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REGIONAL STRATEGIC PLAN FOR IMMUNIZATION 2014–2020

Report of the Secretariat

EXECUTIVE SUMMARY

1. Immunization is considered as one of the most cost-effective public health interventions. Regional coverage with three doses of Diphtheria-Tetanus-Pertussis containing vaccine and the first dose of Measles Containing Vaccine were maintained around 70% during the last three years. There has been an estimated 88% reduction in measles mortality since 2000 and only one country in the Region remains endemic for wild poliovirus.
2. External evaluation of the 2009–2013 Regional Immunization Strategic Plan revealed challenges that hinder access and utilization of immunization services. These include gaps in organization, coordination and management of immunization activities, inadequacy of vaccines and cold storage capacity, limited service delivery points, and inappropriate communication strategies resulting in low community awareness and participation.
3. One of the significant developments in the field of immunization is the Global Vaccine Action Plan that needs implementation in the Region. The Regional Immunization Strategic Plan 2014–2020 is intended to address the identified challenges by providing policy and programmatic guidance to Member States within a strong national health system and also during humanitarian emergencies.
4. The key approaches include integrating immunization into national health policy and plan and during emergencies, strengthening financing, enhancing partnerships, building national capacity, improving monitoring and data quality, improving vaccine management, safety and regulation and promoting implementation, research and innovations.
5. The Regional Committee is invited to review the Regional Immunization Strategic Plan 2014–2020 and endorse the actions proposed and the related resolution.

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INTRODUCTION

1. Immunization is considered as one of the most cost-effective public health interventions. Globally, an estimated 2.5 million child deaths and 600 000 adult deaths are prevented annually through immunization.

2. In 2010, the Sixtieth WHO Regional Committee for Africa adopted a resolution,¹ urging Member States to integrate immunization into national health development policy and plans, and to increase financing. The Regional Committee has also institutionalized an annual African Vaccination Week for sustaining advocacy, expanding community participation and improving service delivery.

3. In 2011, the Sixty-first session of the Regional Committee adopted a resolution² for measles elimination by 2020. The resolution urged Member States to provide adequate resources for the implementation of national plans to sustain the gains in measles mortality reduction.

4. In 2012, the Sixty-fifth World Health Assembly endorsed the Global Vaccine Action Plan (GVAP).³ The GVAP is a strategic framework that aims to realize the full potential of immunization during the Decade of Vaccines 2011–2020. It commits Member States to develop the immunization component of their national health strategy and plans, and allocate adequate resources to achieve the immunization goals.

5. Subsequently, in May 2013, the Sixty-sixth World Health Assembly discussed the Polio Eradication and Endgame Strategic Plan, 2013–2018. This plan has four main objectives: (a) detection and interruption of any poliovirus transmission; (b) strengthening of immunization systems and withdrawal of Oral Polio Vaccine; (c) containment of all polioviruses and certification; and (d) development of a comprehensive legacy plan.

6. In June 2013, an external evaluation of the 2009–2013 Immunization Strategic Plan reported that there has been substantial progress especially a significant decrease in the number of wild poliovirus (WPV)⁴ cases and prompt massive introduction of conjugate meningococcal A meningitis vaccine (MenAfriVac[®]) in the African meningitis belt, with a considerable impact on the annual meningitis epidemics and a significant reduction of measles mortality.

7. However, several challenges were identified, including inadequacy and sustainability of financing, weakness of the health workforce and limited access to service delivery. In addition, interventions were not implemented at full scale; procurement and supply chain systems were weak, community engagement was low in addition to weak surveillance of vaccine-preventable diseases.

¹ Resolution AFR/RC60/R4, Current status of routine immunization and polio eradication in the African Region: challenges and recommendations. In: *Sixtieth session of the WHO Regional Committee for Africa, Malabo, Equatorial Guinea, 30 August–3 September 2010, Final report*, Brazzaville, World Health Organization, Regional Office for Africa, 2010 (AFR/RC60/21) pp.14–17.

² Resolution AFR/RC61/R1, Measles elimination by 2020: a strategy for the African Region. In: *Sixty-first session of the WHO Regional Committee for Africa, Yamoussoukro, Cote d'Ivoire, 29 August–2 September 2011, Final report*, Brazzaville, World Health Organization, Regional Office for Africa, 2011 (AFR/RC61/14) pp.7-8.

³ Resolution WHA65.17, Global Vaccine Action Plan.

⁴ 274 WPV cases were reported in 2013 compared with 691 in 2009.

SITUATION ANALYSIS AND JUSTIFICATION

Situation analysis:

8. Immunization coverage with three doses of Diphtheria-Tetanus-Pertussis containing vaccine (DTP3)⁵ and the first dose of Measles Containing Vaccine (MCV1)¹ for the Region has plateaued at around 70% in the past three years. Twenty-three⁶ of the 31 countries at risk of yellow fever introduced the vaccine, with four countries⁷ attaining 90% coverage in 2012.

9. Additional vaccines were introduced into national immunization schedules. All countries but one had introduced hepatitis B vaccine and *Haemophilus influenzae* type b vaccine as of December 2013. However, there has been a slow pace of introduction of other new vaccines: pneumococcal conjugate vaccines (PCV) and rotavirus vaccines were introduced by 29⁸ and 15⁹ countries respectively while human papilloma virus (HPV) vaccine has been introduced only in Lesotho, Rwanda and South Africa.

10. More than 150 million people in 12 countries¹⁰ have been vaccinated with MenAfriVac[®] in campaigns since 2010, and no confirmed case of meningitis A has been identified among the vaccinated populations.¹¹ In 2013, a total of 87.8 million children received measles vaccination through Supplementary Immunization Activities (SIAs) in 16 countries.¹² Four¹³ of these 16 countries conducted their follow-up SIAs using Measles-Rubella vaccine targeting children from 9 months to 14 years of age, thus pioneering the introduction of rubella vaccine in the Region. Through these efforts, the African Region achieved 88% reduction in estimated measles deaths between 2000 and 2012.¹⁴ The elimination of maternal and neonatal tetanus was also validated in 30 countries¹⁵ as of December 2013.

11. There has been a significant decrease in the number of wild poliovirus cases (WPV) in the Region. Furthermore, 128 WPV cases were reported in 2012 compared with 691 in 2009. Nigeria, the only country still endemic in the Region recorded nearly 70% reduction of confirmed WPV cases between 2009 (388 cases) and 2012 (122 cases). In 2013, Cameroon, Ethiopia and Kenya experienced outbreaks following an increase in importation of WPV1. The outbreaks in Cameroon and Ethiopia have persisted into 2014, and as of April 2014, a fourth country i.e. Equatorial Guinea had also confirmed polio outbreak following WPV importation.

⁵ WHO-UNICEF national immunization coverage estimates.

⁶ Angola, Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Mali, Niger, Nigeria, Sao Tome and Principe, Senegal, Sierra Leone and Togo.

⁷ Côte d'Ivoire, Gambia, Ghana and Sao Tome and Principe.

⁸ PCV: Angola, Benin, Botswana, Burundi, Burkina Faso, Cameroon, Central African Republic, Congo, Democratic Republic of Congo, Ethiopia, Gambia, Ghana, Kenya, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Rwanda, Sao Tome and Principe, Senegal, Sierra Leone, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.

⁹ Rotavirus vaccines: Botswana, Burkina Faso, Burundi, Cameroon, Congo, Ethiopia, Gambia, Ghana, Malawi, Mali, Rwanda, Sierra Leone, South Africa, Tanzania and Zambia.

¹⁰ Benin, Burkina Faso, Cameroon, Chad, Ethiopia, Gambia, Ghana, Mali, Niger, Nigeria, Senegal and South Sudan.

¹¹ Data from the enhanced meningitis surveillance system.

¹² Botswana, Cape Verde, Comoros, Congo, Democratic Republic of Congo, Ethiopia, Ghana, Lesotho, Madagascar, Malawi, Nigeria, Rwanda, Senegal, South Africa, Swaziland and Togo.

¹³ Cape Verde, Ghana, Rwanda and Senegal.

¹⁴ Global control and Regional elimination of measles. 2000–2012. Weekly Epidemiological Record No 6. 2014, 89, 45–52.

¹⁵ Algeria, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Comoros, Congo, Eritrea, Ethiopia, Gambia, Ghana, Guinea Bissau, Lesotho, Liberia, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Senegal, Seychelles, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.

12. Forty-one countries¹⁶ had reported specific budget allocations for immunization in their national health budgets as of December 2012. Government funding for routine immunization increased slightly, on average, from 43% in 2006 to 52% in 2010.

13. Surveillance networks targeting vaccine-preventable diseases (VPDs) have been established in the 47 countries in line with the Integrated Disease Surveillance and Response strategy and the International Health Regulations 2005. This has played a critical role in directing activities of national immunization programmes. Data generated from surveillance networks in the Region indicated a high prevalence of rotavirus diarrhoea, measles, rubella, and pneumonia.

14. Humanitarian emergencies that occurred recently in the Region,¹⁷ regardless of the type or cause, have been associated with epidemics of diarrhoea, measles, meningitis, etc. Most of these diseases can be prevented through vaccination if anticipated by timely intervention.

Justification

15. Despite the progress made, many challenges remain to be addressed. An estimated 8 million children in the Region, 81% of whom live in 10 countries,¹⁸ did not receive their DTP3 vaccine in 2012. There is a resurgence of measles and WPV outbreaks due to gaps in immunization coverage. The high cost of new vaccines poses a real challenge to middle-income countries that are not eligible for GAVI support.

16. The proposed new *Regional Strategic Plan for Immunization 2014–2020* is intended to provide policy and programmatic guidance to Member States, in line with the GVAP, in order to optimize immunization services including in emergencies.

STRATEGY FORMULATION

Priority setting

17. The enabling factors for good immunization performance and broad national commitment include local recruitment of, and provision of support to, community health workers; active community participation in immunization and health activities; partnership between health staff and local government authorities; focus on accountability and performance monitoring; and existence of essential immunization infrastructure¹⁹ at all levels.

18. Reaching the un-served 20% of children represents the most daunting challenge for the Region. Some of the “one infant in five” who are not immunized live in “hard-to-reach” areas or in communities whose access to health services is limited. Others may be living very close to a health centre and yet may have been simply overlooked by the local health staff when microplans for community coverage were drawn up.

19. Making the best use of the available vaccines requires a renewed emphasis on, and prioritization of, routine immunization services – the platform on which all immunization activities can be mounted – within the context of health system strengthening, based on national decision-making.

¹⁶ www.who.int/immunization/programmes_systems/financing/analyses/jrf_analysis/en/. Accessed on 13 March 2014.

¹⁷ Central African Republic, Mali and South Sudan.

¹⁸ Chad, Democratic Republic of Congo, Ethiopia, Kenya, Mali, Mozambique, Niger, Nigeria, South Africa and Uganda.

¹⁹ Justice J. et al., Study of the drivers of routine immunization system performance in Ethiopia, JSI Research and training Institute Inc., ARISE Project for the Bill and Melinda Gates Foundation, 2012.

Aim, objectives and targets

20. The aim of the *Regional Immunization Strategic Plan 2014–2020* is to achieve universal immunization coverage within the WHO African Region.

21. The objectives are:

- (1) To increase and sustain high vaccination coverage.
- (2) To complete the interruption of poliovirus transmission and ensure virus containment.
- (3) To eliminate measles and advocate for the elimination of rubella and congenital rubella syndrome.
- (4) To attain and maintain elimination/control of other vaccine-preventable diseases.

22. The targets are as follows:

Objective 1: To increase and sustain high vaccination coverage.

- (a) Reach DTP3-containing vaccine coverage of at least 90% region-wide by the end of 2020.
- (b) All countries have introduced PCV by the end of 2020.
- (c) At least 37 countries have introduced rotavirus vaccine by the end of 2020.
- (d) At least 35 countries have introduced HPV by the end of 2020.
- (e) At least 25 countries have introduced a birth dose of HepB by the end of 2020.

Objective 2: To complete the interruption of poliovirus transmission and ensure virus containment.

- (a) All countries have interrupted WPV transmission by the end of 2014.
- (b) All countries using OPV have introduced at least one dose of Inactivated Polio Vaccine by the end of 2015.
- (c) All polioviruses are laboratory-contained and the Region certified polio-free by the end of 2018.
- (d) A regional polio legacy plan is finalized by the end of 2015.

Objective 3: To eliminate measles and advocate for the elimination of rubella and congenital rubella syndrome.

- (a) All countries have achieved an incidence of less than one confirmed measles case per million population by 2020.
- (b) Attain MCV1 coverage $\geq 95\%$ at national and district levels and at least 95% SIAs coverage in all districts.
- (c) At least 25 countries have introduced rubella-containing vaccine by the end of 2020.

Objective 4: To attain and maintain elimination/control of other vaccine-preventable diseases.

- (a) All countries have attained and validated the elimination of maternal and neonatal tetanus by the end of 2020.
- (b) All high-risk countries have attained yellow fever immunization coverage $\geq 90\%$ by the end of 2020.
- (c) All countries within the meningitis belt have introduced MenAfriVac[®] through campaigns, and 15 of them have introduced it into routine immunization by the end of 2020.
- (d) Seroprevalence of HbsAg among children below five years of age is less than 2% by the end of 2020.

Guiding principles

23. The guiding principles are the following:

- (a) **Country ownership** to identify and implement national immunization priorities and provide access to quality immunization for all. Countries have a responsibility for establishing good governance; communities and civil society should be actively involved and should play a pivotal role in the implementation of the immunization strategic plan.
- (b) **Partnership and mutual accountability** among individuals, communities, stakeholders and governments. Experiences of global and regional collaboration in immunization will help to expand partnerships, and those at national level will be strengthened and extended to subnational level.
- (c) **Access to universal health coverage** for improved health outcomes among all groups especially underserved and marginalized populations, during humanitarian emergencies, to enhance the contribution of immunization in reducing morbidity, disability and mortality from vaccine-preventable diseases.
- (d) **Integration** of global disease eradication and elimination initiatives within the broader health system in close coordination with primary health care approaches. Surveillance of vaccine-preventable diseases linked to Integrated Disease Surveillance and Response as well as the use of other child health opportunities should be maximized for achieving immunization objectives.
- (e) **Sustainability** through appropriate levels of financing, financial management and oversight, based on evidence-based decisions and implementation of strategies.
- (f) **Innovation** and quality improvements across all aspects of immunization.

STRATEGY IMPLEMENTATION

Key approaches for implementation

24. Implementation of the **Reach Every District (RED)** approach and other locally-tailored approaches will be promoted to maximize the accessibility and utilisation of immunization services. This will ensure greater involvement of individuals and communities in moving from supply-driven to demand-driven immunization services.

25. **Extending the benefits of new vaccines to all.** Countries will be supported to introduce new vaccines and to intensify advocacy for reduction of their prices particularly for middle-income countries. Efforts should be made to improve vaccine procurement, supply and

management systems while ensuring accessibility and affordability to the population in order to achieve universal coverage. Advocacy for developing local capacity for vaccine manufacture within the African Region should continue.

26. **Sustainable immunization financing** will be pursued and domestic resources provided. Efforts to establish national budget lines and allocate and disburse funds for immunization will be supported. The need for additional resources to reach the “last fifth child” and to increase immunization coverage to at least 90% should be strongly emphasized.

27. **Integrating immunization** into national health policy and plan, with immunization interventions quantified, costed and incorporated into the various components of national health systems strengthening. Integration of additional child survival interventions with immunization should be pursued to leverage the potential for prevention of pneumonia and diarrhoea. Immunization will also be included as a priority intervention during humanitarian emergencies to save lives and reduce morbidity, disability and mortality due to vaccine-preventable diseases.

28. **Enhancing partnership for immunization.** Partnership for immunization will be expanded at country level while relying on existing regional initiatives such as Harmonization for Health in Africa (HHA). Continued use of the platform of the Interagency Coordination Committees and other national and subnational coordinating mechanisms to strengthen local partnerships and forge new ones will be strengthened.

29. **Improve monitoring and data quality.** The quality of immunization and surveillance data will be regularly monitored and its use at country level promoted. Information generated from monitoring systems and surveys will be used for advocacy and for programme and service improvement. Sensitive and high-quality surveillance including laboratory confirmation, linked to the Integrated Disease Surveillance and Response platform, should be used to monitor the epidemiological trend of vaccine-preventable diseases and guide implementation of immunization strategies.

30. **Improving human and institutional capacities.** Individual and institutional capacity to adequately plan, implement and monitor immunization programmes should be strengthened through training. The capacity to plan and manage immunization services at district and operational levels should be prioritized with a view to improving and sustaining high vaccination coverage rates.

31. **Improving vaccine safety and regulation.** Vaccine safety monitoring systems should be enhanced by strengthening the capacity of national regulatory authorities through the implementation of institutional development plans. The promotion of safe injection policies and practices and improved surveillance of adverse events following immunization should be assured. Member States’ capacity to authorize and monitor vaccine clinical trials as well as compile evidence for better decision-making on new vaccine introduction should be enhanced.

32. **Promoting implementation research and innovation.** Guidance and capacity for implementation research should be strengthened. Social and anthropological studies should be emphasized for better understanding of the reasons for non-immunization of some populations and low performance of immunization programmes. Member States should be supported to implement the Algiers Declaration and the Bamako Call to Action on research for health in the African Region in order to refine strategies for improved immunization service delivery.

Roles and responsibilities

33. Governments should:

- (a) Develop costed comprehensive multi-year immunization plans (cMYPs) with annual integrated operational plans.
- (b) Mobilize and allocate adequate domestic resources to implement immunization plans.
- (c) Enhance and sustain multisectoral collaboration and partnerships in the implementation of key approaches.
- (d) Mobilize, involve and empower communities to effectively demand and utilize immunization services.
- (e) Promote training, recruitment and retention of the required health workers.
- (f) Conduct implementation research on the various aspects of the priority interventions.
- (g) Document lessons learnt from the implementation of the past strategic plan and identify best practices for emulation and scale up.
- (h) Assess the need for and, where appropriate, implement immunization during humanitarian emergencies.
- (i) Coordinate the efforts and agenda of several stakeholders including the private sector in line with country priorities.

34. Communities should:

- (a) Promote immunization and collaborate closely with local health staff in planned fixed and outreach services.
- (b) Participate in the development and testing of innovative approaches to deliver immunization services.
- (c) Understand the risks and benefits of vaccination, demand safe and effective immunization programmes and participate in decision-making and service delivery processes.
- (d) Empower and engage vulnerable groups, build grass-roots initiatives to track progress and hold governments and stakeholders accountable.
- (e) Contribute to improved monitoring and evaluation systems.

35. WHO and partners should:

- (a) Provide technical, financial and material assistance for the development of cMYPs and integrated annual operational plans.
- (b) Support Member States to mobilize the necessary resources to achieve the set objectives and targets.
- (c) Develop and make available updated standards and guidelines for the implementation of priority interventions.
- (d) Advocate and foster continued collaboration among partners for optimal implementation of the set objectives and targets.

- (e) Support countries in assessing and implementing vaccination as a priority public health intervention during humanitarian emergencies.
- (f) Document and disseminate best practices of countries.

RESOURCE IMPLICATIONS

36. Implementation of the Regional Strategic Plan for Immunization 2014–2020 will require a high level of national and international commitment. Financial support is required for full implementation of comprehensive national immunization plans in order to achieve the set objectives and targets. Improving immunization services should be integrated into the overall health system strengthening.

37. Provisional estimates²⁰ show that the total annual financial requirement for immunization in the Region was US\$ 1.8 billion in 2013. It is estimated that governments and partners financed, respectively, a little over 30% and 50% of the financial requirements, leaving a funding gap of approximately US\$ 340 million.

38. Over the period of 2014–2020, based on the projections of targets, the provisional total cost for the Region is estimated at US\$ 17.2 billion. In order to achieve the targets as articulated in the Regional Strategic Plan for Immunization, financial requirements would have to increase annually, reaching an estimated total of US\$ 2.8 billion by the end of 2020. This increase represents additional resources of US\$ 4.2 billion required for 2014–2020.

39. Based on historical patterns and trends of financing by Member States and partners, a persistent regional funding gap of 20% to 22% per annum should be anticipated over the timeframe of 2014–2020. Member States and partners are therefore encouraged to mobilize the additional resources required to adequately finance national immunization plans that have provisions for procurement of vaccines, strengthening of human resources, conduct of surveillance, programme management, and improvement of supply chain performance. Mechanisms to support GAVI non-eligible countries should be put in place to facilitate their access to new vaccines at affordable price.

MONITORING AND EVALUATION

40. Immunization monitoring indicators recommended by the GVAP should be adapted to the regional context and used to monitor the implementation of this plan annually. Standardized programme evaluation instruments, including appropriate indicators, should be revised and updated to reflect current priorities. A mid-term programme evaluation should be conducted in 2017 and a comprehensive end-term evaluation of the strategy should be conducted in 2020.

41. The Task Force on Immunization in Africa should conduct annual assessment of the progress towards the achievement of the objectives and targets of the Regional Immunization Strategic Plan 2014–2020. The results should be used to re-align and refine the implementation of the regional plan. A progress report should be presented every year to the Regional Committee.

²⁰ Provisional estimates are extracted from the on-going Decade of Vaccine Costing, Financing and Funding Gap Analysis and based on the comprehensive Multi-Year Plans (cMYP) of 39 countries of the African region (high and upper middle income countries, except Angola, are not included in the analysis).

ASSUMPTIONS AND RISKS

42. Optimal implementation of the Regional Immunization Strategic Plan 2014–2020 will depend on government stability and absence from human-made emergencies that facilitate good governance and leadership, leading to increased national commitment to sustain immunization services.

43. Climate change will not significantly change the geographical patterns of the burden of vaccine-preventable diseases and major break-downs in vaccine supply will be mitigated by multiple vaccine manufacturers able to deliver vaccines to countries in a timely fashion.

44. The private sector has adequate incentives to provide immunization services or related expertise in logistics or research.

CONCLUSION

45. The implementation of the Regional Immunization Strategic Plan 2014–2020 will build on the experiences from the past in a manner that strengthens immunization systems. It should also inspire the development of a comprehensive multi-year and operational country plans.

46. The strategic thrusts are to build the competences of health workers to plan, implement and monitor immunization services and strengthen the cold chain system and vaccine management practices. Implementation research will be required for enhanced understanding and better implementation of key approaches to improve and maintain high level vaccination coverage.

47. The implementation of the Regional Immunization Strategic Plan will require country ownership supported by a committed global and regional partnership as well as broad-based local partnerships in order to ensure the availability and efficient use of resources.

48. The Regional Committee is invited to examine and adopt the actions proposed and the related resolution.