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IMMUNIZATION IN THE AFRICAN REGION: PROGRESS REPORT ON THE AFRICAN REGIONAL IMMUNIZATION STRATEGIC PLAN 2009–2013, GLOBAL VACCINE ACTION PLAN AND POLIO ENDGAME

CONTENTS

I. BACKGROUND

1. The *African Regional Immunization Strategic Plan 2009–2013*[1] aimed to: maximize access to and utilization of immunization services; accelerate efforts to achieve polio eradication; eliminate epidemic meningococcal A meningitis and maternal and neonatal tetanus; control measles and yellow fever; strengthen sentinel surveillance of diseases targeted by new vaccines; strengthen immunization systems; promote integrated service delivery; and promote research.

2. In May 2012, the Sixty-fifth session of the World Health Assembly, by its resolution WHA65.17, endorsed the Global Vaccine Action Plan. The Plan provides the strategic framework for realizing the full potential of immunization during the Decade of Vaccines 2011–2020. In the resolution, the Health Assembly urged Member States to report every year to the regional committees on lessons learnt, progress made, remaining challenges and updated actions to reach the national immunization targets.

3. The Sixty-sixth session of the World Health Assembly endorsed the Polio Eradication and Endgame Strategic Plan 2013–2018. This plan has four main objectives: (a) detection and interruption of all poliovirus transmission; (b) strengthening of immunization systems and withdrawal of OPV; (c) containment and certification of all poliovirus; and (d) development of a comprehensive legacy plan.

4. This report summarizes the progress made in the implementation of the African Regional Immunization Strategic Plan 2009–2013, the Global Vaccine Action Plan, and provides global perspectives on the Polio Eradication and Endgame Strategic Plan.

II. PROGRESS REPORT ON THE AFRICAN REGIONAL IMMUNIZATION STRATEGIC PLAN 2009–2013

5. Coverage with three doses of Diphtheria-Pertussis-Tetanus containing vaccine (DPT3)[2] and with the first dose of measles–containing vaccine (MCV1) for the Region was maintained around 70%. Only eight countries (17%) had at least 80% DPT3 coverage in all districts. Eighteen[3] and fifteen[4] countries respectively attained 90% DPT3 and MCV1 coverage in 2012 compared with 13 and 11 in 2008. Over 196 million children were vaccinated against measles during Supplementary Immunization Activities (SIAs) in 43 countries.[5]

6. As of June 2013, all countries in the Region except Equatorial Guinea had introduced Hepatitis B and *Haemophilus influenza* type b vaccines, while Pneumococcal conjugate vaccines have been introduced in 23 (50%) countries.[6] More than 103 million people in 10 countries[7]

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1 WHO, African Regional Immunization Strategic Plan (2009–2013). Immunization And Vaccine Development cluster, WHO/AFRO, Brazzaville, 2009.

2 According to the WHO-UNICEF national immunization coverage estimates.

3 Algeria, Angola, Botswana, Burkina Faso, Burundi, Cape Verde, Cote d'Ivoire, Eritrea, Gambia, Ghana, Malawi, Mauritius, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Swaziland and Tanzania.

4 Algeria, Angola, Botswana, Burundi, Cape Verde, Eritrea, Gambia, Kenya, Malawi, Mauritius, Rwanda, Sao Tome and Principe, Seychelles, Tanzania and Zimbabwe.

5 All countries in the African Region except Algeria, Mauritius and Seychelles, have conducted measles SIAs since the adoption of the Regional measles mortality reduction goals in 2001.

6 Angola, Benin, Botswana, Burundi, Cameroon, Central African Republic, Congo, Democratic Republic of Congo, Ethiopia, Gambia, Ghana, Kenya, Madagascar, Malawi, Mali, Mozambique, Rwanda, Sao and Tome Principe, Sierra Leone, South Africa, Tanzania, Uganda and Zimbabwe.

7 Benin, Burkina Faso, Cameroon, Chad, Ghana, Mali, Niger, Nigeria, Senegal, Sudan.

received the new meningococcal meningitis A conjugate vaccine. As a result, no confirmed case of meningitis due to meningococcal A has been identified within vaccinated population.[8]

7. Twenty-three[9] of the 31 countries at risk of yellow fever introduced the vaccine in their immunization programmes, with four (17%) countries[10] attaining 90% coverage in 2012. As of June 2013, the elimination of maternal and neonatal tetanus had been validated in 30 (65%) countries.[11]

8. Wild poliovirus cases (WPV) reported in the African Region decreased by 81%, from 691 cases in 2009 to 128 cases in 2012. As of June 2013, Nigeria was the only polio-endemic country. No case has been reported from the three countries[12] of re-established transmission in the Region for a period between 12-23 months, while Kenya has been affected by a WPV1 outbreak that has also affected Somalia in the Horn of Africa since May 2013.

9. As of December 2012, 44 countries[13] had specific budget allocations for immunization in their national health sector budgets, compared with 43 in 2009. The percentage of government funding for routine immunization increased from 47% in 2009 to 52% in 2012.

10. Despite the progress, many challenges remain. These include weak immunization systems, inadequate financial resources, and limited access to service delivery in remote districts among others.

Proposed actions

11. Member States should mobilize local communities, national and international stakeholders from public and private sectors, professional societies and nongovernmental organizations so that immunization services would be driven by community demand.

12. Member States should develop and implement country-tailored approaches to provide immunization and other high-impact child survival interventions to unreached communities.

13. WHO and partners should support Member States to build the institutional, human and managerial capacity of national immunization programmes.

III. GLOBAL VACCINE ACTION PLAN

14. The Global Vaccine Action Plan (GVAP) results from a worldwide effort that brought together stakeholders across the vaccine chain to define collectively what the immunization community wants to achieve over the next decade. Member States committed themselves to applying the GVAP vision and strategies to develop the vaccines and immunization components of their national health strategy and plans, and to allocating adequate human and financial resources to achieve the immunization goals.

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8 Data from enhanced meningitis surveillance system.

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

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

11 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 Angola (23 months), Chad (12 months), Democratic Republic of Congo (18 months).

13 Immunization financing indicators database.http://apps.who.int/immunization_monitoring/en/globalsummary/indicatorselect.cfm.

15. To achieve the GVAP vision, Member States will need to increase funding, support and active participation of stakeholders across every sector to help define and execute a comprehensive effort to improve and save lives through vaccination.

16. Member States were given guidance during the EPI Managers meetings on the GVAP goals and objectives as well as monitoring and evaluation mechanisms. The broader African immunization community was also briefed on the GVAP during the Fourth Annual Regional Conference on Immunization.

Proposed actions

17. Member States should prioritize immunization within a strong health system to ensure equitable access to immunization as a universal right. They should develop/update the immunization components of their National Health Strategy and Plans in line with the Global Vaccine Action Plan (GVAP), and allocate adequate human and financial resources to achieve the goals.

18. Member States should report every year to the Regional Committee on lessons learnt, progress made, remaining challenges and updated actions to reach the national immunization targets.

IV. POLIO ENDGAME

19. In May 2013, the Sixty-sixth World Health Assembly endorsed the *Polio Eradication and Endgame Strategic Plan 2013–2018* that was established in response to resolution WHA65.5 requesting the Director-General to develop a comprehensive polio endgame strategy. The new Plan provides a concrete timeline for completion of the Global Polio Eradication Initiative (GPEI) by eliminating all paralytic poliomyelitis due to both wild and vaccine-related polioviruses.

20. Due to the goal of stopping all polio disease, the Plan has substantial near-term implications for both polio-infected and polio-free countries, particularly the 125 countries that use only the oral polio vaccine (OPV) for routine immunization.

21. This section introduces the global perspectives of the polio eradication and endgame strategic plan 2013–2018 in the near-term, particularly to accelerate preparations for global type 2 oral polio vaccine (OPV2) withdrawal, including the introduction of Inactivated Poliovirus Vaccine (IPV) into routine immunization schedules globally, and to inform the development of the GPEI legacy plan.

22. Although wild poliovirus type 2 was eradicated globally in 1999, the type 2 virus component of the oral polio vaccine (OPV2) causes the majority of circulating type 2 vaccine-derived poliovirus (cVDPV2) outbreaks and vaccine-associated paralytic poliomyelitis (VAPP) cases. The importance of withdrawing OPV2 as soon as possible globally was reinforced by the detection in 2012 of polio outbreaks due to a cVDPV2 in Chad, Democratic Republic of the Congo, Kenya, Nigeria, Pakistan and Somalia. In addition to eliminating the leading cause of cVDPV outbreaks, OPV2 withdrawal will immediately eliminate at least 40% of the global burden of approximately 250–500 cases of vaccine-associated paralytic poliomyelitis per year.

23. The Strategic Advisory Group of Experts on immunization (SAGE) recommends that all countries introduce at least one dose of IPV in advance of the replacement of trivalent OPV with bivalent OPV (types 1 and 3) for routine immunization. The *Polio Eradication and Endgame Strategic Plan 2013-2018* targets global introduction of IPV by the end of 2015 to facilitate

global OPV2 withdrawal as soon as possible thereafter. The introduction of at least 1 dose of IPV at the DPT3 contact will boost population immunity against type 2 poliovirus and maintain a polio-primed population following OPV2 cessation. This will in turn reduce the risk of a cVDPV2 emergence at the time of OPV2 withdrawal and improve the response to type 2 monovalent OPV (mOPV2) campaigns in the event of a type 2 polio outbreak after OPV2 withdrawal. The introduction of IPV could also accelerate wild poliovirus eradication as it boosts both humoural and intestinal immunity to wild virus 1 and 3 in previously OPV-vaccinated children.

24. To enhance IPV affordability and availability, WHO and its GPEI partners are striving to reduce the price of IPV for the polio endgame. The current UNICEF-procured price of IPV is US$ 3.25/dose. WHO anticipates that the near-term price for the 73 GAVI-eligible and graduate countries will be approximately US$ 1.00/dose and between US$ 1.30-US$ 1.50/dose for low and middle income countries. Looking forward, further IPV price reductions to below US$ 1.00 per dose may be achievable – for example, either through the use of fractional dosing with intradermal (ID) delivery of one fifth of a full dose of a current IPV product, or intramuscular administration of a new IPV product containing an adjuvant. GPEI is working with multiple manufacturers on these and other options, targeting a price of between US$ 0.50 and US$ 0.75 per dose within 36–48 months. A number of manufacturers are planning to develop IPV-containing hexavalent products, which could be available and priced for public sector use in developing countries as early as 2020. WHO and its GPEI partners continue to support the transfer to developing countries of new production technology for IPV using Sabin-strain polioviruses. It is expected that Sabin-strain IPVs will become available in some countries during the period of implementation of the new strategic plan. The current IPV-containing hexavalent presentations use an acellular pertussis component. As this is a more expensive type of pertussis formulation, the price is US$ 20-40/dose. The development of an IPV-containing hexavalent vaccine using whole-cell pertussis, which would be affordable to low and middle income country markets, is not expected before 2020.

25. A multi-faceted IPV financing strategy is being developed to assist countries in planning for the introduction of 1 dose of IPV into their routine immunization programmes by the end of 2015. This strategy includes a combination of GAVI-assisted procurement, subsidized pricing for introduction in some low and low-middle income countries that are not GAVI-eligible, and self-procurement of low cost products by others. To establish a comprehensive global financing and supply strategy for fast-track IPV introduction using current whole-dose IPV products, WHO and its GPEI partners will need country-specific IPV introduction plans and timelines by the end of 2014. For further information on IPV introduction, please consult ‘Planning for IPV Introduction – Frequently Asked Questions’.

26. A primary goal of legacy planning for the Global Polio Eradication Initiative (GPEI) is to ensure that the knowledge, capacities, processes and assets created by the programme will continue to be of broader benefit to other public health programmes after the completion of the eradication initiative. Such potential benefits include capitalizing on the ability the GPEI has developed over the past 25 years to access most of the chronically unreached, marginalized and most vulnerable populations in the world. This has provided health workers and volunteers with the opportunity to vaccinate children with OPV and also provide a range of other basic health services. In addition, this far-reaching access has resulted in a global surveillance and response capacity for both health and humanitarian emergencies in some of the world’s most demanding settings. Thus a key aim of the legacy planning process is to establish consensus by end-2015 on the extent to which the GPEI’s capacities should be used to benefit other health priorities beyond the planned completion of the polio eradication initiative in 2018-2019.

27. As a basis for GPEI legacy planning, starting in mid-2013, an extensive consultative process is being implemented with WHO Member States, GPEI implementing partners, donors and other stakeholders in both the GPEI and other international health initiatives. These consultations will inform the development of a comprehensive legacy plan and, where appropriate, national and/or regional legacy plans by end-2015. At the request of the WHO Executive Board, an independent study of all of the WHO-contracted human resources (HR) for the GPEI is also underway to help plan for the management of these resources in the context of programme completion by 2018-2019. This study will also inform the development of legacy plans.

28. With the planned completion of the GPEI in 2018 and subsequent programme closure, there are three potential scenarios for the programme's legacy. These scenarios also have implications for the management and use of the extensive resources that were created and deployed for polio eradication. Consequently, in 2013-14 the perspectives of WHO Member States are needed on which of the following three scenarios should drive legacy planning for the GPEI:

(a) *Scenario 1:* the knowledge generated and lessons learned through the polio eradication initiative should be well documented and disseminated to benefit other health priorities, but the programme should plan to sunset its other assets and resources at the time of programme closure or shortly thereafter;
(b) *Scenario 2:* following GPEI closure there should be a transition of the lessons, assets and resources of the programme to benefit other existing and relevant national, regional and/or global public health programmes (e.g. global disease surveillance and response capacity, routine immunization strengthening, new vaccine introduction).
(c) *Scenario 3:* following GPEI closure there should be the establishment of a new global initiative or programme with an equity focus that would utilize the assets, lessons learned and resources of the GPEI primarily to sustain access to chronically missed and underserved populations for priority health interventions.

29. Upon establishing consensus on the appropriate scenario to drive legacy planning, this consultative process will be used to further develop that scenario into specific GPEI legacy plan(s). This will include consultations with countries and regions to understand health priorities and to explore how GPEI lessons, assets and resources could be of potential benefit to those priorities.

Proposed action

30. The Regional Committee is invited to discuss the IPV use in the context of the African Region and the proposed scenarios of the polio legacy plan.

V. CONCLUSION

31. In line with the GVAP, WHO and partners should develop a new Regional Vaccine Action Plan driven by the core values of country ownership and community demand.

32. Member States are urged to prioritize immunization and develop their national immunization plans in keeping with the goals and strategic objectives of the global and regional action plan.