The fifth meeting of the World Health Organization’s South-East Asia Regional Immunization Technical Advisory Group (SEAR-ITAG) was held during 25–29 August 2014 in New Delhi, India. SEAR-ITAG is a regional technical expert group, established by the Regional Director for providing advice on all aspects of immunization, vaccines and vaccine-preventable disease prevention, control, elimination and eradication. It comprises experts from disciplines such as programme management, communicable diseases/vaccine preventable diseases control, virology, epidemiology, and immunization. It meets annually with the participation of national EPI managers and surveillance focal points and partners to review progress on increasing immunization coverage, surveillance performance, programme issues, and matters related to vaccine quality assurance, and provides guidance to countries on ways to improve and sustain overall high quality performance. This report outlines the conclusions and recommendations of this expert group meeting.
South-East Asia Regional Immunization Technical Advisory Group (SEAR-ITAG)

Report of the fifth meeting
New Delhi, India, 25–29 August 2014
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## Acronyms

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<th>Acronym</th>
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<tr>
<td>AES</td>
<td>acute encephalitis syndrome</td>
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<td>AFP</td>
<td>acute flaccid paralysis</td>
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<td>AEFI</td>
<td>adverse events following immunization</td>
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<td>bOPV</td>
<td>bivalent oral polio vaccine</td>
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<tr>
<td>CRS</td>
<td>congenital rubella syndrome</td>
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<tr>
<td>DTP3</td>
<td>third dose of diptheria-tetanus-pertussis</td>
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<tr>
<td>EPI</td>
<td>expanded programme on immunization</td>
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<td>EVM</td>
<td>effective vaccine management</td>
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<td>GAVI</td>
<td>Global Alliance for Vaccines and Immunization</td>
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<td>HSS</td>
<td>health systems strengthening</td>
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<td>IPV</td>
<td>inactivated polio vaccine</td>
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<td>ITAG</td>
<td>Immunization Technical Advisory Group</td>
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<tr>
<td>MCV</td>
<td>measles-containing vaccine</td>
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<td>MCV1</td>
<td>first-dose measles containing vaccine</td>
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<td>MCV2</td>
<td>second-dose measles containing vaccine</td>
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<td>MNT</td>
<td>maternal and neonatal tetanus</td>
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<td>MR</td>
<td>measles and rubella vaccine</td>
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<td>MRI</td>
<td>Measles Rubella Initiative</td>
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<td>NCCP</td>
<td>National Certification Committee for Polio Eradication</td>
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<td>NCIP</td>
<td>National Committee on Immunization Practices</td>
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<td>OPV</td>
<td>oral polio vaccine</td>
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<td>SAGE</td>
<td>Strategic Advisory Group of Experts on Immunization</td>
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<td>SIA</td>
<td>supplementary immunization activity</td>
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<tr>
<td>Abbreviation</td>
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<td>SEAR</td>
<td>South-East Asia Region</td>
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<tr>
<td>tOPV</td>
<td>trivalent oral polio vaccine</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>VDPV</td>
<td>vaccine-derived polio virus</td>
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<td>VPD</td>
<td>vaccine-preventable disease</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>WPV</td>
<td>wild polio virus</td>
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1. Introduction

The fifth meeting of the World Health Organization’s South-East Asia Regional Immunization Technical Advisory Group (SEAR-ITAG) was held during 25–29 August 2014 in New Delhi, India.

SEAR-ITAG is a regional technical expert group, established by the Regional Director to provide advice on all aspects of immunization, vaccines and vaccine–preventable disease prevention, control, elimination and eradication. It comprises experts from disciplines such as programme management, communicable diseases/vaccine preventable diseases control, virology, epidemiology, and immunization. It meets annually with the participation of national EPI managers, national surveillance focal points and partners to (1) review progress on increasing immunization coverage, surveillance performance, programme issues, and matters related to vaccine quality assurance, and (2) provide guidance to countries on ways to improve and sustain overall high quality performance.

The terms of reference of ITAG are:

(1) to review policies, strategies and plans for control, elimination and eradication of vaccine-preventable diseases, especially for polio eradication, measles elimination and control of rubella and congenital rubella syndrome (CRS) and maternal and neonatal tetanus (MNT) elimination of the Member States of the Region, including the setting of regional immunization priorities;

(2) to guide Member States in strengthening routine immunization programmes;

(3) to make recommendations on a framework for national immunization policies as well as operational aspects of the immunization strategies; guide Member States on the incorporation of new scientific knowledge and technology on vaccines, vaccine delivery and immunization practices;
(4) to advise Member States on the appropriate choices of new vaccines, guide optimal strategies for their introduction, and provide technical guidance on monitoring the impact of new vaccines after introduction into national immunization programmes;

(5) to promote and provide technical guidance for the implementation of high-quality vaccine-preventable disease surveillance, including laboratory networks for surveillance;

(6) to advise Member States on regulatory requirements to ensure quality and safety of vaccines used in national immunization programmes;

(7) to identify and advise on appropriate subject areas for operational research in the fields of immunization and vaccines and review the conduct and results of the research projects; and

(8) to advocate and promote linkages and liaise with global policy-making bodies such as the Strategic Advisory Group of Experts (SAGE), and national committees for immunization practices at the country level.

In the absence of the designated chair, Prof. Lalitha Mendis, the meeting was chaired by Dr. T Jacob John, with Dr. Nyomna Kandun as rapporteur. Other ITAG members in attendance were Dr B D Chataut, Dr Khin Pyone Kyi and Dr Paba Palihawadana. In addition to SEAR-ITAG members, SAGE members representing the Region, members of national committees for immunization practices (NCIP) of Member States, EPI programme managers and surveillance focal points from all 11 countries, representatives from the World Health Organization (WHO) headquarters and the Regional Office for South-East Asia and immunization focal points of WHO country offices, United Nations Children’s Fund (UNICEF) headquarters, the South Asia and Eastern Asia and Pacific regional offices, country offices and a number of other local and global partners and stakeholders, also participated.

2. Objectives

Immunization-related areas are very well-funded, but almost disproportionately so by private foundations and global alliances, who
increasingly wield influence on policy and strategy matters at global, regional and country levels. The substantial funding available has encouraged the proliferation of multiple stakeholders beyond the traditional stakeholders. There is an increasing and constant need for ensuring coordination and coherence in the development and implementation of immunization policies. Additionally, there are time-bound immunization and disease eradication/elimination/control targets which attract intense scrutiny by stakeholders. Thus, regular oversight and monitoring of the programme by a regional advisory body and periodic course correction is essential. In this Region, the SEAR-ITAG meeting is the mechanism that supports this role.

The primary objectives of this meeting were:

(1) to review the status of performance of national EPI programmes in relation to disease eradication/elimination/control targets; and

(2) to address and seek guidance on ways to effectively address the following five issues of importance to the Region:

(a) data quality and strengthening routine immunization to achieve and sustain high immunization coverage;

(b) VPD surveillance in general and sentinel surveillance for congenital rubella syndrome (CRS) in particular;

(c) applying lessons learned from implementation of health systems strengthening (HSS) activities and ways to optimize GAVI HSS implementation to strengthen immunization service delivery;

(d) identifying ways to strengthen effective vaccine management in countries; and

(e) bilateral/horizontal collaborative mechanisms between countries on group procurement to obtain better pricing and assured supply of vaccines.

The main outcomes are related to these areas, with advice for countries and stakeholders on the most appropriate way forward.
3. Conclusions and recommendations

Progress has been made in immunization activities in the South-East Asia Region since the last ITAG Meeting held in April 2013. Two notable milestones are Resolution SEA/RC66/R5 on measles elimination and rubella/congenital rubella syndrome control endorsed by the Regional Committee in September 2013, and the certification of the Region as polio-free in March 2014.

While moving forward with its immunization agenda, a number of key challenges confront the countries in this Region. The most notable one is that regional coverage of the third dose of DTP (DTP3) has remained stagnant for the past five years with India and Indonesia accounting for more than 90% of the Region’s unimmunized infants. Other challenges are that regional measles containing vaccines (MCV) coverage will need to reach at least 95% by 2020, and can only do so if India and Indonesia accelerate their efforts, and if countries that have not conducted a wide age-range nationwide catch-up campaign do so. The Region will also need to ensure that countries introduce routine second-dose measles containing vaccine (MCV2), and a special effort is made by the five countries that have yet to introduce a rubella-containing vaccine.

While faced with challenges, the countries in the Region have demonstrated through the success of polio eradication efforts, that the capacity and know-how are in place to tackle other immunization challenges. Lessons learned from polio eradication are already being applied to respective national immunization programmes.

3.1 Quality of immunization data

ITAG noted the emphasis placed by SAGE on the importance of accurate data on immunization system performance and the prevalence and/or incidence of vaccine-preventable diseases for evidence-informed policy and operational support and for monitoring progress towards national, regional and global goals. During this meeting, ITAG reaffirmed the position of SAGE that the improvement of data quality should be one of the highest priorities for all stakeholders in the early part of the Decade of Vaccines. Several issues related to the quality of immunization data came to light...
including but not limited to: (a) inadequate recording and reporting of immunization data; (b) low availability of home-based records for immunization and variable quality of institutional (retrievable) records; (c) uncertainties on the size and distribution of the populations (i.e. denominator) targeted for immunization; and (d) discrepancies between household surveys and administrative data.

Furthermore, ITAG concluded that data can only be considered to be of high quality if it is fit for making policy and/or operational decisions, and monitoring performance, in terms of delivering services (coverage, supply, temperature monitoring) as well as in controlling the targeted diseases at all administrative levels. This would require that data are complete, have internal and external consistency, and are available in a timely fashion at all levels of the system with sufficient detail to allow informed decision-making and effective planning and monitoring.

On the issue of quality of immunization data, the ITAG recommended as follows.

(1) For Member States:

(a) data quality should be improved through making appropriate financial and human resource investments, and measures introduced to improve data quality, specifically to conduct: (i) annual desk reviews to assess data quality; (ii) periodic in-depth data quality assessments; and (iii) periodic household surveys to validate coverage in addition to collection of data on determinants of immunization coverage;

(b) national and sub-national level immunization coverage data and surveillance data should be shared with the Regional Office according to the agreed timelines and processes;

(c) in-country independent resources (e.g. academia, professional associations) may be used to ensure the quality and independence of the data quality assessments;

(d) data quality improvement plans should be developed, implemented and monitored in response to the results of the assessments; and
(e) NCIPs should be engaged to participate in monitoring progress on implementing the strategies for improving data quality.

(2) For WHO:

(a) guidelines for assessing data quality should be developed and published and data quality improvement plans prepared;

(b) technical support should be facilitated to Member States for analysing and interpreting immunization data and using the results to develop relevant policies and data quality improvement plans;

(c) a data quality meeting should be organized including a review of the joint reporting form, just before the ITAG meeting in 2015.

3.2 Maintenance of polio-free status

ITAG congratulated the country EPI teams and their national governments in achieving polio-free certification and maintaining a polio-free status. The hard work done by the front-line health workers, vaccinators, supervisors, and managers for polio eradication and immunization programmes was also acknowledged. Furthermore, ITAG recognized the generous support and guidance by the donors and partners in achieving certification, and the important contributions of the national certification committees for polio eradication (NCCPE) and the Regional Certification Commission for Polio Eradication (RCCPE).

Despite this enormous achievement, ITAG expressed concern over the issue of the persistently low OPV3 coverage through routine immunization in Indonesia and Myanmar resulting in immunity gaps in children less than five years, and the persistent sub-optimal non-polio acute flaccid paralysis (AFP) rate in Sri Lanka and all AFP surveillance indicators in Timor-Leste. Also raised was the concern over India, Indonesia, Myanmar and Timor-Leste which remain in the high-risk category, with Nepal and Thailand in the medium-risk category for polio outbreaks following importation based on the current regional risk assessment. ITAG urged all countries in the Region to avoid complacency and re-commit to
implementing/sustaining certification-level polio eradication programmes including strong routine immunization delivery.

ITAG took the opportunity to commend the Government of India for implementing polio vaccination of travellers to/from polio-infected countries to mitigate the risk of transmission following importation, and also urged other Member States to consider a similar risk mitigation policy.

During this meeting, there was recognition of the importance of environmental surveillance to supplement AFP surveillance through early detection of imported wild poliovirus (WPV) and emerging vaccine-derived polioviruses (VDPVs), and as a tool to monitor Sabin virus circulation after cession of oral polio vaccine (OPV). ITAG also recognized the Region’s progress towards achieving the four objectives of the Polio Endgame Strategic Plan 2013–2018, including plans for IPV introduction; trivalent oral polio vaccine (tOPV) to bivalent oral polio vaccine (bOPV) switch; and ensuring the legacy of polio eradication by utilizing polio-related resources for eliminating measles and controlling rubella/CRS, strengthening routine immunization; and improving epidemiological and laboratory surveillance for other vaccine-preventable diseases.

ITAG also reaffirmed its support of the related and relevant recommendations of the SAGE, RCCPE and the Global Polio Laboratory Network.

On the issue of maintenance of polio-free status, ITAG recommended as follows.

(1) **For Member States**

(a) All NCCPEs should remain active until global certification. Certification activities should continue as per recommendations of the Regional Certification Commission (RCCPE). All Member countries should continue their efforts to sustain certification-level AFP surveillance and polio immunization performance.

(b) Indonesia, Myanmar, and Timor-Leste should urgently address the issue of persistent low polio immunization coverage through routine immunization. These countries should conduct at least two rounds of sub-national polio supplemental immunization activities (SIAs) in 2015 targeting
high-risk populations and areas. Nepal and Thailand, as medium-risk countries, should seriously consider conducting polio SIAs in 2015. Bangladesh, though low risk, should consider conducting appropriate supplemental polio immunization activities in high-risk populations/areas. India and other countries should follow guidance from their respective national level expert advisory bodies.

(c) In view of the persistent sub-optimal non-polio AFP rate in Sri Lanka and all AFP surveillance indicators in Timor-Leste, both countries should conduct EPI and VPD surveillance reviews in 2015.

(d) In view of the continued transmission of polio in Afghanistan, Nigeria and Pakistan, and the consequent potential for polio importation to the Region, all countries should conduct regular risk assessments and risk mitigation activities.

(e) To reduce the risk of importations, all countries should carefully consider introducing polio vaccination for travellers to/from polio-infected countries in line with recommendations by the Polio Emergency Committee under International Health Regulations and WHO’s International Travel and Health Guidelines.

(f) Environmental surveillance should be initiated in Bangladesh, and expanded in Indonesia in 2014. Environmental surveillance should be initiated in Myanmar, Nepal, Thailand, and Timor-Leste in 2015.

(2) For WHO

(a) Countries should be supported to register IPV, bOPV and other EPI WHO prequalified vaccines, using the “WHO Guidelines on Expedited Approval of WHO PQ Vaccines” by September 2015.

(b) WHO should continue to regularly share regional risk assessments with countries, assist them with sub-national risk assessments, and monitor country risk mitigation activities.
(3) For partners

(a) Partners should work with countries to review IPV introduction plans and ensure vaccine availability in line with recommendations for polio vaccination in 2015 and the tOPV – bOPV switch.

3.3 IPV introduction

ITAG applauded the continued commitment of Member States to implement the Polio Endgame Strategic Plan including the introduction of inactivated polio vaccine (IPV) during 2015. During the meeting, ITAG also recognized that ten countries already have introduction plans with Thailand currently in the process of finalizing their plans. ITAG concluded that in order to synchronize with the April 2016 expected timing of the global switch from tOPV to bOPV, all the countries would need to have introduced IPV by September 2015.

On the issue of IPV introduction, ITAG recommended that WHO should provide:

(a) technical assistance to countries for the timely introduction of IPV; and

(b) additional support and guidance on the issue of IPV and bOPV registration and licensing.

3.4 Measles and rubella surveillance and immunization

ITAG was encouraged by the commitment of the countries to the regional goal of measles elimination and rubella/CRS control by 2020, and by the efforts to put in place the necessary programme components leading to this goal, including building laboratory capacity, putting in place systems to conduct case-based reporting, and implementing data feedback mechanisms. ITAG recognized that with the integrated measles and rubella strategy, and the use of a combination vaccine (MR or MMR) rubella/CRS would also be eliminated.
ITAG observed that it would monitor a number of milestones that must be met to ensure that the Region remains firmly on track for measles elimination and rubella/CRS control by 2020.

On the issue of measles and rubella surveillance and immunization, ITAG recommended, and will monitor, the following operational milestones:

(1) By the end of 2014:

(a) Regional surveillance guidelines and national action plans will be in place.

(b) All countries will have initiated case-based reporting of measles/rubella.

(c) All countries will finalize plans to achieve, maintain and verify at least 95% population immunity against both measles and rubella in all age cohorts.

(d) Individual case-based data should be reported monthly to the WHO country offices and Regional Office in line with reporting requirements.

(2) By the end of 2015:

(a) Case-based surveillance for measles and rubella will be fully operational in all countries except for India and Indonesia which will be expanding case-based surveillance (see 3.c.).

(b) All countries will have initiated sentinel surveillance for CRS.

(c) Susceptibility profile of populations to measles and rubella in all countries will have been described.

(d) A Regional Verification Commission will have been established and a national verification committee established in every country.

(e) All countries will have adequate access to accredited national and reference laboratories.

(3) By the end of 2016:

(a) All countries in the Region will have an optimal two-dose measles-rubella containing vaccine schedule.
(b) All countries will have conducted high quality wide age-range immunization campaigns against both measles and rubella.

(c) India and Indonesia will have fully operational nationwide case-based, laboratory-supported measles/rubella surveillance with strong links to outbreak investigations and inclusion of line-listed cases from confirmed outbreaks in the case-based surveillance system.

(d) All countries will plan for evaluations of the impact of the nationwide wide age-range MR campaigns and follow-up narrower age-range MR campaigns.

(4) In addition to the operational milestones outlined for 2014, 2015 and 2016, ITAG made the following country-specific recommendations:

(a) For Thailand to conduct a wide age-range nationwide, serosurvey for measles and rubella at the provincial or lower level and report back to ITAG at its next meeting the results of the serosurvey and its national plan to achieve the 2020 goals. Thailand should specify its plans to close any immunity gaps found and report back to ITAG in 2015.

(b) While Indonesia has made significant progress decreasing measles and rubella cases through immunization, significant challenges remain in achieving the 2020 measles elimination and rubella/CRS control goal. Indonesia should determine the population immunity profile, develop plans for a nationwide, wide age-range MR campaign before the 2015 meeting of ITAG, and conduct the necessary SIAs in 2015 or at the latest in 2016. Indonesia and the partnership should explore options to secure MR vaccine supply and operational costs.

(c) Myanmar should implement a high-quality MR campaign as planned in early 2015, followed by MR vaccine introduction into the routine schedule, and a national coverage survey and to report back on EPI coverage at the 2015 ITAG meeting.
(d) It was noted with appreciation India conducted a post-introduction evaluation of measles second dose and is planning for MR introduction, with a campaign targeting children nine months to <15yrs of age. By the next ITAG meeting in 2015, the country incorporates the recommendations of post-introduction evaluation into their health plans and into the planning for MR introduction into the routine schedule. ITAG strongly recommended that all states in India administer rubella vaccine with both doses of measles vaccine. ITAG would like to review at the 2015 meeting the plans for expansion of the laboratory network as case-based surveillance is initiated in 2015.

(e) Timor-Leste should introduce two doses of MR containing vaccine by 2015.

(f) The progress that Nepal has made was recognized and the high immunization coverage reached by the MR campaign, and recommends that the country introduces a second dose of MR vaccine into the routine vaccination schedule and expands the case-based surveillance system to cover all health facilities in the country.

(g) It was recognized that the Democratic People’s Republic of Korea has controlled measles well, perhaps already having eliminated measles. The Democratic People’s Republic of Korea should conduct a nationwide serosurvey for rubella (across a wide age-range) and for measles, and to introduce a two dose schedule with a measles and rubella containing vaccine. Based on the results of the serosurvey, the country should conduct an MR campaign to close any immunity gaps, and complete the serosurvey and plans for MR introduction and campaign before the ITAG 2015 and report on these at the meeting.

(h) It was noted that Bhutan, Democratic People’s Republic of Korea, Maldives, and Sri Lanka may possibly have eliminated measles. These Member States should begin the process of verifying measles elimination and report back on their progress to date at the next meeting in 2015.
(5) Related to the MR laboratory network, the ITAG recommended that:

(a) Laboratory capacities should be scaled up to be fully functional to meet the demands of greater number of tests and with a turnaround time within four days.

(b) Timor-Leste should enhance its current laboratory to “proficient” status in order to support case-based surveillance.

(c) Laboratory capacity should be enhanced to provide the genotype data for measles and rubella required to identify indigenous transmission, sources of infection and imported and import-related cases.

(d) By 2016, for verifying interruption of indigenous transmission and to identify imported and import-related cases, measles virus genotypes should be characterized in at least 80% of chains of transmission.

(e) By the end of 2015, all Member States should share genotype information in a timely fashion.

(f) The WHO Regional Office should conduct a training workshop on laboratory aspects of CRS in 2015.

Given the numerous milestones related to measles and rubella surveillance and immunization, ITAG requested the Regional Office to provide an annual report on the progress towards reaching these milestones. The report should be made available to all ITAG members at least once a year prior to the annual ITAG meeting.

3.5 Assessing population immunity and defining susceptible populations for action

ITAG recognized that countries have the capacity and will need to commit to activities related to assessing population immunity, identify susceptible populations (geographic, age groups, etc) and develop plans for MR vaccination activities. These vaccination activities, routine and campaign, are required between now and 2016 to ensure that the Region remains firmly on track for measles elimination and rubella/CRS control by 2020.
On the issue of assessing population immunity and defining susceptible populations for action, ITAG recommended that all countries should:

(1) By 2015:
   (a) describe population susceptibility with the purpose of preventing outbreaks of measles and rubella and report back to ITAG 2015; and
   (b) produce annual population immunity profiles and report to ITAG annually.

(2) By 2016:
   (a) identify their remaining susceptible populations following their nationwide wide age-range MR catch-up campaigns and conduct MR follow-up campaigns to achieve 95% immunity.

### 3.6 CRS sentinel surveillance

ITAG recognized the commitment of the countries to the measles elimination and rubella/CRS control target by 2020. Bangladesh and Sri Lanka were appreciated for already having CRS sentinel surveillance systems in place and demonstrating that this is feasible. ITAG was also encouraged by the efforts made in all countries to put in place the necessary components towards this goal, including building laboratory capacity, putting in place systems to conduct case-based reporting, and data feedback mechanisms.

It was acknowledged that the countries will need to commit to several actions between now and 2016 in order to ensure that the Region remains firmly on track for measles elimination and rubella/CRS control by 2020.

On the issue of CRS sentinel surveillance, ITAG recommended as follows:

(1) By 2014:
   (a) For countries that have established CRS sentinel surveillance, a plan should be in place to conduct an evaluation of the
surveillance system (may include retrospective review of data from the reporting sites).

(2) By 2015:

(a) All countries should have initiated sentinel surveillance for CRS.

(b) Countries with established CRS sentinel surveillance should use CRS data in conjunction with case-based rubella data to monitor the progress of the rubella control programme.

(c) All countries with CRS sentinel surveillance should report data to the Regional office.

3.7 Japanese encephalitis

ITAG recognized that there has been significant progress in JE control and prevention in the last few years in the ten endemic countries. This progress has been demonstrated through a number of activities including (a) surveillance which has been established or strengthened in several countries; (b) vaccine introduction through campaigns in selected high risk areas (India and Nepal) or nationwide vaccination (Sri Lanka and Thailand); (c) countries with well-established vaccination programmes are piloting or switching to newer vaccines and evaluating vaccine impact through surveillance or case-control studies; and (d) operational research which has been carried out in the Region. There was some discussion on the new opportunities, including two WHO-prequalified JE vaccines, GAVI financing for eligible countries and a renewed support from partners, now exist to achieve even greater control of the disease.

ITAG also noted that surveillance data are not yet sufficient (in volume, breadth, quality, and/or laboratory confirmation) in some countries. Furthermore, guidance and tools to use country-level data for designing policies and strategies including JE vaccine introduction are still required. It was also recognized that while mosquito control can be part of JE control programme, vaccination against JE is essential.

On the issue of JE, ITAG recommended as follows:

(1) Countries without adequate JE/AIDS surveillance data should establish or strengthen sentinel surveillance.
(2) Of the ten endemic countries (all but Maldives), those that are not vaccinating should establish the disease burden to guide the development of a national policy for vaccination.

(3) Countries that have JE surveillance should analyse available JE/AES data to inform national policies on vaccine use and track progress with disease control.

(4) Where it is not feasible to conduct vaccination in all affected areas at once, countries may consider a phased introduction.

(5) All countries that have introduced JE vaccine should have mechanisms to monitor JE immunization coverage, verify immunization status and conduct surveillance or special studies to evaluate vaccine effectiveness/impact.

(6) The Regional Office should develop regional policy guidelines for JE control and prevention.

3.8 **Maternal and neonatal tetanus elimination**

ITAG recognized that the South-East Asia Region has achieved impressive results in validating MNT elimination in all countries except India and Indonesia, and that the Region has a strong chance of reaching the MNT elimination goal by 2015. It also acknowledged that after the validation of MNT elimination, countries will need to assess their status through an annual review in order to sustain MNT elimination.

On the issue of MNTE, ITAG recommended as follows:

(1) India and Indonesia should verify their elimination status by the end of 2015.

(2) Countries should conduct annual data reviews to assess MNT risk status and to take action as appropriate.

3.9 **Influenza prevention and control**

ITAG recognized that there is evidence of a significant year-round seasonal influenza burden in this Region, and that Thailand is the only country that offers seasonal influenza vaccination through EPI. Furthermore, it noted the importance of delivering seasonal influenza vaccination to high-risk groups,
in particular pregnant women and health-care workers, to mitigate its health and economic impacts in the Region. The significance of the influenza vaccine for effectively responding to future influenza pandemics, as well as sustaining the regional influenza vaccine manufacturing capacity was noted. Predictable demand in the countries is required to sustain the influenza vaccine manufacturing capacity in the Region.

On the issue of influenza prevention and control, ITAG recommended as follows:

(1) The countries in the Region should develop national policies on seasonal influenza vaccination for high-risk groups: pregnant women, children aged 6–59 months, the elderly, individuals with specific chronic medical conditions and for health-care workers.

(2) All countries in the Region should develop plans for generating evidence or collating existing evidence for decision-making by the 2016 meeting of ITAG.

(3) All countries should strengthen influenza surveillance, establish disease burden and share data with the WHO Regional Office.

### 3.10 Effective vaccine management

ITAG recognized that high-quality vaccine supply chain management can only be achieved if all the components in the supply chain comply with recommended storage and distribution practices, and that the effective vaccine management (EVM) initiative provides the guidelines and materials to support countries to improve their supply chain performance.

On the issue of EVM, ITAG recommended as follows:

(1) Countries should conduct EVM assessments and prepare EVM improvement plans with clearly defined roles and responsibilities which address gaps identified and plan for how monitoring will occur regularly, and report to ITAG annually.

(2) Countries should use 30-day temperature recorders at national and sub-national levels with properly trained personnel.
(3) Countries should establish real-time monitoring systems using innovative tools for the availability of data (e.g. temperature, cold chain equipment functionality, vaccine stock level).

### 3.11 Adverse events following immunization

ITAG recognized that the countries of the Region have made significant progress in implementing post-marketing vaccine safety surveillance. However, in order to increase detection and investigation capacity, they need to further develop a training strategy to reach out to frontline health-care workers and enhance capacity at district and regional levels to detect and report adverse events following immunization (AEFI).

On the issue of AEFI, ITAG recommended as follows:

1. Countries should develop guidelines to plan and conduct field investigation of serious AEFI and report back to the 2015 meeting of ITAG.

2. The WHO Regional Office should explore the role of autopsies in investigating AEFI and develop guidelines on how to more effectively capture AEFI-associated deaths and assess causality.

### 3.12 Pooled procurement mechanisms

ITAG recognized that the smaller countries (Bhutan, Maldives and Timor-Leste) may need to review vaccine procurement policies to continue with UNICEF-supplied vaccine (procurement service mechanisms) or procure vaccine directly in compliance with the principles of good procurement practices.

On the issue of pooled procurement mechanisms, ITAG recommended as follows:

1. Countries should share procurement models to both enhance vaccine product and market knowledge, as well as guide policymakers in making informed decisions on their procurement policies.
(2) The WHO Regional Office should provide guidelines and share lessons learned from other pooled procurement experiences with relevant countries.

4. Conclusions

The Fifth Meeting of SEAR-ITAG represents a transitional event, as the term of the current experts who make up its membership expires. The meeting this year also represented a new ITAG format in which three previously separate events, that is, the ITAG Meeting, EPI managers’ meeting, and thematic work were consolidated into one meeting. The expansion of the partnership allowed for more transparency and identification of challenges and synergies. The general consensus was that this consolidation of various meetings, along with the inclusion of stakeholders, was both productive and efficient, and so the Secretariat has concluded that this format would be followed from 2015.

The sixth meeting of ITAG, tentatively planned for June 2015 will have a newly-formed panel of experts operating under revised terms of reference for the next five year period, 2015–2019. The tentative dates proposed for the sixth meeting of SEAR-ITAG are early June 2015.
Annex 1

Agenda

(1) Opening session

(2) Immunization and surveillance, including:
   (a) polio endgame and IPV introduction
   (b) measles elimination and rubella and CRS control
   (c) laboratory network, updates
   (d) vaccine quality assurance and AEFI surveillance response

(3) Thematic work groups
   (a) setting up sentinel CRS Surveillance – practical guidance to countries;
   (b) strengthening data quality of routine reporting and routine immunization;
   (c) Health systems strengthening – lessons from current implementation and future directions
   (d) EVM and vaccine stores management – review of current status and next steps
   (e) group procurement arrangements

(4) Partners’ session
Annex 2

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The fifth meeting of the World Health Organization’s South-East Asia Regional Immunization Technical Advisory Group (SEAR-ITAG) was held during 25–29 August 2014 in New Delhi, India. SEAR-ITAG is a regional technical expert group, established by the Regional Director for providing advice on all aspects of immunization, vaccines and vaccine-preventable disease prevention, control, elimination and eradication. It comprises experts from disciplines such as programme management, communicable diseases/vaccine preventable diseases control, virology, epidemiology, and immunization. It meets annually with the participation of national EPI managers and surveillance focal points and partners to review progress on increasing immunization coverage, surveillance performance, programme issues, and matters related to vaccine quality assurance, and provides guidance to countries on ways to improve and sustain overall high quality performance. This report outlines the conclusions and recommendations of this expert group meeting.