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CURRENT STATUS OF ROUTINE IMMUNIZATION AND POLIO ERADICATION IN THE AFRICAN REGION: CHALLENGES AND RECOMMENDATIONS

Report of the Regional Director

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ANNEXES

ADDENDA

DRAFT RESOLUTION: AFR/RC60/WP/4—Current status of routine immunization and polio eradication in the African Region: challenges and recommendations (Document AFR/RC60/14)

BACKGROUND

1. An estimated 2–3 million childhood deaths are averted each year through vaccination while approximately 600 000 adult deaths are prevented annually, thanks to hepatitis B vaccination.[1]

2. The potential for vaccination to contribute to even greater mortality reduction and accelerate attainment of the health-related Millennium Development Goals (MDG), particularly MDG4, can be realized with further improvements in vaccination coverage and large-scale introduction of new vaccines targeting an increasing number of infectious diseases.

3. The 2006–2009 Regional EPI Strategic Plan[2] developed in line with the Global Immunization Vision and Strategy (GIVS)[3] identified five main strategic areas including strengthening routine immunization and poliomyelitis eradication.

4. In 2008, the Regional Committee for Africa endorsed the *Ouagadougou Declaration on Primary Health Care and Health Systems in Africa,*[4] urging Member States to continue investing in national health systems.

5. In 2009, Member States adopted a regional measles elimination goal[5] to be attained by 2020 and endorsed a stepwise approach requiring the attainment by 2012 of the proposed pre-elimination targets.

CURRENT STATUS

6. Regional routine immunization coverage in 2009 for the third dose of DPT-containing vaccine (DPT3) was 85% compared to 82% in 2008, with 20 Member States reporting at least 90% coverage at national level in 2009 compared with 16 in 2008.[6] The implementation of the Reaching Every District (RED) approach including other innovative strategies like Periodic Intensification of Routine Immunization activities, Child Health Days and Immunization plus Days have contributed to the improved coverage. However, 26 countries have not yet achieved this recommended coverage level.

7. Detailed analysis of regional routine immunization coverage rates reveals disparities between countries. It is estimated that 4.2 million children in the African Region did not receive DPT3

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[1] Duclos P et al. Global Immunization: status, progress, challenges and future. BMC International Health and Human Rights 2009, 9(Suppl 1): S2.

[2] WHO. Resolution AFR/RC56/R1: The regional strategic plan for the Expanded Programme on Immunization 2006–2009. In: *Fifty-sixth session of the WHO Regional Committee for Africa, Addis Ababa, Ethiopia, 28 August–1 September 2006, Final Report,* Brazzaville, World Health Organization, Regional Office for Africa, 2006 (AFR/RC56/24), pp. 7–10.

[3] Global Immunization Vision and Strategy (GIVs) 2006–2015, 2005.

[4] WHO. Resolution AFR/RC58/R3: The Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: achieving better health in Africa in the new millennium: In: *Fifty-eighth session of the WHO Regional Committee for Africa, Yaounde, Cameroon, 1–5 September 2008, Final Report,* Brazzaville, World Health Organization, Regional Office for Africa, 2008 (AFR/RC58/20), pp 13–15.

[5] WHO. Document AFR/RC59/14: Towards the elimination of measles in the African Region by 2020. In: *Fifty-ninth session of the WHO Regional Committee for Africa, Kigali, Republic of Rwanda, 31 August–4 September 2009,* Brazzaville, World Health Organization, Regional Office for Africa, 2009.

[6] Annexes, Table 1: 2008-2009 DPT3 and MCV1 reported coverage and WHO/UNICEF coverage estimates.

vaccine in 2009 compared to 5.2 million in 2008.[7] An estimated 80% of these DPT3 under-immunized children reside in only 10 countries.[8]

8. Mother and child health days and other similar activities are carried out at least once a year in 38 out of the 46 countries in the African Region. The activities include advocacy, immunization targeting hard-to-reach populations and delivered with other child survival interventions.

9. Progress has been made in the introduction of new vaccines. Hepatitis B and *Haemophilus Influenza* type b vaccines have been introduced in 45 and 43 countries respectively. Pneumococcal conjugate vaccine has been introduced in three countries, Rotavirus vaccine in one country, while the Human Papilloma Virus (HPV) vaccine is in the pipeline for introduction.

10. By 2004, indigenous transmission of wild poliovirus had been interrupted in 45 of the 46 countries in the Region, Nigeria being the only endemic country. In 2006, eight Member States[9] suffered polio outbreaks while, in 2009, 18 countries[10] experienced importations following a spread of wild poliovirus from the remaining polio reservoirs[11] into previously polio-free Member States due to inadequate routine immunization coverage and suboptimal Supplementary Immunization Activities (SIAs) resulting in low population immunity.

11. As at the end of April 2010 nine countries in West and Central Africa had reported 40 polio cases compared to 306 cases in 12 countries during the same period in 2009. Intensified efforts to interrupt wild poliovirus transmission in Nigeria are yielding dividends with only two polio cases reported as at the end of April 2010 compared to 236 cases at the same period in 2009.

12. Implementation of measles mortality reduction strategies resulted in a dramatic reduction of estimated measles deaths. As at the end of 2008 estimated measles deaths had been reduced by 92% (representing 28 000 deaths) compared to 2000 levels (371 000 deaths) mainly as a result of the SIAs conducted in the Region. This progress is, however, being jeopardized by suboptimal routine immunization coverage at district level in several countries, resulting in measles outbreaks in 2010.

13. By the end of 2009, 15 countries[12] had been validated as having eliminated maternal and neonatal tetanus. During the same period, 23 of the 31 countries at risk of yellow fever in the African Region introduced yellow fever vaccine into their routine EPI programmes, achieving a regional coverage of 73%.

14. Surveillance of vaccine-preventable diseases (VPDs) plays a critical role in directing activities of the immunization programme. In addition, the VPD surveillance system is enhancing the implementation of integrated disease surveillance and response (IDSR). The IDSR strategy adopted in 1998 in line with Regional Committee Resolution AFR/RC48/R2 is at various stages of

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[7] Data source: MOH-UNICEF-WHO Joint Reporting Forms (JRF).
[8] Angola, Cameron, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Kenya, Nigeria, Tanzania, Uganda and Zimbabwe.
[9] Angola, Cameroon, Chad, Democratic Republic of Congo, Ethiopia, Kenya, Namibia and Niger.
[10] Angola, Benin, Burkina Faso, Burundi, Cameroon, Central Africa Republic, Chad, Côte d'Ivoire, Democratic Republic of Congo, Guinea, Kenya, Liberia, Mali, Mauritania, Niger, Sierra Leone, Togo and Uganda.
[11] Angola, Chad, Democratic Republic of Congo and Nigeria.
[12] Algeria, Botswana, Burundi, Comoros, Congo, Eritrea, Lesotho, Malawi, Namibia, Rwanda, South Africa, Swaziland, Togo, Zambia and Zimbabwe.

implementation in 43 of the 46 Member States. The International Health Regulations (IHR) 2005, call for the strengthening of national core capacities for surveillance and outbreak response.

15. Eighty-five per cent (85%) of Member States have a specific line in their national budget for procurement of vaccines used in routine immunization. The proportion of government funding of the overall expenditure on vaccines in the African Region increased from 48% in 2000 to 53% in 2006. However, the proportion of government funding of overall routine immunization expenditure remained virtually the same at 45% and 43% respectively in 2000 and 2006.[13]

16. Member States are being supported to conduct clinical trials of vaccines against meningitis due to meningococcal A, malaria, cholera, TB and HIV/AIDS. These candidate vaccines, most of them of regional importance, are at different stages of development. Member States are also being supported to ensure that the highest international ethical and regulatory standards are adhered to in all clinical trials through various initiatives including the African Vaccine Regulatory Forum (AVAREF).

17. In order to intensify and improve the scope and quality of technical support to countries, the WHO Regional Office for Africa established the Task Force on Immunization (TFI) which serves as its principal advisory group for the development of policy on vaccines and immunization. In addition, specific working groups[14] have been established to increase the effectiveness of TFI deliberations by reviewing and providing evidence-based information and options for recommendations. Furthermore, the Regional Office established 1009 staff positions, 112 of which are international while 897 are national. Of these positions, 1006 are funded from voluntary contributions and only three are funded through assessed contributions.

18. Despite the significant progress, major challenges remain and should be addressed to improve routine immunization services and achieve polio eradication.

CHALLENGES

19. **Immunization policy and planning:** Although a majority of Member States have written immunization policy, most of the policies are not updated to include recent developments in vaccines and immunization. In addition, national strategic health development planning does not always include immunization as an integral component.

20. **Legislation:** A number of Member States have statutes or public health regulations that can be used to prevent and control outbreaks of vaccine-preventable diseases. Some of the regulations require that parents and guardians present the immunization status of children at school entry. However, these regulations are not being enforced in most Member States, resulting in outbreaks of VPDs in school settings.

21. **District-level planning and strategies:** The low capacity to plan and manage the implementation of the RED approach including strategies for accessing the difficult-to-reach areas is one of the factors contributing to the gaps in immunization coverage. Evaluations carried out in 2002 and 2007 on the RED strategy documented several challenges including inadequate funding and logistics for outreach sessions, vaccine stock-outs and cancelled sessions, insufficient training of

[13] Lyndon P et al. Government financing for health and specific national budget lines: The case of vaccines and immunization. *Vaccine 26 (2008), 6727-6734.*

[14] Polio, Disease control initiatives, Un-immunized children, Immunization financing and Immunization research.

health workers and weak linkages between the health services and communities. Lack of systematic cross-border collaboration and timely sharing of information among Member States has adversely affected the ability to control outbreaks of VPDs.

22. **Financing:** The recent progress in immunization in the African Region was largely due to the availability of international funding and the modest funding by Member States. The predictability of international funding for immunization has often been an issue, hence the need to advocate for long-term domestic financing. With the current levels of national funding for immunization, it would be difficult to sustain the progress in the introduction of new vaccines that are much more expensive than the traditional vaccines, or to scale up vaccine use in the Region. This ultimately compromises immunization service delivery and hence immunization coverage rates.

23. **Inadequate infrastructure:** The poor health infrastructure has had a negative impact on immunization service delivery and consequently immunization coverage. Most of the Member States do not have adequate and optimally decentralized facilities for vaccine cold storage. This has partly hampered the scaling up of the introduction of new vaccines.

24. **Community participation and ownership:** Despite the efforts being made by Member States to bring immunization services closer to communities, the demand for and continued use of immunization services have remained low. This has been due partly to inadequate awareness of the benefits of immunization and lack of community ownership of immunization programmes.

25. **Delivery of Immunization services:** The achievement of a high level population immunity is dependent on high routine immunization coverage and the provision of additional doses of vaccines during SIAs for polio eradication and elimination and the control of other VPDs. In particular, despite national political commitment, substantial numbers of children continue to be missed during the polio SIAs largely because of failure to translate the high-level commitment into action and accountability at operational level.

26. **Monitoring and evaluation:** Availability of accurate and relevant data is crucial to estimating the target population for immunization sessions and monitoring the progress towards the set targets and goals. In some Member States, the population denominators are unreliable and the quality of data suboptimal. This has resulted in the production of inaccurate administrative immunization coverage and incorrect forecast of the supply of vaccines and ancillary items.

27. **Surveillance of vaccine-preventable diseases:** In spite of the progress made in meeting VPD surveillance indicators at the national level, there are still significant gaps at the subnational level. This has contributed to missed or delayed detection of VPD outbreaks. While the VPD surveillance system is relatively functional, the IDSR strategy that was established to encompass all surveillance systems has yet to be scaled up in all Member States.

28. **Immunization research:** Operational research is crucial to discerning various implementation issues related to vaccination against common infectious diseases. Currently there is limited operational research on immunization in the African Region. This has led to poor understanding of the shortcomings in immunization delivery, hindering optimal implementation of immunization activities. In addition, research and development of new vaccines in Member States is hindered by weak infrastructure, lack of prioritization, limited expertise, weak ethical and regulatory oversight and inadequate funding.

RECOMMENDATIONS

29. **Integrating immunization into national health policy and health systems strengthening:** Integrate immunization policy into national health development policy and strategic plans, with immunization interventions quantified, costed, and incorporated in the various components of national health systems strengthening. These components include financing, human resources, procurement and supply management, service delivery, infrastructure including cold chain capacity, information systems, monitoring and evaluation.

30. **Increasing immunization financing:** Build on the effort to establish national budget lines for immunization by ensuring that adequate funds are allocated and actually disbursed for routine immunization and polio eradication initiatives. In addition, countries should effectively utilize and manage existing national and external resources. The need for additional resources to achieve the "last push" and increase immunization coverage from 85% to 90% and beyond, probably with higher marginal costs, should be strongly emphasized.

31. **Fostering partnership for immunization:** Undertake advocacy and mobilize other sectors, leaders and communities to rally behind the goals of polio eradication and high immunization coverage in the African Region. Partnership for immunization should be broadened to reflect other Regional initiatives such as Harmonization for Health in Africa (HHA).

32. **Improving access to new vaccines:** Intensify advocacy for reducing the prices of new vaccines. Furthermore, communication mechanisms should be established among Member States to enable the two Representatives of the African Region on the GAVI board to voice the opinions and views of the Region in international forums.

33. **Enhancing institutional, human resource and managerial capacity:** Improve the capacity of immunization programmes and related structures to develop strategies and plans and ensure implementation, monitoring and evaluation. Adequate staff with the range of disciplines and required skills and appropriate institutional arrangements should be put in place. The capacity to plan and manage at district and subdistrict levels should be prioritized with a view to improving and sustaining high immunization coverage levels (90% coverage at national level and at least 80% in all districts) through the provision of optimal routine immunization services and implementation of high-quality SIAs including cross-border activities.

34. **Broadening community awareness, participation and ownership:** Intensify social mobilization and ensure that health promotion interventions are adequately covered and fully implemented in the comprehensive multi-year plans (cMYPs) for immunization, to engage communities and increase demand for immunization services. Effective links between immunization services and communities should be established and/or strengthened.

35. **Strengthening monitoring and evaluation:** Develop methods for accurate estimation of target populations for planning and monitoring purposes and provide timely annual estimates of the working population. Member States should strengthen their vital registration systems to record all childbirths. Systems for the monitoring and evaluation of immunization programmes and services should be strengthened. Furthermore, immunization coverage surveys should be regularly conducted in order to validate administrative immunization data. Information generated from monitoring

systems and surveys should be widely shared and used for advocacy and for programme and service improvement.

36. **Strengthening surveillance of VPDs:** Achieve and sustain VPD surveillance indicators at all levels by ensuring active surveillance and at least monthly supportive supervision at the operational level. In addition, monthly feedback should be instituted as part of monitoring and evaluation of the programme at all levels. Member States are urged to scale up the implementation of integrated disease surveillance to all districts, including adapting and disseminating the revised IDSR guidelines.

37. **Strengthening immunization research:** Ensure full implementation of the Algiers Declaration[15] and the Bamako Call to Action on research for health in the African Region[16] as a means to enhance understanding of and refine strategies for improved immunization service delivery. Furthermore, countries should promote and increase their involvement in vaccine research for VPDs and other priority diseases such as malaria, tuberculosis and HIV. Member States and partners should explore the possibility of local production of vaccines in the African Region as vaccines would be continuously needed.

38. **Institutionalizing an annual African Immunization Week:** Institute annual commemoration of an African Immunization Week as a means of sustaining advocacy and improving the delivery and uptake of immunization services.

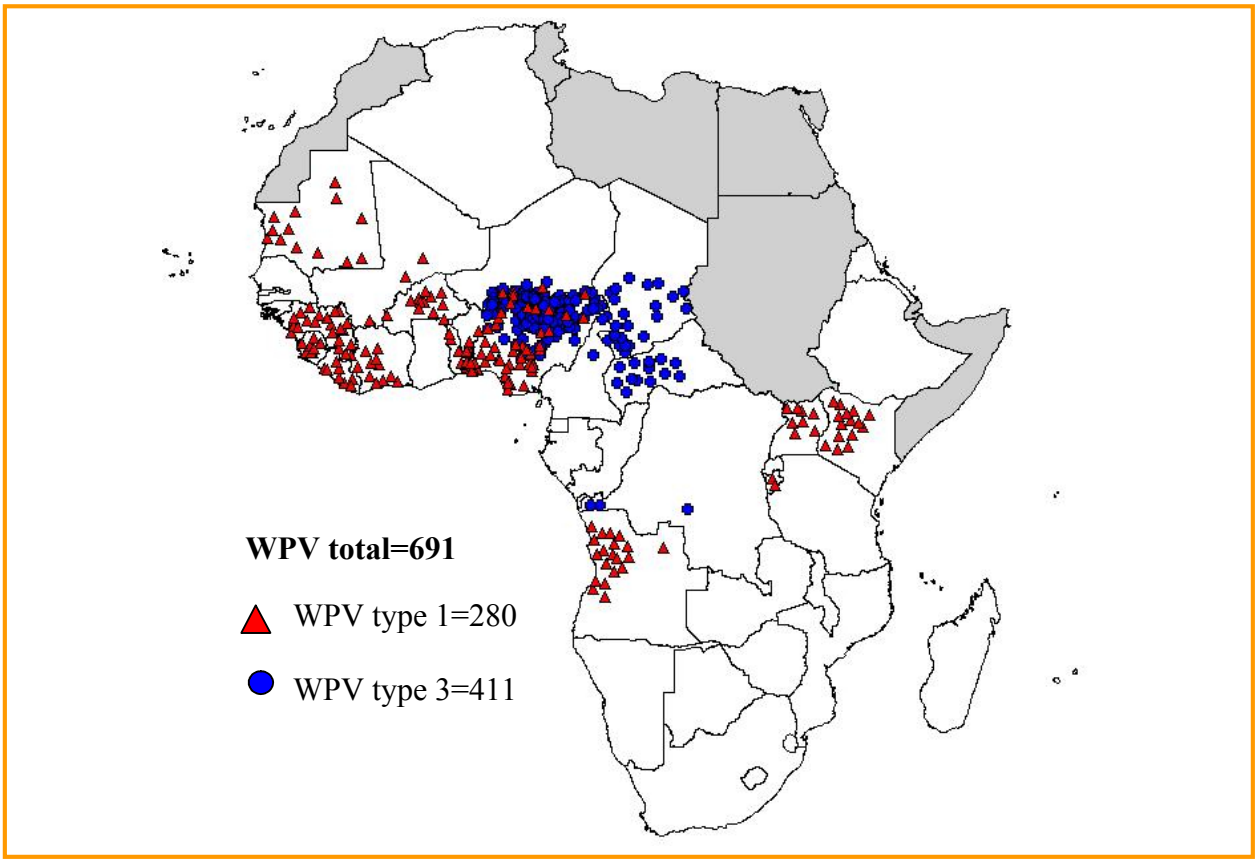
39. The Regional Committee is invited to note the progress made in immunization and adopt the recommendations.

[15] The Algiers Declaration: Ministerial Conference on Research for Health in the African Region – Narrowing the Knowledge gap to improve Africa's Health, Algiers, 23–26 June 2008.

[16] Bamako Call to Action Research for Health, Global Ministerial Forum on Research for Health, Bamako, 16–19 November 2008. Available at www.who.int/rpc/news/BAMAKOCALLTOACTIONFinalNov24.pdf

ANNEX 1

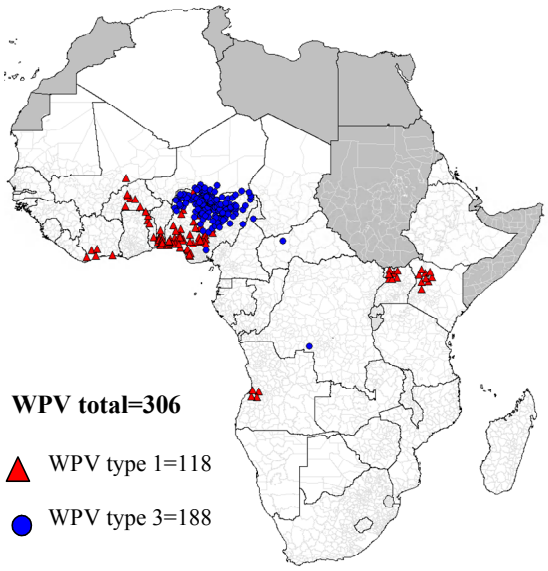
Map 1: Wild Poliovirus (WPV) cases reported in the African Region, January – December 2009



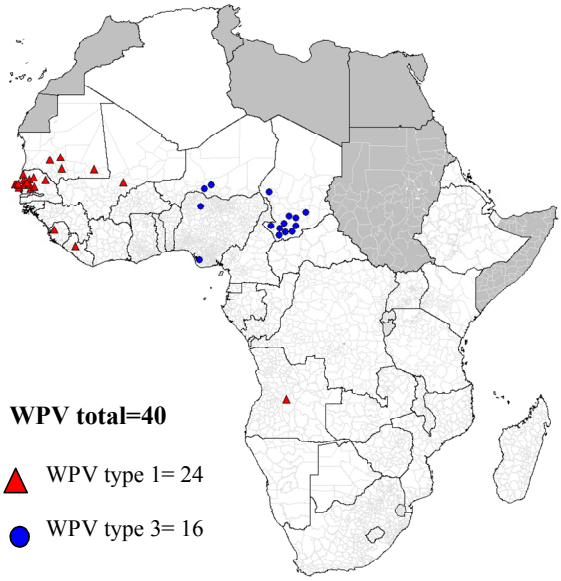
ANNEX 2

**Wild Poliovirus (WPV) cases reported in the African Region,
January – end of April 2009 and 2010**

Map 2: 2009 WPV



Map 3: 2010 WPV



ANNEX 3

Table 1: 2008-2009 DPT3 and measles-containing vaccine-1 (MCV1) reported administrative coverage

Country	2008		2009	
	DPT3	Measles Containing Vaccine-1	DPT3	Measles Containing Vaccine-1
	*Administrative coverage**	*Administrative coverage**	*Administrative coverage**	*Administrative coverage**
Algeria	93%	88%	94%	91%
Angola	81%	79%	73%	77%
Benin	93%	89%	98%	95%
Botswana	93%	91%	96%	93%
Burkina Faso	100%	101%	103%	99%
Burundi	92%	84%	104%	99%
Cameroon	84%	80%	80%	75%
Cape Verde	82%	77%	74%	72%
Central Africa Rep.	51%	53%	76%	94%
Chad	49%	54%	75%	87%
Comoros	81%	77%	83%	79%
Congo	89%	79%	91%	76%
Côte d'Ivoire	74%	63%	81%	67%
D.R. Congo	83%	77%	92%	86%
Equatorial Guinea	74%	76%	74%	77%
Eritrea	68%	80%	85%	80%
Ethiopia	81%	74%	79%	75%
Gabon	82%	67%	76%	63%
Ghana	93%	86%	94%	94%
Guinea	84%	90%	85%	87%
Guinea-Bissau	27%	64%	82%	79%
Kenya	71%	90%	75%	74%
Lesotho	91%	80%	72%	70%
Liberia	92%	95%	93%	96%
Madagascar	88%	91%	89%	85%
Malawi	91%	88%	93%	92%
Mali	100%	97%	89%	86%
Mauritania	74%	65%	67%	62%
Mauritius	95%	98%	93%	93%
Mozambique	80%	85%	93%	90%
Namibia	81%	72%	80%	74%
Niger	89%	80%	93%	87%
Nigeria	78%	68%	79%	90%
Rwanda	97%	92%	90%	93%
Senegal	88%	77%	86%	79%
Seychelles	100%	100%	99%	94%
Sierra Leone	87%	88%	94%	96%
South Africa	98%	85%	90%	90%
Sao Tome & Principe	99%	93%	98%	90%
Swaziland	81%	69%	72%	72%
Tanzania	84%	88%	85%	91%
The Gambia	96%	87%	98%	96%
Togo	89%	77%	89%	84%
Uganda	64%	77%	83%	80%
Zambia	95%	89%	98%	92%
Zimbabwe	75%	70%	73%	76%
Regional coverage	**82%**	**81%**	**85%**	**85%**

* Source : MOH-UNICEF-WHO Joint Report Form (JRF) 2008 and 2009

ADDENDUM 1

Update on measles in the African Region

Background

1. The African Region has adopted the WHO/UNICEF strategies for measles mortality reduction including increasing routine immunization coverage; providing a second opportunity for measles vaccination through catch-up and follow-up Supplementaly Immunization Activities (SIAs);[17] establishing case-based surveillance with laboratory confirmation; and improving case management.

2. Between 2001 and 2009, with the financial and technical support of the Measles Initiative,[18] major achievements were made in implementing these strategies in the African Region. In 2009, according to the WHO/UNICEF coverage estimates for the first dose measles vaccine, 14 countries achieved measles coverage of 90% or more,[19] compared to only three countries in 2001. In addition, 425 million children were vaccinated through Supplemental Immunization Activities (SIAs) between 2001 and 2009 in 43 Member States.[20] Out of the 124 SIAs conducted over this period, 73 attained administrative coverage of 95% or more, while coverage of 23 SIAs was below 90%.

3. With the implementation of these strategies, the African Region achieved a remarkable 92% reduction in estimated measles deaths between 2000 and 2008. As a result, the Region achieved ahead of schedule the 90% measles mortality reduction goal set for 2010.[21]

4. Following the significant reduction in measles deaths in the Region, the African Regional Measles Technical Advisory Group (TAG) reviewed the progress and proposed the adoption of a measles pre-elimination goal to be met by 2012. The proposal was endorsed by the African Regional Task Force for Immunization in December 2008. In 2009, the Fifty-ninth session of the Regional Committee discussed and adopted a regional goal of measles elimination by 2020 (Document AFR/RC59/14), with the 2012 pre-elimination interim goal considered as a stepping stone.

5. The pre-elimination goal consists of the following targets: (a) achieving >98% mortality reduction by 2012 compared to 2000 estimates; (b) achieving measles incidence <5 cases per million population per year in all countries; (c) >90% achieving routine first dose measles vaccination coverage of at least 90% at national level and at least 80% in all districts; (d) achieving 95% or more SIA coverage in all districts; (e) and all countries meeting the targets for the two main surveillance performance indicators. The attainment of the pre-elimination goal by 2012 will bring the African Region closer to adopting an elimination goal.

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17 Nationwide *catch-up* SIAs target all children in a particular age group (most frequently children aged nine months to 14 years) and have the goal of eliminating susceptibility to measles in the general population. Periodic *follow-up* SIAs target all children born since the last SIA. *Follow-up* SIAs are generally conducted nationwide every two-to-four years and target children aged 9 to 59 months, with the goal of eliminating any measles susceptibility that has developed in recent birth cohorts as well as protecting children who did not respond to their first measles vaccination.

18 The Measles Initiative, initially set up by WHO, UNICEF, CDC, American Red Cross and UN Foundation, now includes a number of other global partners committed to providing financial and technical support to Member States in the control of measles. In the African Region, from 2001 to 2008, the Measles Initiative provided approximately US$ 400 million in support of the measles control strategies.

19 http://apps.who.int/immunization_monitoring/en/globalsummary/timeseries/tswucoveragemcv.htm.

20 All countries in the African Region except Algeria, Mauritius and Seychelles.

21 Global reductions in measles mortality 2000–2008 and the risk of measles resurgence. WER. 4 December 2009, vol. 84, 49.

Challenge to large-scale measles outbreak

6. **Continued large-scale and high incidence of measles outbreak in some countries:** In 2009, 16 countries had measles incidence levels of more than 10 cases per million population. Between June 2009 and July 2010, 28 countries in the Region experienced measles outbreaks with a cumulative total of >80 000 reported cases and >1100 reported measles deaths (see Table 2).

7. **Immunity gaps due to suboptimal routine immunization and SIA coverage:** Epidemiological investigations and review of programmatic data in countries experiencing outbreaks indicates that the outbreaks occurred because of immunity gaps resulting from suboptimal routine immunization and SIA coverage at national and subnational levels.

8. **Inadequate access to routine immunization services:** Although Member States have made considerable progress in improving routine immunization coverage, WHO/UNICEF estimates for measles vaccine coverage show that 20 countries in 2008 and 18 countries in 2009 had measles vaccination coverage of less than 80%. Some aspects of the Reaching Every District (RED) approach to strengthening immunization coverage, such as the supportive supervision and outreach services, remain largely under-funded and therefore inadequately implemented. The lack of financing leads to implementation gaps including services not reaching hard-to-reach populations. Health service providers still miss some opportunities for measles vaccination of eligible children in areas accessible for service delivery in many countries.

9. **Suboptimal SIAs coverage:** Eighteen of the 28 countries that reported outbreaks of measles between June 2009 and June 2010 had had their most recent follow-up measles SIAs in the preceding 24 months. These SIAs were obviously unable to provide the herd immunity needed to avert outbreaks. In Lesotho, South Africa and Zambia, the interval between follow-up SIAs was four years, leading to the accumulation of susceptibles and subsequent measles outbreaks.

10. **Gaps in resource mobilization:** Major gaps persist in the mobilization of resources to finance the implementation of proven measles mortality reduction strategies. Because of the success of the measles control efforts, there has been a decrease in political and financial commitment to measles control on the part of countries and donors. Member States have not all been able to allocate or raise the resources needed to implement routine immunization activities and conduct high-quality measles SIAs, contributing to gaps in implementation and coverage.

11. Since 2007, donor support to the Measles Initiative has declined by almost two thirds and the responsibility for funding regular follow-up measles SIAs is being put on national governments and local partners. These resource gaps have had a negative impact on the ability of Member States to attain or sustain high routine immunization and SIA coverage levels.

Actions proposed

Member States

12. **Attain higher level of routine immunization coverage and implement high-quality measles SIAs:** Member States should allocate resources in a timely manner for adequate implementation of proven strategies in order to avoid resurgence of measles and preserve mortality reduction gains from the last decade. Adequate financing of routine immunization activities including the Reaching Every

District (RED) approach, Child Health Weeks or similar activities involving periodic intensification of routine immunization will be important to minimize coverage disparities between districts and sustain the high coverage attained through SIAs.

13. **Allocate adequate funding:** Member States should allocate adequate funding to strengthening immunization systems and implementing preventive strategies (routine immunization and periodic supplemental immunization activities) in preference to reactive funding of outbreak response actions.

14. **Raise the level of financing:** Member States should raise financing for periodic SIAs as a complementary strategy to achieve uniform SIA coverage of 95% in all districts in order to maintain low disease incidence levels and avoid outbreaks, given that SIAs provide a crucial second opportunity to reach marginalized and hard-to-reach populations.

15. **Improve the quality of surveillance and conduct detailed investigation of measles outbreaks:** Member States are requested to make the necessary investment in strengthening disease surveillance and building capacity for outbreak investigation and response. High-quality surveillance and detailed outbreak investigation enhances understanding of epidemiological changes and the underlying programmatic factors, thus fostering adequate and timely response to measles outbreaks.

16. **National ownership and active engagement in measles pre-elimination strategies:** Countries should provide the leadership, allocate the necessary human and financial resources, and facilitate the coordination of partners in support of national plans to fully implement the proposed operational strategies for the attainment of the measles pre-elimination goal by 2012.

Partners

17. The Measles Initiative and other global partners are requested to continue mobilizing the necessary resources to support Member States in addressing challenges and scaling up the implementation of strategies to attain the regional measles pre-elimination goal by 2012 and the expected measles elimination goal by 2020.

Table 2: Countries in the African Region that have experienced large-scale outbreaks in 2009–2010 (data as of 20 July 2010)

Country	Confirmed measles cases nationwide	Reported deaths	Outbreak response vaccination activities	Source of financial support for outbreak response
Benin	180	3	Limited selective vaccination conducted in affected areas	Government funding
Botswana	984	0	Limited response vaccination activities conducted	Government funding
Burkina Faso	327	25		89% of confirmed measles cases are not vaccinated. 66% of confirmed measles cases are from districts not involved in the 2009 measles outbreak response
Burundi	298	0	response vaccination conducted in the two affected provinces (Bujumbura, Mairie and Rural) targeting all children between nine months and 14 years	Government funding
Cameroon	426	5	83 433 children aged 9–59 months reached in Kousseri and Yagoua districts	Government funding
Côte d'Ivoire	347	6		
Chad	9428	108	Vaccination response carried out in N'Djamena in March 2010 targeting 9–59 months, and in Ouaddai in May targeting persons aged nine month to 14 years to a total of 973 359 persons.	
Ethiopia *	2726	24	961 798 children aged 6–59 months were reached through response vaccination activities in Southern nations Region	Government funding
Guinea	351	2		
Lesotho	1166	35	Preparing to conduct nationwide measles SIAs in September 2010	CERF support
Liberia	1225	89	Measles outbreak response vaccination conducted nationwide and integrated with polio immunization.	Government funding
Malawi	34 841	133	District-wide vaccination response SIAs already conducted in heavily affected districts; preparing for a nationwide large-scale follow up SIAs to be carried out from 9 – 13August 2010 targeting children aged nine months to 14 years	MSF financed the limited response; Government funding for the nationwide response
Mali	858	5	Selective vaccination response conducted in affected districts	MSF support
Mauritania	500	9		

Mozambique	262	0	Limited vaccination activities conducted (eg., at a police training centre in Maputo province)	
Namibia*	3034	58	Large-scale vaccination response activities conducted in late 2009	Government funding
Niger	197	3	District-wide vaccination response SIAs already conducted in heavily affected districts targeting a population of 79 000	MSF support
Nigeria	4014	39	Selective vaccination response conducted in affected districts	Government funding
Senegal	369	0	Response vaccination targeting children 6–59 months conducted in 46 districts (85% coverage)	Government funding
Sierra Leone	78	1		
South Africa*	16 028	18	Conducted nationwide measles SIAs reaching 11 821 695 children aged nine months to 14 years (79% of the target)	Government funding
Swaziland	609	2	Considering a nationwide response targeting children aged six months to 14 years	Yet to mobilise resources
Togo	168	0	Outbreak response vaccination organized in areas affected by the measles outbreaks reaching 900 children aged six months to five years in different locations.	
Zambia	5670	90	Selective vaccination activities conducted in Lusaka where 77% cases were reported; nationwide follow up measles SIAs conducted from 19 – 27 July 2010 targeting 1 713 161 children aged 9 to 47 months.	Government funding
Zimbabwe	8708	517	Nationwide measles SIAs carried out reaching 4 912 375 children aged six months to 14 years (97% coverage of target)	CERF support

* Data from outbreaks that started in 2009.

NB: Other countries with outbreaks of lesser magnitude include Angola, Central African Republic, Congo, Democratic Republic of the Congo, Kenya, Rwanda, Tanzania, etc.

ADDENDUM 2

Update on polio eradication in the African Region

Current status:

1. Between 1 January and 6 August 2010, a total of 75 wild poliovirus cases (WPVs) were reported in 10 countries[22] in the African Region, compared to 545 cases in 15 countries[23] for the same period in 2009 (Figure 1). This marked drop in the total number of WPV cases is attributable to the 98% reduction of cases confirmed in Nigeria (6 cases) as at 6 August 2010 compared to 372 over the same period in 2009.

2. In countries where poliovirus transmission has been re-established (Angola, Chad and Democratic Republic of the Congo - DRC), there was a spread of wild poliovirus within Angola resulting in a total of 19 wild poliovirus cases as at 6 August 2010 compared to 18 over the same period in 2009, all of type 1. Wild poliovirus linked to the transmission in Angola has further spread into DRC, so far resulting in six cases. The outbreak that escalated in Chad in the second half of 2009 continued into the first half of 2010 and has resulted in 14 WPV cases (all type 3) as at 6 August compared to 13 cases in the same period in 2009.

3. Out of the 14[24] outbreak countries that reported wild polioviruses in 2009, only five countries namely Liberia, Mali, Mauritania, Niger and Sierra Leone have reported wild poliovirus cases in 2010. Senegal reported wild poliovirus cases starting in 2010.

4. Circulating vaccine-derived poliovirus cases (cVDPVs) were reported in Nigeria (154), DR Congo (4) and Guinea (1) in 2009. This number has dropped significantly to only 9 so far in Nigeria, 3 in DRC and 5 in Ethiopia. The main predisposing factor to cVDPV transmission is the persistently low routine immunization coverage.

Activities to interrupt transmission:

5. The 63rd World Health Assembly adopted the Global Polio Eradication Initiative Strategic Plan 2010–2012[25] that was developed taking into account the outcomes of the 2009 programme of work and the recommendations of the Independent Evaluation carried out in September 2009, combined with the core eradication strategies.

6. At least two rounds of supplemental immunization activities have been implemented in a synchronized manner in 19 countries in West and Central Africa this year. Two or more additional rounds and mop-up activities have been implemented in priority countries including Angola and DRC.

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[22] Angola, Chad, DR Congo, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal and Sierra Leone.
[23] Angola, Benin, Burkina Faso, Central African Republic, Chad, Cote d'Ivoire, DR Congo, Guinea, Kenya, Liberia, Mali, Niger, Sierra Leone, Togo and Uganda.
[24] Benin, Burkina Faso, Burundi, Central African Republic, Côte d'Ivoire, Guinea, Kenya, Liberia, Mali, Mauritania, Niger, Sierra Leone, Togo and Uganda.
[25] www.polioeradication.org.

7. Independent monitoring of the supplemental immunization activities has been instituted in all the countries and has shown a gradual reduction in the number of children missed. However, in some areas, unvaccinated children are clustered in numbers that have facilitated the continued transmission of wild poliovirus.

Surveillance of acute flaccid paralysis:

8. Surveillance indicators monitored on a weekly basis show that as at 6 August 2010, 16[26] out of the 46 Member States compared to 10[27] in the same period in 2009, have not met either or both of the operational surveillance indicators. Corrective measures are being taken through desk reviews, peer reviews and external surveillance reviews to identify areas on which attention should be focused.

Monitoring global eradication milestones 2010 to 2012:

9. Milestones have been outlined in the Global Polio Eradication Initiative plan 2010–2012 and will be monitored by a new independent advisory body. In the African Region, however, monitoring and feedback are carried out on a monthly basis. The status as at end of June 2010 is summarized below:

Milestone 1:

Cessation of all polio outbreaks with onset in 2009 by mid 2010, validated after confirmation that at least six months have passed without a WPV case linked to the 2009 importation.

Status:

- Out of the 12 outbreak countries[28] that had not stopped transmission by the end of December 2009, seven countries namely Benin, Burundi, Burkina Faso, Central African Republic, Cote d'Ivoire, Guinea and Kenya have not reported any wild poliovirus between 1 January and 31 July 2010.
- The remaining five countries namely Liberia, Mali, Mauritania, Niger and Sierra Leone have reported confirmed wild poliovirus cases in 2010.
- Senegal, the only new outbreak country in 2010, has reported a total of 18 wild poliovirus cases with the last case having a date of onset of 30 April 2010.

[26] Algeria, Benin, Botswana, Burundi, Cote d'Ivoire, Equatorial Guinea, Guinea, Guinea Bissau, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Senegal and South Africa.
[27] Algeria, Botswana, Cameroon, Guinea-Bissau, Madagascar, Malawi, Mauritius, Mozambique, South Africa, Zimbabwe.
[28] Benin, Burkina Faso, Burundi, Central African Republic, Côte d'Ivoire, Guinea, Kenya, Liberia, Mali, Mauritania, Niger, Sierra Leone.

Milestone 2:

Cessation of all 're-established' poliovirus transmission by end 2010, validated when at least 12 months have passed without a WPV case linked to the previously circulating virus.

Status:

Three countries in the African Region (Angola, Chad and DRC), fall into the category of this milestone

- Viruses reported in Angola (latest date of onset of WPV:2 July 2010) and Chad (latest date of onset of WPV:10 May 2010) are still linked to the previously ongoing transmission.
- DRC has reported a new importation of wild poliovirus resulting in six cases (date of onset of last case:11 July 2010) linked to transmission in the Chitato district of Angola. Prior to that, the last WPV in DR Congo linked to transmission being monitored dated back to 24 June 2009.

Milestone 3:

Cessation of all polio transmission in at least two of the four endemic countries by end 2011, validated when at least 12 months have passed without a WPV case linked to indigenous transmission.

Status:

Only Nigeria falls in this category in the African Region and is targeted to be one of the two countries to achieve the milestone by end of 2011. The last wild poliovirus reported had onset of 18 June 2010.

Actions proposed:

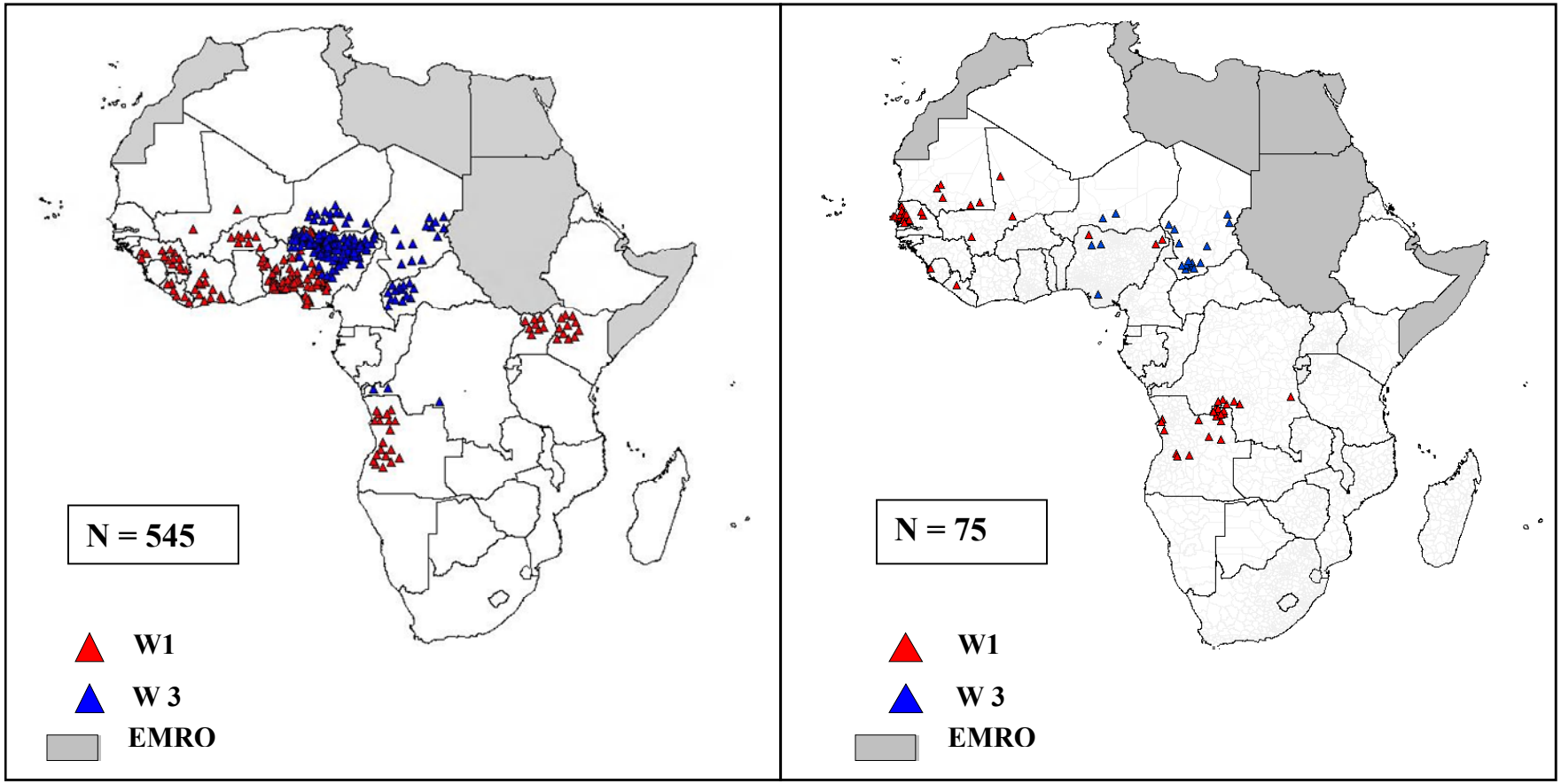
10. Member States are urged to mobilize local leaders and administrators to take ownership of polio eradication activities and be accountable for the results as a means of translating the commitment demonstrated at the highest government levels into concrete action at the operational level.

11. In order to ensure that wild poliovirus transmission is not missed, Member States should provide adequate resources for active search for acute flaccid paralysis cases (AFP), the quarterly monitoring and evaluation meetings as well as the essential recurrent capacity building.

12. As part of strengthening the health system to deliver the routine immunization services necessary for achieving and sustaining polio eradication, Member States should provide adequate cold chain capacity for vaccine storage, appropriate transport logistics for outreach immunization services and carry out regular capacity building in the light of the high staff attrition rates.

13. Member States should allocate more financial resources and mobilize additional resources among in-country partners including the private sector for implementation of polio supplemental immunization activities (SIAs).

Figure 1. Distribution of WPV in the African Region – 2009 and 2010 as at 6 August, 2010



AFR/RC60/WP/4
4 August 2010

DRAFT RESOLUTION

CURRENT STATUS OF ROUTINE IMMUNIZATION AND POLIO ERADICATION IN THE AFRICAN REGION: CHALLENGES AND RECOMMENDATIONS

The Regional Committee,

Having carefully examined the progress report of the Regional Director on the current status of routine immunization and polio eradication activities in the African Region;

Recognizing that, although there was quite substantial progress in improving routine immunization coverage in the African Region during the period 2006–2009, a significantly high number of children are still missed every year and need to be vaccinated if the agreed regional and global targets are to be met;

Concerned that there are substantial disparities within and between countries despite the improved overall regional immunization coverage;

Further concerned that the current levels of national budgetary allocation to immunization can not sustain the progress made in the introduction and scaling up of new vaccines which are more expensive than the traditional vaccines;

Aware that the recent gains in polio eradication and measles control are fragile as evidenced by the recent polio and measles outbreaks and are being jeopardized by suboptimal routine immunization coverage at district level and the significant number of children not reached during supplementary immunization activities in countries;

Mindful that access to and utilization of immunization services can be improved through the full implementation of the Reaching Every District (RED) approach and other innovative strategies;

Emphasizing the need for all countries to strive towards achieving the internationally-agreed Millennium Development Goal 4, namely to reduce under-five mortality by two thirds by 2015;

Reaffirming its commitments to implementing various resolutions and decisions on the Expanded Programme on Immunization (EPI) in recent years including resolutions AFR/RC42/R4, AFR/RC43/R8, AFR/RC44/R7, AFR/RC45/R5, AFR/RC52/R2, AFR/RC56/R1 and AFR/RC59/14;

1. ADOPTS the Report of the Regional Director (Document AFR/RC60/14) and its proposed actions aimed at strengthening routine immunization and polio eradication activities in the African Region;

2. URGES Member States:

(a) to integrate immunization into national health development policy and plans and health systems strengthening with immunization interventions quantified and costed;

(b) to increase immunization financing by ensuring that funds are allocated and disbursed in adequate amounts for routine immunization, polio eradication and measles control;

(c) to increase institutional, human resource and management capacity to deliver immunization services especially at subnational levels;

(d) to improve the quality of supplementary and routine immunization activities through detailed microplanning; provision of adequate human, financial and material resources; and utilization of lessons learnt from independent monitoring;

(e) to intensify and expand social mobilization activities in order to increase community awareness, participation and ownership;

(f) to strengthen vaccine-preventable diseases surveillance at all levels by ensuring active surveillance and at least monthly supportive supervision at the operational level as well as improving monitoring and evaluation;

(g) to strengthen immunization research in order to increase understanding of immunization service delivery and define strategies for its improvement;

(h) to institutionalize an annual African Vaccination Week for sustaining advocacy, expanding community participation and improving immunization service delivery;

3. REQUESTS the Regional Director:

(a) to continue to monitor the implementation of accelerated disease control initiatives with particular emphasis on polio eradication, to control measles and to strengthen routine immunization systems;

(b) to advocate and foster continued collaboration with international and multilateral agencies, donor organizations and EPI partners to rally behind the goals of polio eradication and routine immunization in Africa;

(c) to provide technical support to Member States and liaise with regional economic communities for the implementation of an annual African Vaccination Week;

(d) to report on progress to the Sixty-first session of the Regional Committee and on a regular basis thereafter.