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“With the cooperation of the ministers of health in the state governments, we hope to further improve the increasing coverage and achieve the goals set by the National Rural Health Mission”, said the Minister of Health and Family Welfare of India.
The health and economic development of a nation depends on the health of its population - women and children in particular. Their health, in turn, depends on a few drops, or, even a simple injection administered by a trained health-care provider, of vaccines that would help prevent life-threatening diseases such as tuberculosis, diphtheria, tetanus, pertussis (whooping cough), polio and measles. Immunizations have been carried out globally for more than a century now, but even with all the progress and resources, every fifth child born in this world is missed by these programmes and one in four of them is from the WHO South-East Asia region. Consequently, they are susceptible to what are called “vaccine-preventable diseases (VPDs)”.

Estimates available from various organizations show that with an expanded vaccine delivery focusing on routine immunization, lives of nearly 8.5 million children can be saved annually. Bill Gates, who has proposed the current decade as the “Decade of Vaccines”, calls it the “best buy” in development and has characterized vaccines as the “weapon of mass protection”. While virtually every child in the developed world completes a course of routine immunization, 10 million vulnerable children in the South-East Asia Region do not complete the course and remain exposed to diseases, disabilities and deaths. In India alone, 6.7 million children are under-vaccinated, which means that one-in-four newborn children are at risk of a vaccine-preventable disease.

These are sobering questions: Why does, even after decades of running information campaigns, creating demand, improving the supply chain and training health workers in delivering vaccines, the rate of routine immunization has been one of Bangladesh’s greatest public health successes. It has prevented an estimated 2 million deaths between 1987 to 2000 and continues to prevent approximately 200,000 deaths each year from vaccine preventable diseases.
immunization (RI) continue to hover around only 70 per cent in the South-East Asia Region? What are the bottlenecks that exist in delivering a few drops or simple injections to millions of newborn babies in South-East Asia? Why are countries like India, Nepal and Timor-Leste not able to achieve the same levels of national RI coverage as can Maldives, Sri Lanka and Bangladesh? Indeed, what lessons can be learnt from successful cases so that all countries can achieve a more uniform as well as a high regional cumulative coverage? Finally, what are the new frontiers in immunization vis-à-vis vaccine development and coverage, and how would countries fund and sustain these?

To address these important questions the WHO Regional Office for South-East Asia (SEARO) organized a one-day High-Level Ministerial meeting on Increasing and Sustaining Immunization coverage in the South-East Asia Region (HLM) in New Delhi on 2 August 2011. This was set against the backdrop of WHO SEARO preparing to declare 2012 as the “Year of Intensification for Routine Immunization in the South-East Asia Region”. The meeting was attended by most Ministers of Health of Member States of the Region – Bangladesh, Bhutan, India, Maldives, Myanmar, Nepal and Sri Lanka – along with parliamentarians and senior officials of the Ministries of Health from all 11 Member States.

Ministers of Health took part in a moderated panel discussion in which a news anchor from Al Jazeera News exposed the achievements over immunization in the Region and explored solutions to the challenges faced by countries to increasing RI coverage. A Partners’ Panel discussion was also moderated by a Wall Street Journal Mumbai journalist who provided an opportunity for Ministers to hear the views of partners in this endeavour. These partners include UN organizations such as UNICEF and UN Foundation, voluntary organizations such as Rotary International, donors such as the Global Alliance for Vaccines and Immunization (GAVI) and the Bill and Melinda Gates Foundation (BMGF), technical support institutions such as the Centre for Disease Control (CDC) and the United States Agency for International Development (USAID), and vaccine producers such as Bio Farma of Indonesia and the Serum Institute of India.

The discussions were thought-provoking, forthright and forward looking, with the focus firmly on the main item on the agenda – a call for action to intensify efforts for increasing routine immunization in the Region.
In 2005, WHO and UNICEF jointly put out the Global Immunization Vision and Strategy (GIVS) covering the period 2006 to 2015. This has served as a touchstone to evaluating progress that countries have made in their efforts at achieving the targets aligned with the MDGs.

The GIVS target is for countries to achieve 90% RI (up to the third dose of DTP3) at the national level and at least 80% coverage at the district level. Seven countries in the South-East Asia Region have managed to achieve the first target – Bangladesh, Bhutan, DPR Korea, Maldives, Myanmar, Sri Lanka and Thailand. In comparison, only four out of these seven – Bhutan, DPR Korea, Maldives and Sri Lanka – have been able to achieve 80% at the district level.

Four countries in South-East Asia that are experiencing challenges to immunization are India, Indonesia, Nepal and Timor-Leste. The discussions during both ministerial and partners’ panels focused on what lessons can be learnt from countries which have been successful and on identifying the challenges of those who have not.

Until the early 1990s, Bangladesh was one of the countries where the rate of routine immunization was considered to be low.

The backbone of Bhutan’s primary healthcare system is the Expanded Programme of Immunization or EPI programme and we have directed most of our efforts towards maintaining a very good immunization programme.
In less than two decades, it has been able to achieve the 90% national target, and most of its districts (but not all) have achieved the district-level target of 80% as well. Bangladesh is a role model of what can be achieved when political commitment and forged partnerships engage to address a public health problem as a priority.

In the ministerial panel, it was stated that the key factor behind Bangladesh’s success is the commitment at all levels of the political leadership and health service personnel. Nearly 68,000 government workers and 160,000 unpaid volunteers contributed to the human resources needed for this effort.

During the periodic immunization drives that are carried out, a key role is played by the community health workers (CHW) who penetrate remote areas to provide access to the “hard-to-reach” populations. Data collected during the immunization campaigns is analysed to identify gaps in implementation and reported to the top political leadership with the Ministry of Health being held directly accountable. Immunization is a national priority and has remained in the spotlight for the last decade even with changes in governments at the national level.

Reaching the “hard-to-reach” requires commitment and innovation in places such as Maldives and Bhutan, which are topographically diametrically opposite. Every means of transportation is made use of to overcome constraints of cost and logistical challenges. In Maldives, over 70% of the cost of delivering vaccines is used on transport. The national government provides funds from its own resources not depending on donor financing. However, as the Minister of Health pointed out, “now that Maldives has reached above 95% coverage, the sustainability question is becoming important especially in light of new vaccines that are being introduced”.

The Health Minister of Bhutan noted that he was “moved and touched by health workers who were working in the health centre in remote areas without electricity where they kept the refrigerator running on a kerosene generator to deliver vaccines”. The problem of supply chain and cold storage facilities were highlighted on several occasions as one of the most critical challenges that are faced by countries.
that have been able to scale up coverage of immunization programmes, which they have been able to overcome with strong commitment and innovative methods to ensure delivery of services.

India has one of the largest immunization programmes in the world. The scale of the effort can be gauged from the fact that 26 million babies are born every year in the country. Being a vast and diverse country, there are challenges of geography, culture and infrastructure in addition to the huge numbers of children who need to be immunized. In India health is a state subject. The federal government provides the vaccines and meets the operational costs of the immunization programme but depends on the state governments for immunization service delivery. The Minister of Health and Family Welfare of India stated that “with the cooperation of the ministers of health in the state governments, we hope to further improve the increasing coverage and achieve the goals set by the National Rural Health Mission”.

Better coordination between federal and local governments already has had an impact in one of the most underdeveloped states of the country – Bihar, which has doubled its RI coverage from less than 30% to over 60% within five years. Although coverage is still relatively low, Bihar has been able to demonstrate that political and administrative commitment backed by strong political will can achieve the same results as seen in Bangladesh, Maldives, Bhutan, Sri Lanka and Thailand.

In response to a measles outbreak in 2007, DPR Korea targeted 6 month to 45 year olds. 16 million were targeted out of the total population with coverage of 99.5%
“I was moved and touched by the health workers who were working in the health centre in remote areas without electricity where they kept refrigerators running on a kerosene generator to deliver vaccines”, noted the Minister of Health of Bhutan.
The discussions at the HLM devoted significant attention to the issue of the logistical challenges faced by most countries in the Region as far as vaccine supply and cold chain management is concerned. While different views were expressed as to how critical these are to achieving GIVS targets, the general consensus was that immunization services are delivered better and more cost-effectively if the public health system functions properly. In terms of its reach, primary health centres or sub-centres are the backbone of any public health system, offering a range of services that cover ante and neo-natal interventions as well as basic curative services. The infrastructure is used as storage and distribution points enabling the community health workers to reach out to the uncovered and the drop-outs, as well as to refer to the primary health care centres any cases that would need more attention especially if it is related to adverse effects following immunization (AEFI).

It is, therefore, no surprise that countries like Sri Lanka and states in southern India which have a network of well functioning public health systems are able to scale up and maintain coverage of RI. While from a policy point of view, the existence of a...
good network of public health clinics is both desirable and essential for a range of interventions, the discussions at the ministerial panel also discussed the fact that a country like Bangladesh has gone ahead with the CHW model while at the same time trying to improve the public health infrastructure. India seems to be embarking on the same route – obtaining services of village-level health workers, called ASHAs, was motivated by the fact that they would be the key link between the communities on the one hand and the health system on the other. The strengthening of India’s health system that is currently underway through the National Rural Health Mission (NRHM) would address the issue of lack of health care workers and inadequate infrastructure. Improving health infrastructure is necessarily a long-run process, but the immediate task of increasing RI coverage would have to be undertaken through the CHW model for the time being. One thing is certain: achieving and maintaining universal coverage is difficult if the immunization programme does not have a well functioning public health system to rely on.

The other critical issue that emerged from the panel discussions on immunization systems is the need for surveillance and monitoring of the quality of services. Gathering of epidemiological data through the national disease surveillance system provides EPI managers with information on existing and emerging hotspots, which feed into policy decisions on (i) the extent of gaps in the coverage of RI, and (ii) the need for new vaccines that can be delivered cost-effectively and in a sustained manner.

Monitoring quality of services is critical to ensure safe vaccine delivery and identifying gaps and impediments to meet RI targets. Advocacy and social mobilization are also a crucial component to address existing myths, beliefs and customs that act as barriers to the acceptance of vaccines by parents and the wider community. Ensuring safety of vaccine and quality delivery of immunization also helps to prevent AEFIs which reinforce these beliefs.

Management of services requires high levels of technical skill which are often in short supply in countries of South-East Asia.
One possible solution is to follow Sri Lanka’s strategy of having a dedicated cadre of health workers who are focused only on public health. This requires resources to adequately staff, train and monitor performance which in Sri Lanka is met out of a separate budget for public health services and within that for vaccines under the Ministry of Health.

Finally, the meeting also discussed the strategy of using country-specific best-case scenarios to increase RI coverage. All countries in the Region have had some measure of success in covering at least one vaccine-preventable disease – the case of polio in India and measles in Nepal were specifically mentioned. “The platform provided by the successful measles program was utilized to extend the coverage of Japanese encephalitis vaccines in Nepal. Now we have very few cases compared to the situation that prevailed before the campaign”, the Minister stated. It was suggested that the polio and measles structure could be used as a vehicle for delivering other components of RI, provided management issues highlighted above are addressed accordingly.

There were, however, concerns that funding and some of the same structures built for these disease-specific campaigns would be scaled down as polio is close to eradication and measles is controlled. This may prove to be counter-productive and weaken RI in the long term. However, the consensus was that lessons can be learnt from the successes of countries in case of specific diseases and piggybacking on these campaigns can be a stop-gap arrangement for RI while more extensive and permanent structures for immunization service are put in place. Overall, the prevailing consensus was that it is the country that needs to commit, decide and invest to save the lives of its population.

In Maldives, health staff administers all scheduled vaccines before the mother and baby leave the hospital. If any child is missed, public health staff follows up with the mother and vaccinates the child.
“Now that Maldives has reached above 95% coverage, the sustainability question is becoming important, especially in light of new vaccines that are being introduced”, mentioned the Minister of Health of Maldives.
The vaccine market is constantly changing. The three key elements – discovery, development and delivery – together constitute the process through which new technologies are adapted and adopted for inclusion into RI programme. Countries often express their desire to include new vaccines in their immunization schedules that are provided routinely in developed countries. However, they are often constrained by high costs that they have to bear, not only for the current period but also in the foreseeable future. Without the large market for vaccines in developing countries such as the ones represented in the HLM, companies will not be able to invest in research and development (R&D) leading to the suboptimal situation of low coverage of vaccine-preventable diseases.

Breaking this logjam requires (a) countries to declare their will to adopt new vaccines in their RI programmes; and (b) to make a commitment to fund the medium-term costs of delivery. Above all, these requirements need to be guided by evidence-based data on the ability of these new vaccines reducing the disease burden as well as a cost-benefit analysis and fair assessment of the capacity of the EPI programmes to successfully introduce and sustain coverage with the same and not increasing the prevailing equity gaps in accessing routine immunization.

At the HLM, most countries reaffirmed their desire to include either new or underutilized vaccines into their RI schedules.

“Myanmar has maintained effective Neonatal surveillance. Routine Immunization of pregnant women with TT immunization has been a part of the national EPI. A validation survey proved that Myanmar eliminated Neonatal Tetanus in 2010.”
Bangladesh stated that they are going to introduce both rubella and pneumococcal vaccines, which implies an increase in cold chain capacity for storage of the vaccines will have to be addressed. Looking at the increasing incidence of cervical cancer among women, Bhutan decided to introduce the HPV vaccine although it cost US $360 per dose. Until now, more than 60,000 women across the country have been vaccinated, which means that from now on only school-going girls would have to be covered each year which would make the task of delivery much easier. The cost is being met by a donation at present, but will be borne out of a trust fund of US $24 million created to finance HPV delivery once the donation stops after five years. India has decided to introduce hepatitis B, Japanese encephalitis (JE) (in endemic states) and second dose of measles vaccination as part of the Supplementary Immunization Activities (SIA) or through RI schedules, depending on state coverage. Likewise, Nepal has also introduced JE vaccination while Sri Lanka is currently working on introducing pneumococcal and HPV vaccines, acknowledging that the cost of introducing HPV is still very high.

To address the issue of cost, the Global Alliance for Vaccines and Immunization (GAVI) was set up in 2000. It acts as an intermediary between national governments, donors and vaccine manufacturers to create a win-win situation for all parties concerned. Similar to the Global Fund for AIDS, TB and Malaria (GFATM), GAVI works as a public-private partnership (PPP) model under which they raise a corpus through grants from various donors (approximately 25% from the private sector and philanthropic entities and 75% from donor governments),

Nepal achieved the measles mortality reduction goal and recently set a goal for measles elimination by 2016. Nepal plans to utilize the measles elimination platform to control rubella and CRS.
distributes grants on the basis of proposals from national governments and negotiates with private manufacturers to procure assured quality vaccines at the lowest available price in the market.

GAVI co-financing has allowed countries such as Bangladesh and Sri Lanka to include new vaccines in their RI schedules, with the expectation that economies of scale would induce producers to lower prices in the long run which would allow them to deliver them in the long-term. This point was acknowledged by representatives of vaccine manufacturers. Bio Farma stated that their policy in Indonesia is to supply vaccines first to the national programme and then use the remaining production capacity to export to other markets. GAVI’s advance market commitments allow them, as well as the Serum Institute from India, to scale up R&D for new vaccine discovery and development. GAVI partners, such as UNICEF, CDC and WHO, provide technical support for supply chain management, monitoring and policy guidance at national and regional levels. Increasing coverage and inclusion of new vaccines into existing RI programmes, therefore, rest crucially on the effectiveness of global partnerships that create an enabling environment for achieving the GIVS and MDG goals. Apart from vaccine procurement, GAVI also provides financial support to eligible countries for upgrading their logistics, cold chain and management systems.

Since 1995, Routine Immunization coverage for all vaccines has been above 95% in Sri Lanka. Public Health services are a national priority. The government dedicates financial resources and dedicated medical staff to sustain it.
“Bangladesh’s success is due to the commitment at all levels of the political leadership and health service personnel, including the active participation of the Prime Minister in National Immunization Days every year”, said the Minister of Health of Bangladesh.
WHO SEARO’s call for declaring 2012 as the “Year of Intensification of Routine Immunization” begs the question: would it be more of the same or countries would use this opportunity to do something new? Since there are countries in the Region with different levels of achievement, the answer to the question would depend on their perception of what intensification means. Bangladesh, for example, stated that the year of intensification meant “self analysis”, that is, evaluating what more needs to be done to reach the unreached even if it is as low as 1% of the target group? In the same vein, for Bhutan, the year of intensification would mean a push towards 100% RI. Sri Lanka and Maldives proposed that they would use the opportunity of 2012 to strengthen advocacy among parliamentarians and local council representatives respectively in order to sustain the already high level of political commitment seen in the two countries. Nepal would introduce the National Immunization Act giving the government the power of legal sanction to undertake immunization and achieve the GIVS targets in a time-bound manner. India stated that the success of the pulse polio campaign

Thailand has a policy to promote local vaccine production to ensure national vaccine security. Thailand expects to produce a new generation JE vaccine, dengue vaccine and some combination vaccines in a few years time.
“One of the factors that has worked well in Sri Lanka is the model adapted to have a dedicated cadre of health workers who are focused only on public health, backed by a separate budget for public health services with adequate resources and performance monitoring” said the Minister of Health of Sri Lanka.
has provided the necessary momentum for energizing the health workers and extracting commitments from all political levels to provide a big push towards increasing and sustaining RI coverage.

Formalizing these observations, the HLM ended with a Call for Action (text attached) adopted by all the attending Ministers. This call for Action reaffirmed their commitment to securing the basic right of every child to be immunized through intensified efforts of routine immunization coverage in the South-East Asia Region. WHO will propose the adoption of a resolution at the Sixty-fourth Session of the Regional Committee in Jaipur in September 2011 which would make it binding on all Member States of Region. The resolution will also provide an opportunity to review progress in countries on a yearly basis with a view to assess and adjust strategies in 2013 at a regional review meeting.

It is time that the Delhi Call for Action for Intensification of Routine Immunization is translated into action on the ground which will lead to saving millions of young lives in the years to come.

One of the key elements in Timor-Leste’s development plan is to ensure access to safe and quality vaccines with the introduction of Pentavalent in 2012 and Rotavirus and Pneumococcal vaccines in the near future.
Parliamentarians’ lunch

Parliamentarians from six Member States took part in a lunch briefing and interactive session with WHO experts. The Honourable Dr J. Mirdha, Member of Parliament from India, chaired the working lunch session. Dr Thomas Cherian from WHO and Prof. Helen Rees from the Strategic Advisory Group of Experts of WHO provided a brief on the roles parliamentarians can play in the legislation process, appropriate allocation of resources to immunization systems, the economic benefits of immunization and the importance of ensuring accountability and advocacy within their constituencies and the government. Parliamentarians actively discussed the availability of evidence to support decisions on whether to strengthen routine immunization coverage before introducing new vaccines or to take a simultaneous approach.

Ministerial lunch

Attending Ministers of Health took part in the ministerial working lunch chaired by H.E. Mr Maithripala Sirisena, Minister of Health, Sri Lanka. Ministers reviewed and discussed details of the Delhi Call for Action to Intensification of Routine Immunization. Various Ministers provided inputs and amended the document in order to strengthen it while committing to advocate for action in their own countries. They congratulated WHO for having organized the High-Level Meeting and agreed on the importance of 2012 to be used as the year for the launch of intensified efforts along with the need to sustain efforts beyond 2012.
We, the Ministers of Health of Member States of the WHO South-East Asia Region recognize that immunization against the major infectious diseases is an essential component of primary health care as enshrined in the Alma-Ata Declaration.

Recognizing that access to immunization by children and women of child bearing age is a basic human right and acknowledging that immunization is an important tool to achieve Millennium Development Goals 4 and 5 and that immunization is one of the most cost-effective interventions known in public health;

Informed that among the WHO Regions, the South-East Asia Region is home to the largest birth cohort of 38 million infants and the Member States of the Region together immunized 28 million (73%) of this cohort with three doses of DPT in 2009;

Noting with concern the disproportionately high level of unimmunized children less than one year old in the Region and aware of the threat this poses to child survival and development;

Acknowledging that recent experiences demonstrate that strong country-led initiatives advance effective health policy and reforms which contribute to broader development goals, and that improving immunization coverage is only achievable with concerted efforts and commitments from all stakeholders;

Welcoming the call by WHO Regional Director for South-East Asia to declare 2012 as the Year of Intensification of Routine Immunization;

We, the Health Ministers:

Pledge to reinvigorate routine immunization by launching and declaring the year 2012 as the Year of Intensification of Routine Immunization within the framework of Primary Health Care and ensure its financial sustainability thereafter;

Delhi Call for Action for Intensification of Routine Immunization

[...]

We, the Health Ministers:

Pledge to reinvigorate routine immunization by launching and declaring the year 2012 as the Year of Intensification of Routine Immunization within the framework of Primary Health Care and ensure its financial sustainability thereafter;

Acknowledge the importance of innovative strategies to overcome the challenges in increasing and sustaining equitable immunization coverage and recognize the opportunities available for increasing access to new life saving vaccines against common childhood diseases;

Commit to provide high-level political advocacy and oversight to support immunization programmes in our respective countries and to draw up and implement country-specific strategies and action plans; and

Resolve to engage with all immunization stakeholders in an open and constructive dialogue to ensure increasing coverage in the South-East Asia Region;

Request the WHO Regional Office for South-East Asia to provide strategic inputs, technical guidance and mobilization of additional resources for the intensification of routine immunization and support Member States in evidence-based decision making for increasing and improving the health of children and women from vaccine preventable diseases;

Request all development partners, civil society and the private sector to coordinate their technical and financial support at the country level; and

Urge the WHO Regional Director for South-East Asia to obtain endorsement from the Sixty-fourth Session of the WHO Regional Committee for South-East Asia for 2012 to be declared the Year of Intensification of Routine Immunization in all Member States.

New Delhi, India
2 August 2011
2012
Year of intensification of routine immunisation
in South-East Asian countries