where available.
- District allocated funds are not sufficient to sustain activity and national level involvement is still needed.

Training guidelines developed by the national level, determined by the interventions to be included, staff availability and capacity levels and conducted through cascade training format.

Data collection for activity monitoring and evaluation is either integrated into the national routine HMIS for routine data or treated separately (SIA model).

Promotion of increased utilization of mother and child health services, Kenya Malezi Bora example:

**Challenges**
- Planning and evaluation continually hampered by inexact population information.
- Existing poor health infrastructure and staff levels/quality.
- Coverage of activities which rely on delivery through existing health structure national level support is still needed.
- Improve overall coordination of donor resources to respond in a cohesive manner to stated national and sub-national health priorities.
Integration of vital events registration.

**Conclusions**
- Evolution is toward more decentralized, district-planned activities.
- Multi-sector collaboration between government, development partners and private sector.
- Number of interventions included should be realistic vis-à-vis available human as well as logistic resources.
- Improved documentation of activities noted: third party evaluation, multi-method survey of health staff and communities.

**Integrated Pre and In-Service Training on Child Survival: the Way Forward**
Dr. Evariste Mutabaruka, IVD WHO/AFRO

**Background**
- Regional consensus workshop on integrated training packages for child health held in August 2007.
  - Contents and processes for integrated pre and in-service training packages on child health and child survival.
  - POA 2007-2010 developed.
- Established context for integration:
  - MDGs, especially MDG-4
  - Priority Intervention Areas of the regional child survival strategy
  - GIVS 2006-2015
  - Regional EPI strategic Plan 2006-2009
- Guiding principle: all health professionals should be trained in an integrated primary health care approach, regardless of whether they practice at primary, secondary or tertiary level.

**Summary**
- Pre-requisite for integrated training on child health:
  - Integrated service delivery, funding and management
  - Life cycle approach: an integrated ANC, TT and childhood immunization card…
  - Integrated strategic approach integrated with RED
  - Integrated staff categories
  - Integrated cross – cutting functions
- Design of integrated in –service training on child survival:
- Integrated Training Package for health workers – at first-level facility:
  - Case classification and management
  - Surveillance and data management and use
  - Disease prevention strategies
  - Management skills for service delivery
- Integrated in-service training plan of action for 2008: HQ and regional levels
- Put in place an advisory body at global/regional level
- Set up regional partnerships for resource mobilization, technical support and advocacy.
- Develop & disseminate framework for integrated training for child survival/child health.
- Develop & disseminate generic integrated training materials and tools child survival/child health.
- Conduct a regional TOT on integrated training materials and tools on child health.

Integrated in-service training plan of action for 2008: Regional and IST levels

- Support countries to get updated/integrated training materials and to refresh EPI/CH managers, professors/teachers (TOT)
- Support countries to adapt their respective CH curricula in line with the adopted integrated training packages and existing curricula prototypes
- Support/expand network for pre-service training
- Monitor progress made in this revision process and in the implementation of the Ouidah POA 2007-2010
- Support countries to supervise and evaluate Integrated courses on CH

Integrated in-service training plan of action for 2008: Country level

- Advocate for policy that accommodates integrated training.
- Establish/strengthen partnership thru a multi sectoral coordinating body (resource mobilization,)
- Establish/strengthen technical working group to develop/adapt tools and guidelines for planning, implementing, monitoring and evaluation.

Issues for TFI consideration

- How to better support integrated EPI/child health training in order to better strengthen health systems?
- How to better link integrated EPI/child health training with integrated supportive supervision?
- How to better involve health schools in vaccine research and development?

Integration Track Summary

Discussion points

- Why is OPV not systematically integrated into multi-intervention activities?
- Documentation of integrated activities is not enough, need for better evaluation of integrated activities.
- Issue of treating “integration” as the end point without taking into all necessary factors.
- There is a need to support countries to improve central level coordination bodies (ICC).
- Need highlighted for simple harmonized messages on integration with clear definition to countries.
- Need for an inter-sectorial committee to coordination integration of pre-service curricula.

Issues for TFI consideration

- There is a continued need to establish best practices related to integrated immunization and child survival interventions. Hence, it is recommended that further efforts be made to design and conduct operational research related to the delivery of integrated interventions in order to evaluate the effectiveness and programmatic implications of integrated activities.
**F. NEW VACCINE TRACK**

**ACCELERATING ACCESS TO PNEUMOCOCCAL CONJUGATE VACCINES FOR AFRICA’S CHILDREN: PNEUMOADIP’S UPDATE**

**Chizoba Wonodi, MBBS, MPH; Johns Hopkins School of Public Health**

**Background**

- Pneumococcal disease is the leading cause of vaccine preventable deaths in the under 5 year olds. The disease burden is relatively high in the AFR region.
- The incidence of pneumococcal disease is increased in sickle cell disease, malnourished children and is also 20-40 times higher with HIV/AIDS.
- Pneumonia/LRTI is second only to Malaria in cause of <5 years death.
- ~ 40% of pneumonia deaths caused by Streptococcus Pneumoniae
- S. pneumoniae, is a leading cause of meningitis in children <5 years old in Africa.

**Summary**

- Types of Pneumococcal Vaccines currently available: Polysaccharide and conjugate vaccines. Protein candidate vaccines are in development.
- An efficacious, cost-effective 7-valent (PC7) vaccine is now available and 10 and 13-valent vaccines are in advanced stages of development.
- Pneumococcal Conjugate Vaccines demonstrated efficacy in Africa:
  - Trials in South Africa and The Gambia demonstrated that conjugate vaccine (9-valent) was safe and efficacious.
  - The Gambia trial showed 7 deaths prevented per 1000 vaccinated children
  - The vaccine was shown to be effective in children with HIV and in high malaria endemic areas.
- Historically 15-20 years passed before new vaccines reached poorest children. Currently, 30 countries globally have expressed interest in pneumococcal vaccine (PC7) introduction; 18 of them are in the AFR region.
- Countries will need assistance with the hurdles that lie ahead including: cold chain expansion and the preparation of applications.
- There is a high and innovative donor commitment to supporting pneumococcal vaccine purchase for low income countries as demonstrated by:
  - The GAVI Board’s endorsement of the first ever Investment Case for accelerated (pneumococcal) vaccine introduction
  - A pilot case US$1.5 billion pledge in an Advance Market Commitment for pneumococcal vaccines.

**Key points during discussion**

- Given the increasing number of new vaccines, countries should be encouraged to analyze available information, so as to make informed decisions on prioritization.
  - This includes the WHO position papers available (on Hib, Pneumococcal and Rota vaccines); cost of the vaccines, cost effectiveness studies, country economic situations etc.
- TFI should consider a recommendation on addressing the challenges faced by middle-income (non-GAVI-eligible) countries for the introduction of Hib, Pneumococcal as well as future vaccines.

**Conclusions:**

- Accelerated pneumococcal vaccination is a cost-effective way to save lives and improve health
- Affordable, sustainable supply of pneumococcal vaccines is possible for Africa
- Donor commitment to support vaccines purchase is high.
- Countries with expressed interest in pneumococcal vaccine need to translate this interest into GAVI applications and vaccine introduction.

**ACCELERATING THE INTRODUCTION OF HIB VACCINE IN AFRO: LESSONS LEARNED AND IMPLICATIONS FOR OTHER NEW VACCINES**

**Rana Hajjeh, M.D., Director, the Hib Initiative**

**Background**

- Pneumonia causes almost a million child deaths in Africa every year
- Hib causes up to 20% of severe pneumonia
- Efforts to prevent pneumonia essential to reach MDG4

**Summary**

- Over 140 countries including 54 GAVI eligible countries have introduced Hib containing vaccine in 2007 compared to 19 in 2005
- In AFR, by 2007:
  - 32 out of 36 GAVI eligible countries have either introduced Hib vaccine or applied for support and the remaining 4 countries will apply in 2008
  - 2 out of 10 non-GAVI countries have introduced Hib vaccine by 2007
- Accelerating Hib vaccine introduction worked due to favourable environment:
  - WHO revised position paper on Hib vaccine in November 06
  - GAVI co-financing guidelines to ensure long term support
  - Improved supply due to additional pentavalent product
  - Hib Initiative collaborative activities
Challenges

- Financial limitations:
  - Expanding fiscal space
  - Empower countries to justify support for new vaccine
  - Work with donors and partners
- Ensuring adequate affordable supply
- Communications and Coordination:
  - Recognizing the real barriers: Not always disease burden
  - Reaching the right audience: Information rarely trickles down by itself
  - Bringing in other stakeholders (e.g., pediatricians, civil societies, etc…)
  - Ensuring adequate resources for coordination
- Non GAVI eligible low middle income countries

Conclusions

- Focused efforts to accelerate Hib vaccine introduction are effective and were successful in AFR region.
- Regional office support and adequate resources are critical – Could not be done without country commitment.
- Continuous country support and monitoring of impact is very important for long term sustainability: urgency to maintain good surveillance.
- Lessons learned from Hib vaccine introduction important for other new vaccines: meningococcal, pneumococcal, HPV, rotavirus.

Discussions

- TFI should consider a recommendation on addressing the challenges faced by middle-income (non-GAVI-eligible) countries for the introduction of Hib, Pneumococcal as well as future new vaccines.
OVERVIEW OF RECENT DEVELOPMENTS IN THE AREA OF NEW VACCINES

Marie-Paule Kieny, Director, Initiative for Vaccine Research, WHO/HQ

1. HIV vaccines: Global landscape
   - Growing number of low- and middle-income countries participating in preparation and conduct of HIV vaccine clinical trials.
   - The Phase IIB trial of the Merck Ad5-based vaccine was terminated prematurely because of no efficacy. Analysis of a possible enhancement of infection in vaccinees is ongoing.
   - There remains one candidate under phase III trials (Thailand) and another with phase IIb results under discussion.

2. Tuberculosis vaccine development
   - Six vaccine candidates are/have undergone one or several phase 1 clinical trials:
     - 3 adjuvanted protein subunits
     - 1 MVA-vectored product
     - 1 recombinant adenovirus-35 vector
     - 1 recombinant BCG (abandoned due to regulatory shortcomings)
   - In 2006, an advanced candidate, MVA85A has entered phase I/II evaluation in South Africa, one of the 22 TB highest-burden countries.
   - Six more products in the immediate pipeline (1-3 years before entrance into clinical trials).

3. Influenza vaccine Global Action Plan:
   - WHO involved in several aspects including:
     - Strengthening of NRAs for licensing of vaccines
     - Capacity building for transfer of technology for H5N1 vaccine manufacturing in 6 developing countries (none in AFR)
     - Evaluation of vaccine delivery strategies in case of an epidemic.

4. Rotavirus vaccines
   - Phase III trials in Kenya, Mali and Ghana for “RotaTech” (started in 2007).
   - Phase III trials in RSA and Malawi for “Rotarix” (started in 2005).

5. Enteric bacterial vaccine initiatives
   - There are a number of initiatives including a BMGF Cholera vaccine grant to WHO to evaluate various factors for a Cholera vaccine stockpile in the future.
   - WHO does not recommend a stockpile of the presently available vaccine.

6. WHO Categorization of Vaccine-Preventable Diseases
   - A landscape analysis was conducted for the prioritization of licensed vaccines that are not routinely recommended or not widely used as well as those anticipated to be available by 2012 (e.g. Malaria, Pneumococcal, HPV, Rota, Cholera, Rabies etc.).
   - Objectives of the categorization:
     - Categorize vaccine-preventable diseases by public health priority.
Diseases with vaccines currently available (but not routinely recommended/widely used) or available in the near-term.

- Provide guidance to Member States, partners, and industry: for which diseases to prioritize activities.
- Preliminary results are now available and were broken into three groups: High, Second and Low priority VPDs.
- The next steps include refinement of criteria and a regional evaluation of the initial categories (beginning with AFR and EUR).

STRATEGIES FOR INTRODUCTION OF HPV VACCINES IN AFRICA

Marie-Paule Kieny, Director, Initiative for Vaccine Research, WHO/HQ

Background

- Estimated number of cervical cancer cases per region in 2002
  - Africa 78,897
  - Asia 265,884
  - Central & South America 71,862
  - Europe 59,931
  - North America 14,670
- Age adjusted incidence rates are highest in Africa as most women have no access to early cancer detection and treatment

Summary

- As of October, 2 HPV vaccines against cervical cancer and/or anogenital warts were licensed in all regions, including 11 countries (quadrivalent) and one country (bivalent) in Africa.
- WHO's HPV Expert Advisory group met in September 2007 to address HPV vaccines related issues.
- WHO also monitored regional perspectives and meetings in SEARO, WPRO and EURO have consistently shown that:
Interest in vaccines, but cost and delivery major concerns.

While awaiting affordable vaccine prices, countries should
- Establish or strengthen collaboration between programmes
- Assess burden of HPV-related disease, especially cancer
- Assess prevention programmes, e.g., education, screening
- Assess options to deliver vaccines to adolescents, monitor impact

- AFRO Regional meeting is planned for 2008
- SAGE, WHO's leading vaccine advisory body, has considered HPV vaccines twice in April and November 2007 and made important conclusions.
- WHO is closely tracking operations research on HPV vaccine delivery. In Africa this is being done in collaboration with experts in Uganda and PATH and they are exploring several delivery options:
  - School based delivery appears promising in Uganda and elsewhere in Africa
  - Child health days are another promising strategy
  - The strong EPI programmes in African are well placed to delivery HPV vaccines but would need some new components
- For maximum impact in Africa and other regions, HPV vaccine introduction will require many needs and WHO is taking many steps in collaboration with partners such as PATH

**Discussion**

- How can we overcome cost as an obstacle to the accelerated introduction of HPV vaccine in AFR where the burden of disease is greatest?
- An investment case for HPV has been presented to the GAVI Board

**MALARIA VACCINES: UPDATE & PLANS FOR THE MOST ADVANCED VACCINE CANDIDATE, RTS,S/AS**

* Alan Brooks, Director, Policy & Access, PATH Malaria Vaccine Initiative

**Background**

- Most of the vaccine candidates are in preclinical stages
- There is planning in advance for malaria vaccines
  - Policy & decision-making pathways
  - Economics & Financing
  - Key collaborators
  - Clinical Trials & Product Presentation Analyses
- A malaria vaccine decision-making framework is under development

**Summary**

- Plans for the most advanced malaria vaccine candidate, RTS,S/AS include
  - Collaboration between PATH MVI, GSK Biologicals, & trial partners under a Clinical Trial Partnership Committee
  - $107M plus in public sector funding to the collaboration from BMGF; GSK estimates spending over $300M to date
  - Phase 3 data in 2010/11, regulatory opinion/pre-qualification in 2012
  - Phase 3 licensure trial in 10 sites representing different transmission settings
Phase 3 licensure trial sites

- 10 sites representing different transmission settings
- Up to 16,000 children in two age categories:
  - 6 weeks to 12 weeks (6,000 minimum)
  - 5 to 17 months (6,000 minimum)
- All subjects using bednets; some areas spraying insecticide

Source: Modified from Abdulla, ASTMH, 2007

- Phase 3 efficacy and safety trial of RTS,S/AS malaria vaccine candidate is designed to provide:
  - Key safety and efficacy data for regulatory file & WHO pre-qualification
  - Full evaluation of relevant disease and public health endpoints to inform implementation planning
  - Most of the RTS,S/AS product characteristics are still under evaluation
  - MVI-GSK has a strategic vision for implementation of RTS,S/AS to ensure that robust evidence and resources are available to all countries in sub-Saharan Africa to facilitate decision making

Issues for TFI Consideration

- Targeted input to date includes: EPI Manager’s Meetings, Regional Working Group, SAGE and WHO HQ
- Would TFI like to contribute to product development & planning, and if so, what type of input and when would TFI like to contribute?
  - 2008-10 Prior to phase 3 data?
  - 2010-11 After phase 3, but before SAGE review, licensure, as potential for implementation becomes “real”?
  - 2012 After SAGE decision and licensure and as part of implementation roll-out?
G. ACCELERATED DISEASE CONTROL

Meeting the threat of epidemic meningitis in Africa: introducing a new Meningococcal conjugate vaccine
Mark Laforce, Meningitis Vaccine Project

Background
- A more potent and affordable ($US 0.40/dose) Group A meningococcal conjugate vaccine exists: MenAfriVac.
- Vaccine will be available in quantity as of 2009.
- Vaccine is highly immunogenic in adults and toddlers and confers long-term protection.
- Induces herd immunity (based on results with pneumococcal and Hib vaccines).
- There is an imminent threat of a major epidemic from Group A meningococcus (ST 2859).

Summary
- Introduction of Men A conjugate vaccine to take place between 2009-2015.
- Single dose in “one-time” catch up vaccination campaigns for 1 to 29 year olds:
  - Target population over 350 million in 19 countries with hyper-endemic countries prioritized.
- Delivery mechanism to protect birth cohorts – two choices:
  - Within EPI schedule: single dose at 9 months or two doses (14 weeks and 9 months).
  - Follow-up campaigns (1-4 year olds) every 5 years
- Surveillance data indicates that a large epidemic of new Men A strain (ST2859) is imminent:
  - Thus, the availability of sufficient PS vaccine stocks must be ensured for epidemic response during the introduction of the Men A conjugate vaccine.
  - Consider introducing Men A conjugate vaccine in hyper-endemic countries without delay.
Proposed introduction approach 1: No major epidemic in 2008
- Develop epidemic response stockpile of PS and conjugate vaccines; implement reactive strategy as in the past.
- Continue with clinical development plan for the Men A conjugate vaccine; introduce in 2009

Proposed introduction approach 2: Major epidemic in 2008
- Develop epidemic response stockpile of PS vaccines; implement reactive strategy as in the past.
- Consider early introduction of Men A conjugate vaccine in mass campaigns and as an epidemic response vaccine.

Summary
- A new epidemic wave of meningococcal meningitis appears to be imminent.
- A solution (new conjugate vaccine) is near.
- AFRO leadership and GAVI support (strategic plans, funding, donor coordination, country planning, vaccine introduction, surveillance, regulatory, AEFI…) are key elements in an effective response to this threat.

Regional Overview of Measles Control
Dr. Balcha Masresha, IVD WHO/AFRO

Background
- 2006 TFI recommendations to address gaps in routine EPI coverage and report on the status of implementation of 2005 Measles TAG recommendations have been achieved:
- Regional goal of reducing measles mortality by at least 90% (compared with 2000 estimates) has already been achieved.
Summary

- Regional routine measles immunization is 84%.
- Overall, 314 million children vaccinated during measles SIAs by the end of 2006:
  - 31.5 million children in 16 countries targeted by measles SIAs in 2007.
  - IFFim funding available to support SIAs in 2007-2008.

- Of the 16 countries conducting follow-up campaigns in 2007, all integrated at least one of the following child survival interventions: vitamin A (13), deworming (9), ITNs (7) and oral polio virus (2).
- 38 countries are under case-based measles surveillance and 41 national measles laboratories exist.
- 2007 Measles surveillance performance (January – October):
  - 95% of 19,174 suspected measles cases have been investigated with a blood specimen.
  - 68% of districts have investigated at least one cases with a blood specimen and this should increase
  - 5 467 cases have been confirmed and incidence is 0.8 per 100 000 population.
  - Annualized non-measles febrile rash illness rate is 1.7 per 100 000 (target: ≥2.0 per 100 000).

Challenges

- Improve routine measles vaccine coverage to reach and maintain at > 90%:
  - >65% of confirmed measles cases with recorded vaccination status are NOT VACCINATED.
- Gaps in funding for follow-up SIAs and surveillance.
  - Country financing of ops costs for follow-up SIAs
  - Questions surrounding partner funding levels beyond 2008.

Issues for TFI consideration

- How can we maintain the gains in measles mortality reduction in the background of infrastructure and resource limitations, and weakness in health systems?
Is it appropriate for a second Measles TAG to revisit, among others:

- The Regional measles goals
- The role of MCV2 in measles control in AFR

**Maternal and Neonatal Tetanus Elimination: Update**
Dr. Ahmadu Yakubu, UNICEF/ESARO

**Background**
- Of the over $23 million IFFIm funds utilized thus far in 2007, 78% was allocated to 15 AFR countries
- 14 countries in African region conducted TT SIAs in 2007.
- An estimated 42,000 deaths have been prevented in the African region.
- GAVI / IFFIm funds available through 2009.

**Summary**
- TT2+ coverage reached 62% in the African region in 2006 but is likely higher because most women’s TT immunization is re-started with each pregnancy due to poor care retention.
- Despite high antenatal care (ANC) coverage, skilled attendance at birth is still very low in the African region, 42%.
- The following countries have eliminated MNT since 1999: Eritrea, Malawi, Namibia, Rwanda, South Africa, Togo, Zambia and Zimbabwe.
- MNTE validation protocol:
  - When? All districts report performance (reliable surveillance or skilled delivery >70% or TT2+ coverage around 80%) compatible with elimination.
  - Where? In the district with the worst performance: higher/highest probability to find neo-natal rates above 1 per 1000 live births.
  - Results? Hypothesis of elimination is accepted ("Pass") or rejected ("Fail") using the Lot Quality Assurance (LQA). If worst district passes then it is assumed that all other districts have also achieved elimination.
  - Implications of failure: Failure does not imply all districts have failed. A review of district level data for selected districts needing corrective rounds. Country can reclaim elimination one year after last corrective SIAs round.

**Challenges**
- Equatorial Guinea, Gabon and Nigeria have yet to produce their elimination action plans.
- Insufficient performance of SIAs in some districts will require corrective rounds.
- RED approach is still not addressing TT coverage issues.
- Mali and Tanzania failed their MNTE validation exercise and urgently need to conduct corrective rounds in districts with sub-standard performance.
**Activities for 2008**

- Conduct validation surveys in countries claiming elimination (Benin, Burkina Faso, Comoros Islands, Congo-Brazza, Ghana and Mozambique) after review of district performance.
- Ensure high quality TT SIAs and provide technical support for micro planning and supervision.
- Support integration with other high impact interventions.
- Liaise with reproductive health to promote clean delivery & cord care practices.
- Promote active surveillance for NT as part of IDSR.

**Recommendations for TFI consideration**

- TT SIAs should be the prime strategy in all identified districts at high risk for MNT.
- RED performance reports should systematically include TT2+ coverage in addition to current requirements of DPT3 & measles.
- Before claiming elimination an in-depth district performance assessment by MOH, WHO and UNICEF should be undertaken to justify the claim.

**Yellow Fever Control in the African Region**

Dr. Fenella Avokey, IVD – IST West Africa WHO/AFRO

**Background – Implementation of 2006 TFI recommendations**

- Financial support for surveillance and lab activities secured through the YF investment case.
- Sufficient quantities of YF reagents secured from the CDC and Institut Pasteur Dakar (IPD).
- WHO AFRO survey of yellow fever vaccination policy determined:
  - That no written policy for vaccination in routine EPI beyond 9 months in 14 out of 20 of countries (70%).
  - Revaccination of groups beyond the EPI age group through SIAs has occurred in 18 of 20 countries.

**Summary**

- Key achievements in 2007:
  - Briefing and planning meetings conducted in at-risk countries.
  - Draft guidelines for epidemiologic surveillance and vaccination campaign planning and organization developed.
  - Yellow Fever Partnership (UNICEF, WHO, AMP, CDC, ECHO, PATH) conference calls occur bi-monthly.
- YF vaccination in routine EPI services:
  - 22 out of 27 high risk countries with YF vaccine in EPI.
  - 9 countries achieved ≥ 80% coverage.
  - Regional mean coverage = 76% versus 68% in 2006.
- District-level risk assessment conducted in Burkina Faso, Mali, Senegal and Togo.
  - 22.5 million doses estimated to be needed for campaigns.
  - This figure is 85% higher than the original 12.1 million doses originally estimated.
Preventive vaccination campaigns:
- Conducted in 2 of the 4 planned countries (Senegal and Mali).
- Burkina Faso and Mali to conduct campaigns in 2008.

YF case-based surveillance:
- 37% of districts in 17 reporting countries investigated a suspected case with a blood specimen.
- 2,575 suspected cases and 7 IgM positive.
- 85% of specimens collected within 14 days of onset.
- Response activities in conducted in Togo, Mali, and Cameroon.

Challenges
- High vaccine uptake based on risk assessment requires more vaccine for the preventive campaigns in 12 countries. Meeting this increased demand will be a challenge.
- Conducting risk assessment and subsequent preventive vaccinations in Nigeria.
- Securing support for surveillance activities in non-investment case countries at risk.

Perspectives for 2008
- Introduction into EPI of YFV in Guinea Bissau.
- Establishing case-based surveillance in Nigeria (three national laboratories) and Guinea Bissau.
- All countries to finish risk assessments in 2008 and preventive campaigns in <= 3 countries.
- Preparation of fund raising proposals for preventive campaigns and surveillance strengthening activities.

Challenges in VPD Surveillance in the African Region
Dr. J.M. Yameogo, IVD WHO/AFRO

Background
- Issues related to AFP, Measles, NNT, YF, PBM and Rota surveillance performance discussed.

Summary
- AFP surveillance: significant sub-national surveillance gaps remain:
  - IST/Central – Chad, Angola and Cameroon.
  - IST/SE – Mozambique, Tanzania, Malawi, Zimbabwe, S. Africa and Somali Region in Ethiopia.
  - IST/West – Algeria, Guinea Bissau, Ghana and Mali.
- Measles surveillance performance:
Yellow fever surveillance performance:

- Case-based surveillance established in 18 of 31 at risk countries.
- 37% of districts in 12 countries reported suspected cases.
- Only 7 out of the 2575 suspected cases IgM+.
- 85% specimen collected within 14 days of onset.
- 92% specimens in good condition.

Neo-natal tetanus (NNT) surveillance performance:

- Gaps in data collection exist.
- 319 NNT cases reported from 19 countries and 170 confirmed based on the clinical case confirmation criteria.
- NNT surveillance guidelines being adapted and NNT surveillance feedback bulletin has been initiated.

Pediatric bacterial meningitis (PBM) surveillance performance:

- 22 countries reporting PBM sentinel sites surveillance (since 2001).
- Hib impact assessments conducted in 6 countries.
- Pneumococcal serotyping being done in collaboration with NetSPEAR supported network in East Africa.
Rotavirus surveillance:
- Sentinel hospital-based surveillance targeting children < 5 years in 13 countries, 9 supported by WHO, 3 by other partners (RVP and Bill-Melinda Gates Foundation).

**Key actions**
- Joint evaluation/follow up meetings (e.g. TAG meetings).
- Surveillance reviews:
  - 17 of the 20 surveillance reviews planned for 2007 were conducted
  - 4 comprehensive reviews (Angola, Namibia, Tanzania and Ghana).
  - 13 desk reviews.
- Technical support missions, capacity building and regular feedback.
- Additional resource allocation.

**Key challenges**
- Sustaining optimal surveillance indicators in countries at sub-national level.
- Improving data quality (data cleaning, analysis, completeness, and timeliness).
- Inadequate and partial implementation of surveillance review recommendations.
- Need to mobilize additional funds locally for surveillance activities.

**Priorities for 2008**
- Improve surveillance performance at sub-national level.
- Support capacity building at all levels including refresher trainings, supportive supervision and monitoring and evaluation meetings at all levels.
- Mainstream polio infrastructure to support other VPD surveillance.
- Innovative resource to involve new partners to support surveillance system at country level.

**Issues for TFI consideration**
- Is the current status of vaccine preventable disease surveillance in the region sensitive enough to detect in a timely manner any outbreak in the Region?
- Are the identified priorities adequate to improve and sustain high quality surveillance indicators in the Region?

**Integrating AFRO Surveillance Laboratory Networks**
Dr. Francis Kasolo, IVD WHO/AFRO

**Background**
- Coordination of laboratory activities decentralized to the IST level:
  - Polio LabNet.
  - Measles, YF, rubella LabNet [Integrated].
  - Pediatric Bacterial Meningitis LabNet.
  - Rotavirus LabNet.
- Human Papilloma Virus LabNet.

Summary
- Issues with IVD lab integration:
  - Characteristics of tests and specimen collection procedures to be used.
  - Availability of infrastructure and resources to support selected tests.
  - Existence of national laboratories which may be incorporated into the network.
  - Willingness of the country and its institutions to integrate.
  - Cost-effectiveness and management levels necessary to ensure sustainable integration.
- Successful integration of polio and measles lab networks:
  - Share facilities and equipment as well as human and financial resources.
  - Joint planning and laboratory accreditation for diseases covered.
- Measles / rubella and yellow fever lab integration:
  - Similar standardized sample collection and testing strategies used (training, equipment, reagents, quality assurance and accreditation).
- PBM and rotavirus integrated laboratory network:
  - Same hospital-based sentinel sites.
  - Staff -data management and clinical staff.
- Potential for further integration of lab surveillance:
  - Season and HPAI Influenza lab network
  - Human Papilloma virus using laboratories with molecular capacities, i.e., PCR and virus sequencing facilities.

Conclusion
- Integration of IVD laboratory surveillance networks is on course at all levels.
- There is no one model that will fit our current needs and thus we may have to adapt various models when integrating other IVD LabNet.
- Potential exists for further integration of IVD labs into already existing lab networks.

Issues for TFI consideration
- How do we accelerate the integration of IVD Labnets without losing focus on individual control/eradication programs needs?
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Ms Marie T. Avoaka Faye, Addis Ababa, Ethiopia
Email: mt.faye@aiic.net
### Tuesday, 11 December 2007

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>08h15-08h45</td>
<td>Registration</td>
</tr>
<tr>
<td>08h45-09h00</td>
<td>Administrative Announcements</td>
</tr>
<tr>
<td><strong>A. Overview</strong></td>
<td></td>
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<tr>
<td>09h00-09h20</td>
<td>Implementation Status of TFI Recommendation: Nov. 2006, Director, DDC a.i.</td>
</tr>
<tr>
<td>09h20-09h40</td>
<td>Global Immunization Update, J.-M. Okwo-Bele, IVD/HQ</td>
</tr>
<tr>
<td>09h40-10h00</td>
<td>Regional Immunization Update, D. Nshimirimana, IVD/AFRO</td>
</tr>
<tr>
<td>10h00-10h40</td>
<td>Discussion</td>
</tr>
<tr>
<td>10h40-11h00</td>
<td>Coffee/Tea Break</td>
</tr>
<tr>
<td><strong>B. Routine Immunisation</strong></td>
<td></td>
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<tr>
<td>11h00-11h15</td>
<td>Routine EPI Performance in the African Region, R. Macauley, IVD/AFRO</td>
</tr>
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<td>11h15-11h30</td>
<td>Results of the RED Evaluation, M. Watkins, CDC</td>
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<td>11h30-11h50</td>
<td>Discussion, Chairperson</td>
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<tr>
<td>11h50-12h05</td>
<td>Achieving and Maintaining High Immunization Coverage Through RED: Burkina Faso, MoH/Burkina Faso</td>
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<td>12h05-12h20</td>
<td>Routine Strengthening Through Different Approaches: Madagascar, MoH/Madagascar</td>
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<td>12h20-12h40</td>
<td>Discussion</td>
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<td>12h40-14h00</td>
<td>Lunch</td>
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<tr>
<td>15:00-16h30</td>
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<td>16h30-18h00</td>
<td>TFI Members - Closed Meeting, Chairperson</td>
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### Wednesday, 12 December 2007

<table>
<thead>
<tr>
<th>Time</th>
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<tr>
<td><strong>C. Polio Eradication</strong></td>
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<tr>
<td>09h00-09h15</td>
<td>Global Polio Update and Post-Polio Eradication Era, B. Aylward, POL/HQ</td>
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<td>09h15-09h30</td>
<td>Polio Eradication Efforts in the African Region - Overview, S. Okiror, IVD/AFRO</td>
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<tr>
<td>09h30-09h50</td>
<td>Discussion, Chairperson</td>
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<tr>
<td>09h50-10h05</td>
<td>Nigeria: Progress in Polio Eradication Initiative, MoH/Nigeria</td>
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<td>10h05-10h20</td>
<td>Angola/DRCongo/Chad Polio Outbreaks, J. Cabore, IST/Central</td>
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<td>10h20-10h35</td>
<td>Communication for Polio Eradication, UNICEF</td>
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<td>Time</td>
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<td>10h35-11h00</td>
<td>Discussion</td>
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<td>11h00-11h30</td>
<td>Coffee/Tea Break</td>
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<tr>
<td>11h30-11h45</td>
<td>Resource Mobilization for Immunization: The Debt Relief Initiative</td>
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<td>11h45-11h55</td>
<td>Status of Implementation of TFI Recommendation on the Revolving Fund</td>
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<td>12h10-12h20</td>
<td>National Regulatory Authorities: Progress in Vaccine Regulation in the Region</td>
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<td>Discussion</td>
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<td>12h30-14h00</td>
<td>Lunch</td>
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<td>14h00-14h15</td>
<td>GAVI - Health Systems Strengthening</td>
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<td>14h15-14h30</td>
<td>Vaccine Investment Strategies</td>
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<td>14h30-15h00</td>
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<tr>
<td>15h00-15h30</td>
<td>Coffee/Tea Break</td>
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<tr>
<td>15h30-15h45</td>
<td>Update on Implementation of the Child Survival Strategy</td>
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<tr>
<td>15h45-16h00</td>
<td>Update on Implementation of the Child Survival Strategy</td>
</tr>
<tr>
<td>16h00-16h30</td>
<td>Discussion</td>
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<tr>
<td>16h30-16h45</td>
<td>Regional Experiences with Integrated Interventions</td>
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<tr>
<td>16h45-17h00</td>
<td>Integrated Pre- and In-Service Training on Child Survival: Way Forward</td>
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<tr>
<td>17h00-17h30</td>
<td>Discussion</td>
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<tr>
<td>15h30-15h40</td>
<td>Pneumococcal Vaccines</td>
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<tr>
<td>15h40-15h50</td>
<td>Accelerated Hib Vaccine Introduction in the African Region: Lessons Learnt and Implications for other New Vaccines</td>
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<tr>
<td>15h50-16h25</td>
<td>Discussion</td>
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<tr>
<td>16h25-16h35</td>
<td>Overview of Recent Developments in the Area of New Vaccines</td>
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**Wednesday, 12 December 2007 (cont.)**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Speaker/Location</th>
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<tbody>
<tr>
<td>15h30-15h45</td>
<td>Update on Implementation of the Child Survival Strategy</td>
<td>S Muziki, CAH/AFRO</td>
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<tr>
<td>15h45-16h00</td>
<td>Update on Implementation of the Child Survival Strategy</td>
<td>A Kabano, UNICEF/ ESARO</td>
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<td>16h00-16h30</td>
<td>Discussion</td>
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<tr>
<td>16h30-16h45</td>
<td>Regional Experiences with Integrated Interventions</td>
<td>S. Sosler, IST/Central</td>
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<tr>
<td>16h45-17h00</td>
<td>Integrated Pre- and In-Service Training on Child Survival: Way Forward</td>
<td>E. Mutabaruka, IVD/AFRO</td>
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<td>17h00-17h30</td>
<td>Discussion</td>
<td>Chairperson</td>
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<tr>
<td>15h30-15h40</td>
<td>Pneumococcal Vaccines</td>
<td>Pneumo ADIP</td>
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<tr>
<td>15h40-15h50</td>
<td>Accelerated Hib Vaccine Introduction in the African Region: Lessons Learnt and Implications for other New Vaccines</td>
<td>R. Hajjeh, CDC</td>
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<td>15h50-16h25</td>
<td>Discussion</td>
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<td>16h25-16h35</td>
<td>Overview of Recent Developments in the Area of New Vaccines</td>
<td>M.-P. Kieny, IVR/HQ</td>
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<tr>
<td>Time</td>
<td>Event Description</td>
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<tr>
<td>16h35-16h45</td>
<td>Strategies for Introduction of HPV Vaccines in Africa</td>
<td>M.-P. Kieny, IVR/HQ</td>
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<tr>
<td>16h45-16h55</td>
<td>Clinical Trials and Planning for RTS/S, the Furthest Advanced Potential Malaria Vaccine for Africa</td>
<td>A. Brooks, PATH - Malaria Vaccine Initiative</td>
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<tr>
<td>16h55-17h30</td>
<td>Discussion</td>
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<tr>
<td>17h30-18h30</td>
<td>TFI Members Closed Meeting</td>
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</tr>
<tr>
<td>19h00-20h00</td>
<td>Regional Director’s Reception</td>
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**Thursday, 13 December 2007**

<table>
<thead>
<tr>
<th>Time</th>
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<th>Presenter/Initiative</th>
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<tr>
<td>09h00-09h30</td>
<td>Feedback from Tracks</td>
<td>Rapporteurs</td>
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<tr>
<td>09h30-09h50</td>
<td>Meningitis Vaccines Project</td>
<td>M. Laforce, MVP</td>
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<tr>
<td>09h50-10h05</td>
<td>Regional Overview of Measles Control</td>
<td>B. Masresha, IVD/AFRO</td>
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<tr>
<td>10h05-10h30</td>
<td>Discussion</td>
<td>Chairperson</td>
</tr>
<tr>
<td>10h30-11h00</td>
<td>Coffee/Tea Break</td>
<td></td>
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<tr>
<td>11h00-11h15</td>
<td>MNT Elimination and Validation in the African Region</td>
<td>F. Gasse, UNICEF/HQ</td>
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<tr>
<td>11h15-11h30</td>
<td>Yellow Fever Control in the African Region</td>
<td>F. Avokey, IST/West</td>
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<tr>
<td>11h30-12h00</td>
<td>Discussion</td>
<td>Chairperson</td>
</tr>
<tr>
<td>12h00-12h15</td>
<td>Challenges in VPD Surveillance in the African Region</td>
<td>J.-M. Yameogo, IVD/AFRO</td>
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<tr>
<td>12h15-12h30</td>
<td>Discussion</td>
<td>Chairperson</td>
</tr>
<tr>
<td>12h30-14h00</td>
<td>Lunch</td>
<td></td>
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<tr>
<td>14h00-14h15</td>
<td>Integrating AFRO Surveillance Laboratory Networks</td>
<td>F. Kasolo, IVD/AFRO</td>
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<tr>
<td>14h15-14h30</td>
<td>Discussion</td>
<td>Chairperson</td>
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<tr>
<td>14h30-15h00</td>
<td>Coffee/Tea Break</td>
<td></td>
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<tr>
<td>15h00-16h30</td>
<td>TFI Members’ Closed Meeting</td>
<td>Chairperson</td>
</tr>
<tr>
<td>16h30-17h30</td>
<td>Recommendations and Wrap-Up</td>
<td>Chairperson</td>
</tr>
</tbody>
</table>
## ANNEX 3: ARICC MEETING AGENDA

### 14th African Regional Inter-Agency Coordination Committee (ARICC) Meeting

**Friday, 14 December 2007**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>09h00-09h10</td>
<td>Introductory Remarks</td>
<td>Chairperson, ARICC</td>
</tr>
<tr>
<td>09h10-09h25</td>
<td>Review of 2006 ARICC Recommendations</td>
<td>D. Nshimirimana, IVD/AFRO</td>
</tr>
<tr>
<td>09h50-10h20</td>
<td>Discussion</td>
<td></td>
</tr>
<tr>
<td>10h20-10h30</td>
<td>Decentralization of Administrative Services to IST Sites</td>
<td>IST Coordinator</td>
</tr>
<tr>
<td>10h30-10h45</td>
<td>Mainstreaming the Polio Eradication Infrastructure - Ways Ahead</td>
<td>B. Aylward, POL/HQ</td>
</tr>
<tr>
<td>10h45-11h00</td>
<td>Discussion</td>
<td></td>
</tr>
<tr>
<td>11h00-11h20</td>
<td>Coffee/Tea Break</td>
<td></td>
</tr>
<tr>
<td>11h20-11h35</td>
<td>WHO Strategic Objectives + 2008 IVD Plan of Action</td>
<td>D. Nshimirimana, IVD/AFRO</td>
</tr>
<tr>
<td>11h35-11h45</td>
<td>Resource Mobilization - Ways Forward</td>
<td>C. Obidairo, External Relations Consultant</td>
</tr>
<tr>
<td>11h45-12h20</td>
<td>Discussion</td>
<td></td>
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<tr>
<td>12h20-12h50</td>
<td>Partners Statements</td>
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<tr>
<td>12h50-13h00</td>
<td>Closing Ceremony</td>
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</tbody>
</table>
ANNEX 5: TFI AWARDS

2007 Recipients

1. **Benin Ministry of Health**

En mai 1995, en vue de contribuer à l’atteinte des Objectifs du Millénaire pour le Développement, l'Assemblée Mondiale de la Santé a adopté la Vision et Stratégie Mondiale pour la vaccination (GIVS) pour la période 2006-2015 qui sert actuellement de guide et cadre de travail de référence pour tous les acteurs et bénéficiaires de la vaccination. L'un des objectifs clés de GIVS est que tous les pays devront avoir atteint et maintenu 90% de couverture vaccinale au niveau national d'ici 2015.

Le programme national de vaccination de ce pays qui a une population totale de 7.4 millions d'habitants a donné le bon exemple lui-même en maintenant son taux de couverture vaccinale en DTC3 à au moins 90% au cours des 3 dernières années. De plus, le taux de couverture vaccinale anti-rougeoleuse a été lui aussi maintenu à plus de 85% au niveau national au cours des 3 dernières années consécutives.

Le TFI apprécie hautement les efforts consentis par le Gouvernement de ce pays et ses partenaires pour atteindre et maintenir le haut niveau de couverture vaccinale.

Sur base de cette performance remarquable, le TFI a le plaisir de conférer au Ministère de la Santé du Benin le prix TFI 2007 pour le maintien de la couverture vaccinale à plus de 90% pendant au moins une période de 3 ans.

2. **Burkina Faso Ministry of Health**

Ce pays n’a pas d’accès à la mer, enclavé qu’il est dans le Sahel à la frontière du Sahara qui, inexorablement grignote chaque année une bonne part de ses terres arables! Il a le privilège, pour prendre les choses avec humour, de figurer parmi les « pays les moins avancés », parmi les « pays pauvres très endettés » et j’en passe!

Cependant, ces difficultés géo-économiques loin de handicaper ses habitants les ont plutôt galvanisés et fait d’eux des travailleurs honnêtes et infatigables! Je voudrais en donner pour preuve le fait qu’ils aient pu atteindre et maintenir une couverture vaccinale de routine de plus de 90% DTC3 pendant les 3 dernières années!

Les citoyens de ce pays ont une si haute passion pour l’intégrité qu’ils en ont fait le nom de leur pays!

Le TFI salue cette performance remarquable et encourage le Burkina Faso à persévérer sur cette voie. Pour ce faire, il décerne au Ministère de la Santé le prix TFI 2007 !

3. **Gabon Ministry of Health**

La performance du programme national de vaccination a été faible dans ce pays a telle enseigne que la couverture vaccinale DTC3 a été moins de 50% pendant 8 ans au cours de cette décennie. C’est pourquoi ce pays a été longtemps reconnu comme étant l'un des moins performants dans la Région africaine.

Lorsque le Gouvernement a compris la gravité de la situation, il a décidé de réagir au plus vite et, avec l'appui des partenaires, d'entreprendre les interventions nécessaires pour renverser la tendance.

Ainsi, très tôt cette année, ce pays a accéléré l'extension et l'expansion de l'approche Atteindre Chaque District dans tous les districts, et en particulier l'intensification des prestations des services de vaccination en stratégie avancée. Dès le mois d'aout déjà, ce pays a pu effectivement renverser la tendance et atteindre plus de 80% de couverture pour le DTC3.
Le TFI apprécie hautement les efforts consentis par le programme national de vaccination et ses partenaires et encourage ce pays à continuer sur cette lancée pour atteindre non seulement plus d'enfants mais aussi maintenir les gains acquis.

Sur base de ces réalisations très louables, le TFI a le plaisir de conférer au Ministère de la Santé du Gabon le prix TFI 2007 pour l'augmentation de la couverture vaccinale.

4. Jennifer Linkens

I have the honour and privilege to present the next award to a person who has demonstrated to date outstanding skills in the area of administrative management.

This person started his/her career at WHO over 10 years ago quickly becoming an indispensable asset to the Organization. When the opportunity arose to work with the Global Polio Eradication Initiative, the largest public health initiative ever launched, an initiative which, in order to be successful, must reach every child, no matter where he or she lives, this person embraced this posting.

Since joining the Global Polio Eradication Initiative, this person has significantly contributed to the management of polio grants and funding provided to the Region. Without proper grant management, donors would be reluctant to entrust the polio programme with adequate financial resources for programme activities. Over the past number of years, this person has provided consistent support to the African Region by actively participating in a number of joint AFRO/HQ Administrative and Managerial Reviews of the Polio Eradication Initiative as well as having led a number of selected EPI administrative reviews at the country level.

This award recognizes the exemplary leadership qualities this person continues to display in administratively managing the Global Polio Eradication Initiative. It is thereby my pleasure to present this well-deserved award to Jennifer Linkins.

5. Dr. Mohammed Duale

The individual referred to here joined WHO in 2001 as Medical Officer in-charge of surveillance in one of the Provinces with the most difficult to reach areas in that country from where he was identified as an able leader for the EPI team in the country. Various indicators for EPI have continued to improve under his leadership and support our WHO team provides to government. In particular, DPT3 coverage has remained above 80% over the past 3 years, AFP surveillance in particular has been maintained at certification level standards.

Hardly two years after taking this leadership role, was that country confronted with an outbreak of wild poliovirus imported from a neighboring country. This individual led the WHO team to provide very crucial technical support to government to investigate and respond to the wild poliovirus outbreak which was controlled within a record time of two months from confirmation of the first of the two cases.

TFI is pleased to recognize the vital contribution to the EPI programme in Kenya of Dr. Mohammed Duale with the 2007 TFI award.

6. Le Groupe Régional de Travail GAVI pour l’Afrique de l’Ouest et du Centre

Lorsque l’Alliance mondiale pour les vaccins et la vaccination, plus connue sous son sigle anglais GAVI, a vu le jour, il s’est alors trouvé au sein des organisations, qui soutenaient déjà la vaccination sur le terrain en Afrique, des agents de la ligne de front qui ont pensé qu’il fallait s’organiser pour mieux expliquer aux pays les initiatives de GAVI et leurs conditionnalités, coordonner, voire harmoniser les appuis que les partenaires de GAVI sur le terrain pouvaient apporter aux pays. C’est alors qu’est née en Afrique une initiative qui a été appréciée non seulement par le Secrétariat de GAVI, mais aussi les autres Régions qui se sont toutes mises à l’adopter et à la dupliquer.
L'une des structures ainsi créées eut à prendre en charge l’appui à des pays qui étaient en majorité loin de la barre verte de 80% de couverture en DTC3 et qui, en plus faisaient face à la polio endémique, au tétanos maternel et néo-natal, aux épidémies de rougeole et de fièvre jaune! L’appui technique approprié et efficace fourni par ce groupe a permis à ces pays d’effectuer un bond en avant dans tous les domaines du PEV, notamment en matière de vaccination de routine, d’introduction des nouveaux vaccins et de contrôle des maladies.

Ce résultat n’a pu être atteint qu’au prix d’un esprit d’équipe exemplaire de la part des agents de différentes agences et organisations partenaires.

Mesdames et Messieurs, j’ai nommé le « Groupe de Travail GAVI pour l’Afrique de l’Ouest et du Centre ». C’est avec plaisir que le TFI accorde au Groupe et à ses membres le Prix 2007 du TFI.