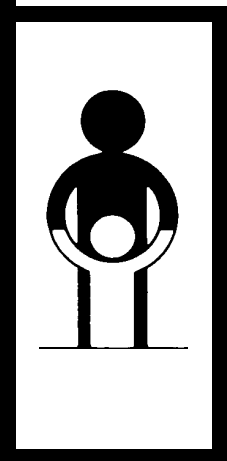


Report of the meeting of interested parties of the Global Programme for Vaccines and Immunization

Geneva 12 June 1998



**GLOBAL PROGRAMME FOR VACCINES AND IMMUNIZATION
EXPANDED PROGRAMME ON IMMUNIZATION**



World Health Organization, Geneva, 1998

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List of abbreviations

AFP	acute flaccid paralysis
AMRO	WHO Regional Office for the Americas
AusAID	Australian Agency for International Development
CDC	Centers for Disease Control and Prevention (US)
DAP	Action Programme on Essential Drugs (WHO)
DFID	Department for International Development (UK)
EPI	Expanded Programme on Immunization (WHO)
FWHF	Federation of World Health Foundations
HIV	human immuno deficiency virus
GPV	Global Programme for Vaccines and Immunization (WHO)
GTN	Global Training Network
ICO	Division of Intensified Cooperation with Countries and Peoples in Greatest Need (WHO)
JICA	Japanese International Cooperation Agency
NCA	National control authority
NID	National immunization day
OPV	oral polio vaccine
PAHO	Pan American Health Organization
SAGE	Scientific Advisory Group of Experts
SEARO	WHO Regional Office for South-East Asia
SNID	sub-national immunization day
UNICEF	United Nations Childrens' Fund
USAID	United States Agency for International Development
VRD	Vaccine Research and Development (WHO)
VSQ	Vaccine Supply and Quality (WHO)

Opening statement

Dr Ralph Henderson, Assistant Director-General of WHO, opened the meeting by quoting from the original World Health Assembly resolution that called for global polio eradication:

“...eradication efforts should be pursued in ways that strengthen the development of the Expanded Programme on Immunization as a whole, fostering its contribution, in turn, to the development of health infrastructure and primary health care”.

He described some of the long-term benefits that are already becoming apparent as a result of the Polio Eradication Initiative. He singled out the value of a success story to motivate and reactivate people working in health services.

He concluded by proposing that the Chair, Vice-chair and Rapporteur should be re-appointed from the morning session: Mr Robert Clay (Deputy Director, Bureau for Global Programs, Field Support and Research, United States Agency for International Development), Dr Khadija Msambichaka (EPI Programme Manager, Mabibo Vaccine Institute, Tanzania), and Ms Janey Parris (Chief Programme Officer, Commonwealth Secretariat, United Kingdom), respectively.

Mr Clay then invited Dr Jong Wook Lee (Director, GPV) to open the meeting. Dr Lee welcomed the participants, and wished all a fruitful afternoon with good discussions.

Polio status report – brief introduction

Dr Bjorn Melgaard, Chief, EPI

Dr Melgaard introduced the work of the Polio Eradication Initiative of the Global Programme for Vaccines and Immunization (GPV) by describing the dramatic decline in polio cases reported to WHO between 1988 and 1998. He reported that the Region of the Americas is already free from polio as are areas of Europe, Asia and the Western Pacific. Most cases reported are now in central Africa and the Indian sub-continent.

The supply of sufficient high quality oral polio vaccine remains a high priority for Vaccine Supply and Quality (VSQ). The unit has been working to assure local production capacity in countries such as Egypt and India. Bulk supply contracts have been established.

The thermostability of the vaccine and wastage reduction continue to be a focus for the programme, with work continuing on providing all OPV vials with vaccine vial monitors. The stability requirements are part of the UNICEF tender.

In 1994, Vaccine Research and Development (VRD) was asked to facilitate the evaluation of oral polio vaccine safety with a test using mice instead of monkeys. This has been achieved through a neurovirulence test using transgenic mice. They were also asked to develop a simpler diagnostic test for polio surveillance. This has also been achieved. The test is highly selective for poliovirus and in field conditions it is simpler, faster and more specific than other available tests. It has already been introduced into polio laboratories worldwide.

The impact of the polio eradication initiative on health systems will be assessed in Africa. The evaluation results and lessons learned will be important for EPI in the future.

The recommendations from earlier in the week made by the Scientific Advisory Group of Experts (SAGE) with regard to polio eradication were presented. The three main recommendations were:

- WHO should call urgently on the international leadership to ensure that the goal of polio eradication by the year 2000 is translated into reality. To secure necessary funding, the Director General should ensure that resources are identified by late 1998 and made available in a timely manner.
- GPV should rapidly expand eradication activities in the remaining polio endemic areas: additional national immunization day (NID) rounds, mopping-up, additional staff.

- An annual report on progress towards polio eradication should be made to the World Health Assembly.

Figure 1: Global polio situation 1988

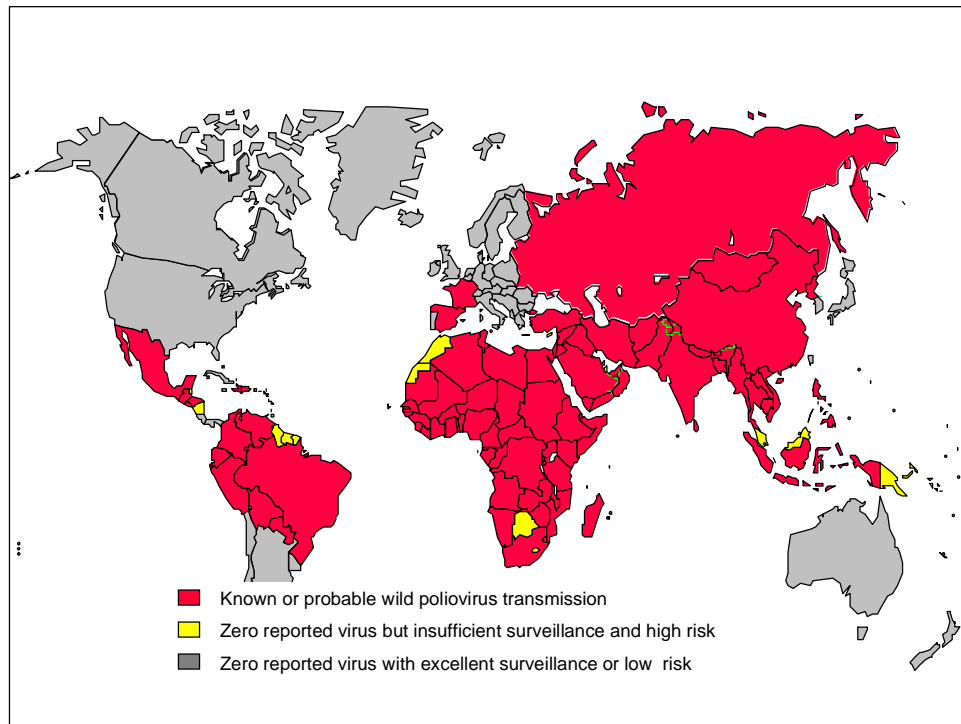
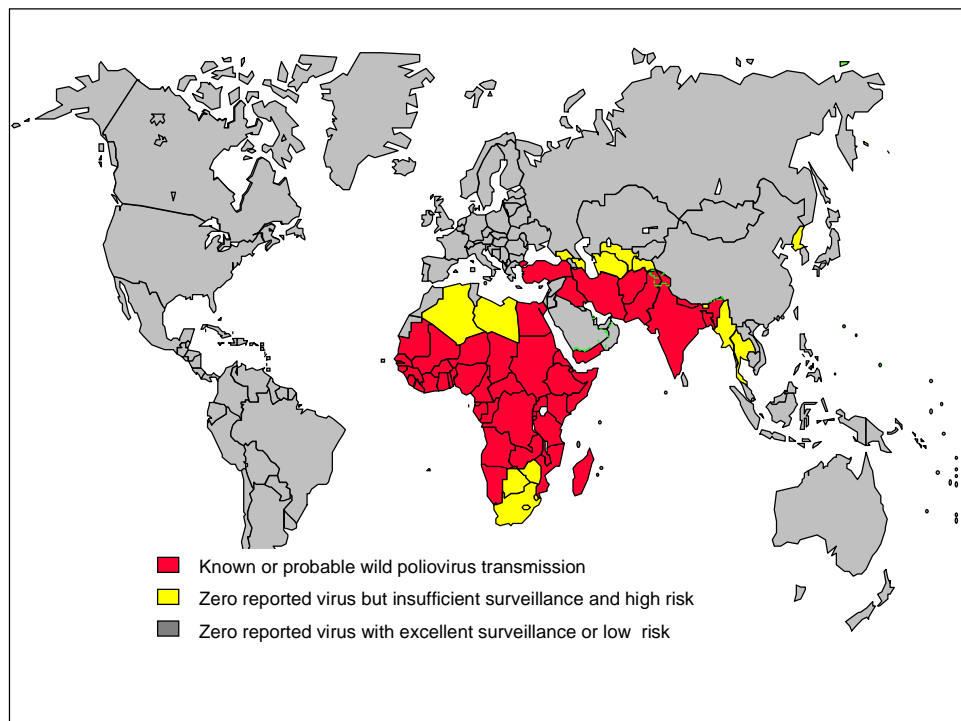


Figure 2: Global polio situation 1998



Progress in the Polio Eradication Initiative

Dr Harry Hull, Medical Officer, EPI

Tremendous progress has been achieved since WHO's polio eradication goal was established in 1988. Today, it seems possible that the target will be met – if not in the year 2000, then certainly shortly thereafter.

This progress is primarily seen as the result of the co-operative efforts of the expanding partner coalition which includes Rotary International, UNICEF, the United States of America (through both the Centers for Disease Control and Prevention and USAID), Australia, Canada, Denmark, Germany, Japan, the United Kingdom and many other countries. The corporate sector, especially the vaccine manufacturers have also made important donations. However, the most important partners are the polio-endemic countries themselves. They are to be congratulated on their efforts.

WHO's plan for polio eradication relies on four basic strategies: routine immunization, national immunization days (NIDs), acute flaccid paralysis (AFP) surveillance and mopping-up immunization. More than 80% of the children born worldwide each year since 1990 were immunized with three doses of oral polio vaccine (OPV) as part of their "baby shots". NIDs deliver two doses of OPV to all children less than five years of age, even if they have been previously immunized.

In 1997, more than 450 million children were immunized during NIDs in 75 countries - approximately two-thirds of the world's children of less than five years of age. One hundred and thirteen countries have conducted NIDs since 1988. AFP surveillance is used to track down the last cases of polio and then conclusively demonstrate that polio is gone. AFP surveillance has been established in all polio endemic countries. However, the system is in very early stages in Africa and the reliability of the system is low on that continent. A global network of 133 laboratories has been established to provide reliable identification of polioviruses. Mopping-up immunization is the end-game strategy for polio. When polio is confined to a few final reservoirs, vaccinators go from house to house in high-risk areas so that every child is reached. Mopping-up immunization was recently undertaken in the Mekong Delta in Cambodia and Viet Nam, reaching 2 000 000 children. As a result, there has been no polio in either country for 15 months now.

As a result of these activities, the number of polio cases has declined by nearly 90%. From 35 000 reported cases in 1988 to 5 000 reported cases in 1997. Polio is now essentially confined to South Asia (Afghanistan, Bangladesh, India, Nepal and Pakistan) and sub-Saharan Africa, with major concentrations in West Africa (Nigeria), Central Africa (Democratic Republic of the Congo (Zaire) and the Horn of Africa (Ethiopia, Somalia and Sudan).

The work of polio eradication will not end when the last case occurs. Intensive AFP surveillance must continue for at least three years to ensure that polio really is gone. WHO has convened a Global Commission for the Certification of Poliomyelitis Eradication and projects that certification will occur in the year 2005. The two closing chapters for polio will be the containment of wild polioviruses and the stopping of immunization. Wild polioviruses are used extensively in research and are found in many diagnostic laboratories. WHO has started a process to restrict the laboratory use of wild polioviruses. One year after the last case of polio, all wild polioviruses will be confined to a limited number of high security laboratories to eliminate the possibility of an accidental release of poliovirus. Stopping immunization against polio is the final step. WHO convened a meeting in March 1998 to define a research agenda so that a firm recommendation on stopping immunization can be made around the year 2000.

Polio financing

Dr Bruce Aylward, Medical Officer, EPI

Referring to the 90% reduction in reported cases and the limitation of wild poliovirus transmission to sub-Saharan Africa and South Asia, Dr Aylward reiterated that global polio eradication is within reach. However, the most difficult phases of the initiative lie ahead. Fifty-two countries remain endemic. Fifteen of these will prove especially challenging. Seven countries are affected by conflict where health infrastructure is minimal, access to children is limited and programme costs will be much higher. Eight countries are considered major reservoirs where large populations with large birth cohorts, low immunization coverage, overcrowding, poor sanitation and high migration rates combine to make poliovirus transmission particularly intense.

If the target date is to be met and the costs of global eradication kept to a minimum, the eradication activities must be accelerated and intensified. This will require strengthening of routine immunization programmes, additional rounds of sub-national immunizations days (SNIDs)/national immunization days (NIDs) in major reservoirs, the establishment of polio eradication teams in conflict countries and the assignment of personnel specifically for surveillance to all remaining endemic countries. To achieve this, additional financial support must be secured. The shortfall for 1998 at mid-year is \$65 million of the \$217 estimated total cost. Primary shortfalls are in the areas of operational costs of NIDs and acute flaccid paralysis (AFP) surveillance including laboratory costs. Geographically, 50% of the shortfall is in Sub-Saharan Africa. Funding is also needed for WHO Headquarters, particularly for the performance of its co-ordination functions and the mobilization of support for countries in conflict, cross-border activities and emergencies.

The implication of these shortfalls as well as the delayed arrival of funds is inadequate to fund NIDs and improve surveillance. Given the difficulties in eradicating polio in the conflict countries and major reservoirs, delays in these countries will postpone the date at which polio eradication will be achieved and the total programmatic cost will rise significantly. Mobilizing these funds will require the full support of the Director-General of WHO and other international leaders.

Accelerating immunization towards the year 2000 and beyond

**Ms Adelaide Shearley, EPI Manager,
Ministry of Health and Child Welfare, Zimbabwe**

The 0-10-20 is an initiative to accelerate planned immunization activities and implement innovative approaches in poor countries. The initiative is aiming to reach the goals and targets related to vaccine preventable diseases (90% immunization coverage, elimination of neonatal tetanus, control of measles by the year 2000 as well as introduction of hepatitis B and yellow fever vaccines), set by the World Summit and the World Health Assembly

The following areas for improvement were identified:

- Reaching the "unreached".
- Improving the management of immunization.
- Sustaining immunization through "health sector reform" and "decentralization".
- Introducing "new" financing mechanisms – dealing with competing health priorities.
- Maintaining public confidence in immunization.
- Improving the effectiveness of the global partnership for immunization

Selected issues were highlighted:

- In 1998 a large number of developing countries have an unreached population resulting from a combination of poor geographical access to immunization services and poor utilization of accessible immunization services. Most countries with DPT3 coverage of less than 50% in 1990, are still below 50% in 1997. These countries are the poorest in the world and are donor dependent. Nevertheless, national immunization days (NIDs) for polio eradication and the high risk approach for neonatal tetanus undertaken in these countries have demonstrated that women and children can be immunized in hard-to-reach areas in all countries. Microplanning at district level will become an essential tool to develop innovative and effective approaches to immunize unreached populations. Innovative approaches may include sustained outreach services with an appropriate package of health intervention provided periodically. Community participation and specific communication strategies will become crucial to make this approach cost effective.

-
- Health sector reform and decentralization are ongoing in most developing countries and can have a significant impact, both positive and negative, on EPI. The preliminary lessons learned have revealed that some essential EPI functions such as national policies, standards and procurement and assurance of quality, should not be decentralized. Tools and guidelines should be developed for decision-makers and programme managers to enable effective participation in the reform process. There is a need to advocate the use of EPI coverage and surveillance indicators in monitoring the performance of the health reform process.
 - Through the banding strategy, major progress has been achieved in self-sufficiency for traditional EPI vaccines but the poorest countries remain donor dependent for traditional vaccines, new vaccines and the delivery of immunization services to the hard-to-reach population. Promotion of government budget lines for immunization and a system to monitor and report contributions and unmet needs appear essential to mobilize the required funds. The effective European Union model to fund vaccines could be expanded to new vaccines and unmet needs. New loan mechanisms by Regional and Global Development Banks, and the creation of revolving and trust funds are definitely required.

In order to facilitate the process of making projects operational, other key issues will be reviewed and a plan of action developed. This will be undertaken, initially in selected countries, and in close collaboration with partners.

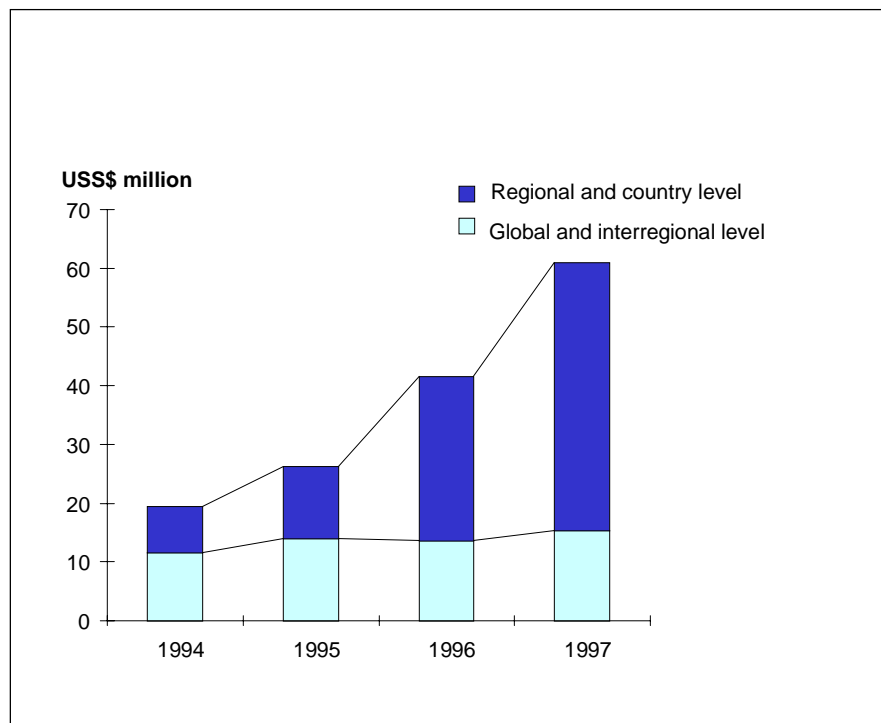
Report on GPV – financial and global overview

Mr James Cheyne, Programme Officer, GPV
Ms Fabienne Adam, Administrative Assistant, GPV

During the four years that GPV has been in existence, there has been a general increase in funding both at Headquarters and in the Regions. There has been a small increase in Headquarters funding (+29%), from US\$ 11.6 million in 1994 to US\$ 15 million in 1997. In the same period, regional income increased considerably, from US\$ 7.9 million to US\$ 45.6 million.

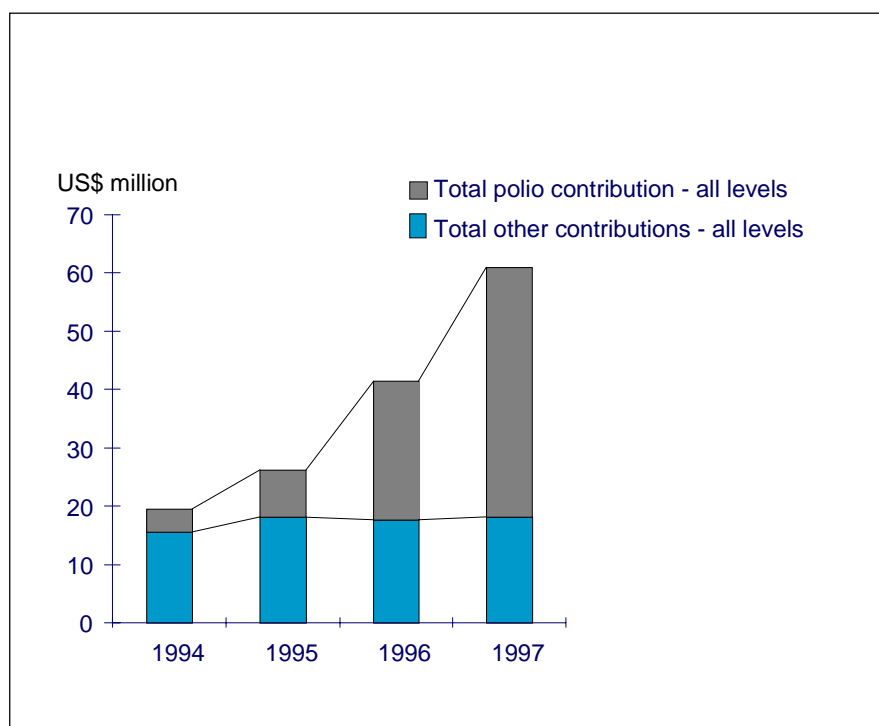
The increase in contributions is the result of a global effort, by Headquarters, by our colleagues in the regional offices, and also by donors who play a major advocacy role in raising interest in vaccine-preventable diseases globally.

Figure 3: Increase in voluntary contributions at all levels



During 1994-1997, voluntary contributions increased most for the regions and the countries.

Figure 4: Analysis of increased contributions



The exponential increase was largely due to the extensive commitment of some donors towards the eradication of poliomyelitis.

Polio contributions increased from 21% of the total contributions received in 1994, to 70% in 1997. It should however be emphasized that contributions for polio also support other aspects of EPI, particularly the cold chain, training, surveillance, and laboratory work. This support also builds on international awareness and a commitment which should certainly benefit other forthcoming efforts against vaccine-preventable diseases. It is interesting to note that other contributions also increased, by 14%, between 1994 and 1997, during which time other WHO programmes, largely funded by voluntary contributions, were facing different situations.

Figure 5: Voluntary contributions

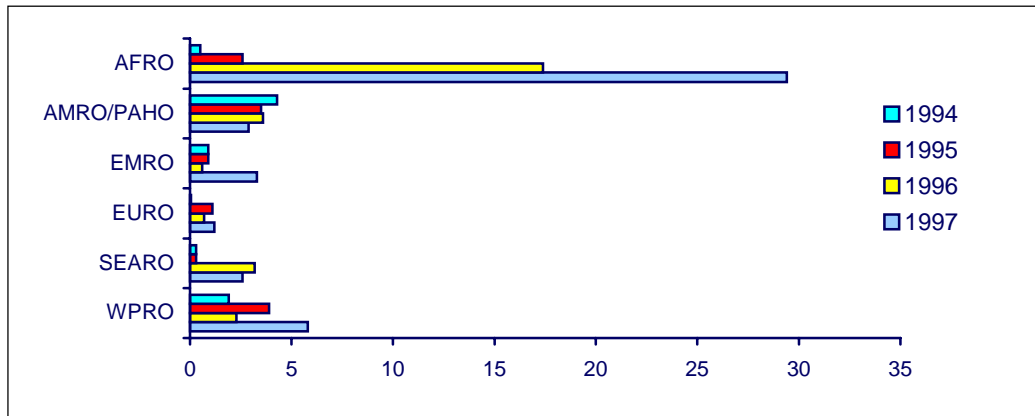


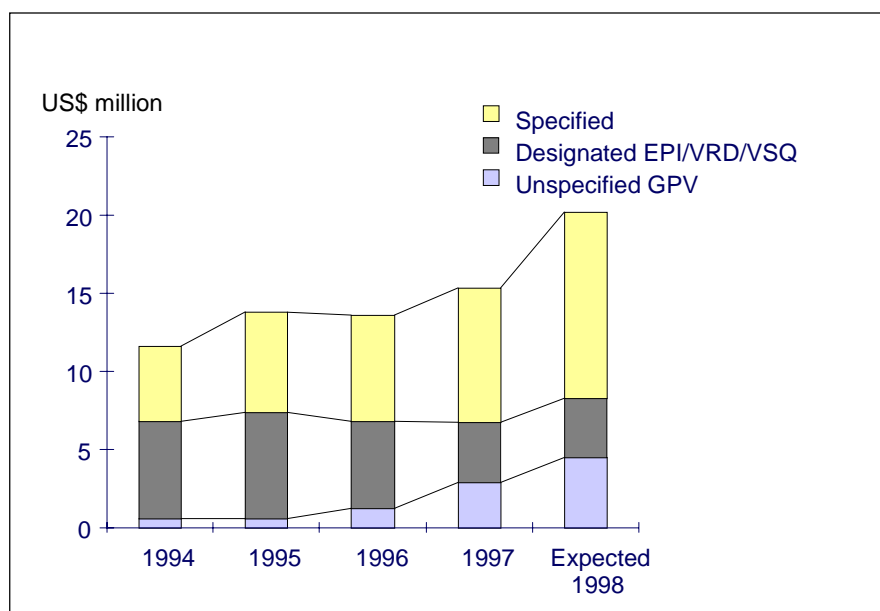
Figure 5 shows all voluntary contributions received at the regional and country level for GPV activities in 1997 (including contributions received by the Pan American Health Organization for immunization activities).

Three regions, Africa, Eastern Mediterranean and Western Pacific, benefited most from the increase in voluntary contributions in 1997.

The income in the African Region increased from approximately US\$ 0.5 million to almost US\$ 29.4 million over four years. The South-East Asian Region received a contribution of US\$ 2.3 million from Denmark in January 1998 which is not accounted for in Figure 5.

New contributors to the Regional Offices in 1996-97 were the governments of Canada, Denmark, Germany, the Netherlands, the Republic of Korea and Spain. Other contributors included Ms Martina Hingis and the American Association for World Health. Ms Adam thanked all the contributors for their valuable support, and especially welcomed the new contributors. Without this support the Regional Programmes would not have been able to make the progress described in the earlier presentations.

Figure 6: Evolution of contributions to Headquarters during 1994-1997



The total of specified and designated contributions remains stable at US\$ 7 million per year. We expect this total to increase in 1998 to reach US\$ 8.3 million. The largest increase has been in contributions for specified projects. Specified contributions represented 41% of the total received in 1994 and 56% in 1997. Ms Adam thanked all donors for their increased support. She did however emphasize the need for more unspecified funds as the lack of such funds limits the capacity of the programme to fund priority projects and support its partners in the regions to the extent desirable

The new contributors to the Headquarters programme in 1996-1997 were the Governments of Canada, Finland, Luxembourg and Switzerland. The International Federation of Pharmaceutical Manufacturers' Associations contributed for the first time. Ms Adam emphasized the hope of a good and long-term collaboration. She concluded by thanking the Government of the United Kingdom which has increased its contribution in 1998 to US\$ 3.3 million.

Ms Adam then showed an analysis of how the programme had used its financial resources, both voluntary contributions and WHO regular budget allocation, in 1996-1997. The detailed analysis may be found in the GPV Financial Report for the biennium 1996-1997. (GPV document WHO/GPV/98.05).

Ms Adam concluded her presentation by pointing out that the *Strategic Plan 1998-2001* shows a funding shortfall of US\$ 8.5 million per year for 1998-99. With the guidance of outside experts and SAGE, priorities and strategies have been determined with clear targets and indicators. Additional resources are needed by the programme if it is to reach its goals and also prepare for the ones beyond 2001.

Mr Cheyne gave a brief introduction to *the Strategic Plan 1998-2001 (WHO/GPV/98.04)*. He described the development of the plan and pointed out the details of areas where the funding shortfalls are most acute – in the development and introduction of new vaccines, polio eradication, immunization safety, vaccine quality and surveillance.

Injection safety

Mr Michel Zaffran, Technical Officer, EPI

Mr Zaffran began his presentation by pointing out that the first priority of the Expanded Programme on Immunization (EPI) is the eradication of poliomyelitis. EPI does however have many other priorities, among which are the following :

- Increasing immunization coverage and ensuring equitable access to immunization.
- Strengthening immunization services in countries in greatest need.
- Maximizing the benefits of the Polio Eradication Initiative to health services.
- Reducing measles morbidity and mortality.
- Eliminating neonatal tetanus.
- Reducing the hepatitis B carrier rate.
- Introducing yellow fever vaccine in countries at risk.

GPV/EPI is actively involved in all of these areas. Objectives, indicators and progress over the past few years are described in detail in the *GPV Programme Report* and the *GPV Strategic Plan*.

One area, cutting across all other priorities of the programme, is the need to improve and maintain a high quality of immunization services. In this area the programme is facing several challenges:

- The quality of services needs to be maintained in the phase of health-sector reform and decentralization. Particular attention must be paid to staff performance and the development of strategies adjusted to the local conditions.
- Potency and safe handling of vaccine have to be guaranteed at the point of use. This requires the strengthening of central vaccine storage and the streamlining of vaccine distribution in order that safer but less expensive, more flexible peripheral cold chain and vaccine delivery systems can gradually be introduced.
- Last, but not least, one of the most daunting challenges of immunization services today is the need to guarantee the highest level of injection safety.

In 1997, 1.2 billion injections were administered through immunization programmes worldwide. These represent only 10% of all injections administered for all purposes. Unsafe injection practices carry a high risk of transmission of blood-borne pathogens such as hepatitis B, hepatitis C and HIV. Over the past years, numerous reports have documented that unsafe injection practices are most often caused by the reuse of

disposable injection equipment and the absence of equipment and management system for the handling and destruction of contaminated equipment.

Over the years, intensive efforts have been made by EPI to ensure safety through the introduction of suitable equipment and the training of health care workers. However, GPV/EPI has recognised that efforts in immunization are insufficient to address the broad issue and that progress in the safety of immunization injections is often limited because they are limited to only one particular sector. Rapid and substantial progress towards safer injections needs a much broader approach to encompass all types of injections. In collaboration with other WHO divisions, GPV/EPI has developed a strategy aiming to improve the safety of all injections.

This strategy is based on five objectives :

- Raising awareness.
- Developing and introducing new technologies.
- Developing policies and guidelines.
- Building capacity.
- Developing financing mechanisms.

The implementation of this strategy requires broad consensus and support from all partners including agencies, industry, non-governmental organizations and countries. GPV is currently collaborating with the United Nations Children's Fund (UNICEF), the United States Agency for International Development (USAID) and the Centers for Disease Control and Prevention (CDC) to put a mechanism for the co-ordination of these efforts into place.

A framework for selecting priorities for vaccines and vaccination research in GPV

Dr Paul-Henri Lambert, Chief, Vaccine Research and Development

Dr Lambert presented to the delegates the need to prioritize topics for vaccine and vaccination research in a rapidly changing and more demanding world. The following list of criteria describes a methodology used by GPV/VRD to do that. The methodology has two levels. Level one falls into two broad categories: the importance of the disease to be prevented and the potential impact of research on vaccination strategies. Level two consider both groups together.

VRD decision-making criteria	
Level 1	
Criteria for disease-related research	<ul style="list-style-type: none">• Global disease burden• Potential impact of vaccines on disease burden• Potential to contribute to eradication/elimination• Importance of the disease to developing countries• Epidemic potential of the disease• Antimicrobial resistance• Inadequacy of other control strategies
Criteria for research on vaccination strategies	<ul style="list-style-type: none">• Potential positive impact on vaccination programmes• Potential to identify and avoid serious adverse effects• Potential of vaccination strategies in selected target groups• Decision-making process for the introduction of new vaccines
Level 2 (common to both level 1 groups)	
Common operational criteria	<ul style="list-style-type: none">• Probability of success• Time-course for impact• Responsibility of GPV• Potential impact of GPV involvement• Level of funding required for impact

Global disease burden is a measure of the importance of the disease to public health. Factors that need to be considered include mortality, acute morbidity, long-term morbidity, age distribution and long-term trends of the burden of disease. The Disability Adjusted Life Year (DALY) is also a helpful measure. The table below provides an example.

Global disease burden	
Deaths per year	
High priority:	
Pneumonia	1 200 000
Rotavirus	800 000
Shigella	730 000
Tuberculosis	2 800 000
Low priority:	
Hepatitis A	
Lyme disease	
Otitis media	

The vast majority of the people dying from infectious diseases are young, and under different conditions fit, people in the developing world. Extreme poverty – one fifth of the world lives in poverty and almost a third of all children are undernourished – rapid travel, migration and uncontrolled urban growth are likely to make the threat of infectious diseases worse before it gets better. It is conceivable, therefore, that the heaviest burdens of ill-health will continue to fall mainly on those who live in deprived areas, which are often unable to sustain economic development. Special attention must be paid to the needs of poor communities and developing countries. In this respect, diseases that are or may become of particular importance to developing countries e.g. malaria and typhoid fever, assume greater importance than those that specifically affect developed countries.

Other sets of criteria are the importance of the disease in developing countries, its potential to cause epidemics or to be eradicated, the overall impact that vaccination may have on the burden of the disease, the inadequacy of other existing control studies, and the increasing growth of anti-microbial resistance.

Another criterion is the potential positive impact on immunization programmes including the efficacy and safety of immunization.

At level 2 selected criteria are intended to be applied to both disease and vaccination related research. It particularly takes into consideration the potential impact of GPV involvement. In some areas GPV has a greater potential to exert an impact in vaccine research and development due to its special relationships with health institutions and communities in developing countries. Its input can be very cost-effective. Dr Lambert suggested that the following questions be asked in this context:

-
- Can seed-funding for research attract the attention of national agencies and industry?
 - Can GPV co-ordinate a global research agenda?
 - Can GPV exert a normative function?

The best example of GPV exerting a triple role of catalyser, coordinator and legislator is in tuberculosis research. A GPV Working Group for the Development of New Tuberculosis Vaccines is currently coordinating a comprehensive strategic plan aimed at filling the existing gaps at the same time as setting-up common guidelines for tuberculosis clinical trials and developing standardized animal models and assays for correlates of protection.

Other criteria included in this category are related to the probability of success, time schedule for impact, responsibility of GPV and level of funding required to exert an impact.

The Global Training Network – ensuring vaccine quality

Ms Christina Villar, Short-term professional, VSQ

The number one priority of GPV/VSQ is to ensure that vaccines are of consistently high quality. Nineteen out of 53 producing countries do not have national control systems in place. 44 out of 58 countries purchasing vaccines do not have the basic infrastructure in place to ensure the quality of the vaccines they buy.

A seven-step model to address these problems has been developed:

- Priority countries eligible for targeted WHO support will be identified.
- National control authorities (NCAs) in these countries will be strengthened, primarily by carrying out assessments against indicators.
- Institutional development plans including training plans will be developed, in collaboration with the countries.
- Training plans will be implemented through the Global Training Network (GTN).
- GTN will offer training to priority procuring countries as well as producing countries.
- A module for a procurement workshop including strengthening of the NCAs will be implemented.
- Follow-up, monitoring and evaluation will be coordinated.

The GTN has expanded rapidly over the last year. The number of training centres has increased from three to ten and an additional two have recently submitted their curricula for review. In 1997 five people were trained in formal courses through the GTN. In 1998 more than 100 will be trained. With regard to training courses, curricula focusing on NCA needs in procuring countries are currently under development. Courses in lot release and post marketing surveillance form part of these curricula. Additionally, the current course in licensing will include information to help procurement agents determine when they can accept data on a vaccine from an NCA in another country.

Recently, several new approaches have been developed for coordinating activities :

- Mobile training centres to offer targeted training in Russian and French in Eastern Europe, Africa and the Eastern Mediterranean.
- Procurement/NCA strengthening workshops to be followed by GTN training.
- New GTN curricula focusing on critical control functions that NCAs in procuring countries must assure.

WHO activities have shown that a strong NCA is critical for viable local production and effective procurement. Ms Villar made a call upon donors to assist WHO by, inter alia:

- Not providing technical or financial support to local producers in countries without a fully functional NCA and a strategic business plan assuring long-term viability of the manufacturer.
- Encouraging countries to take advantage of international agency procurement services should they not have the basic infrastructure in place to judge the quality of the vaccines they buy.

In 1997 and 1998 the GTN received support from the World Bank, Japan and the Department for International Development (DFID) in the United Kingdom. Training Centres received support for 1997 and 1998 from the Japanese International Cooperation Agency (JICA) in Japan and the Office of the Director General for International Cooperation (DGIS) in the Netherlands. They also received support from the United States Agency for International Development (USAID) and the Australian Agency for International Development (AusAID) in Australia.

Discussion

Polio eradication

There was general agreement that a greater external effort is needed to alert the world to the eradication process and mobilize worldwide support.

Furthermore there is a need for greater flexibility in the provision of funds. If opportunities are not to be missed, this must be a high priority.

Dr Victor Grachev (Russian Federation) asked if immunization against polio eradication would be completed by the year 2000. Dr Melgaard said that although the last case will be in the year 2000, or soon after, immunization would probably have to continue to the year 2005.

Dr David Salisbury (United Kingdom) called for more information on polio eradication. It should be made available to the general public to raise awareness of the need for more support in the few months that are left. On the same issue, Sir Gustav Nossal (Chairman of SAGE) suggested that EPI put together a slide package for Rotarians to promote the importance of polio eradication. Dr Stephen Cochi (CDC) said that polio eradication had come a long way but the hardest part is yet to come. He stressed the need for more partners in the initiative.

Dr Ciro de Quadros (AMRO/PAHO) asked if UNICEF would be creating a common fund for “end-game strategies” for polio eradication. Dr Suomi Sakai (UNICEF) replied that priorities for funds provided to the countries are decided in the country concerned and always in association with WHO.

Health sector reform

Health sector reform was a major topic of discussion. Questions were raised as to how GPV could work with other WHO programmes to ensure the delivery of high quality health care within changing health systems.

Ms Papineau-Salm (Netherlands) pointed out that health reforms were happening at a fast pace and were throwing focus on the need for ensuring that funding is continued for vital programmes. However, funding had to be assured for many programmes at the same time. While support was specifically expressed to be for immunization, it was also important to ensure that funding continued for other programmes e.g. tuberculosis control. Overall health financing needed to be considered. There was support for the idea of a single cross cutting surveillance system. All governments were encouraged to establish a budget line for immunization.

Dr Bjorn Melgaard (Chief, EPI) responded by mentioning work currently being undertaken within GPV focusing on the impact of the health reform process on immunization and the minimizing of negative effects while maximizing the positive effects. GPV is working with other programmes in Geneva and the Regions to use the experience gained in polio eradication to promote strong surveillance systems that monitor other diseases.

Ms Amie Batson (World Bank) stressed the need for focusing on health outcome indicators during health reform. She called for greater emphasis on *outcome* measures rather than *process* measures in health sector reform. She described a six-country study being sponsored by the World Bank in which it will learn how to work better with its partners and encourage the countries to promote immunization as a priority for new loans. Ms Batson concluded by saying that the World Bank will focus on what it does well through its contacts in the Ministries of Finance and that the monitoring and follow-up of World Bank loans should improve in the future.

The participants of the meeting were assured that GPV is addressing issues associated with health sector reform in three areas, working with other programmes in WHO in each one. The first area is financing mechanisms for immunization and other drugs programmes, where EPI is working with the Action Programme on Essential Drugs (DAP) and the Division of Intensified Cooperation with Countries and Peoples in Greatest Need (ICO) on developing a trust fund mechanism for Bhutan. Secondly, the polio initiative is being carefully evaluated for its impact on other health services, with a view to showing how the eradication efforts can benefit other programmes. Thirdly, there is a co-operative inter-programme effort to promote injection safety.

Dr Stephen Cochi (CDC) expressed the need for partners to cushion the financial burden on countries involved in health reform. He noted that health reform is undermining the EPI programmes, the very ones which will introduce the new vaccines in which the Bank is interested.

Dr Suomi Sakai (UNICEF) stressed the need to keep a watch on country health budgets during reform, ensuring EPI was featured in the national planning.

General

Mr Clay (Chair) agreed on the appropriateness of bringing funding mechanisms into the discussions on how to reach immunization tools and targets and congratulated Ms Shearley on her presentation.

Dr Neil Squires (United Kingdom) welcomed the World Bank's involvement as a partner in immunization with WHO and UNICEF. He noted that each partner had a unique contribution to make and that it was important to ensure that there was complementarity rather than competition between them.

Ms Batson agreed that the World Bank neither could, nor wished to do everything and was relying on other partners to do their part, such as the technical side provided by GPV. The World Bank was interested in providing the optimal support to countries and was especially interested in outcome indicators and the following-up on loans and their implementation.

The Chairman made a plea for more partners in immunization – especially in polio eradication – in order to attract additional funds, as opposed to competing with other programmes for existing funds.

Following questions from Dr Pia Rockhold (Denmark) Dr Melgaard assured her that there was close cooperation between GPV and other programmes in WHO. Mr James Cheyne reminded the meeting of the agreement of the Programme and its partners to aim for 50% unspecified funding to give the programme the flexibility it needs in order to respond to upcoming high priority activities and be able to respond to activities that would not attract designated support. He continued by explaining the method the programme used to arrive at its priorities, which are presented in detail in the *Strategic Plan*. Finally, he requested that potential contributors look at the programme's track record as a reference for what it can do in the future.

Dr Félix Kùchler, (FWHF) asked about the longer-term effects of successful immunization programmes. The delegate asked what would happen to the many more children who survived into adulthood? Would there be enough food and water? Would there be enough schools and jobs? He asked whether family planning programmes should accompany immunization programmes. In his response, Dr J.W. Lee (GPV) stressed the importance of these questions, and the need for WHO to search for answers. He reassured the meeting that the new administration had already made clear that all WHO initiatives would be evaluated and assessed in a more comprehensive way, involving the skills and knowledge of a number of programme areas.

Dr Iman Mochny (SEARO) informed the meeting that in Indonesia, Family Welfare Packages (POSYANDU), including both EPI and family planning as a single intervention, were already active.

Ms Adelaide Shearley (EPI, Zimbabwe) asked why so little funding was set aside for advocacy in the GPV budget. She stressed the importance of advocacy in immunization programmes, and the need to ensure that adequate funding is available for this important work.

Dr Yoshiko Saito (Japan) expressed appreciation for the research work on transgenic mice and said that both the work to improve National Control Authorities and the work of the Global Training Network would be useful.

Dr Lee spoke about the strength of the GPV team, which is a solid platform for its success. He thanked the donor partners that have made this possible with their support. He reminded the group that nearly a billion dollars had been spent on polio eradication so far and that, now we are in the final phase, no technical problems remain. The only substantial obstacle is the shortage of funds to finish the job.

Mr Robert Clay closed the meeting by saying that there has been very exciting progress – particularly in the introduction of new vaccines and polio eradication and this forms a positive foundation for work in the next century. The challenge put to the participants of the meeting was how to expand the resources flowing to vaccines and immunization. There may not be another Meeting of Interested Parties for the Programme, but whatever new arrangements are made, there will always be a need for the Programme to receive advice from its partners.

Annex 1:

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Annex 2: Agenda

- 13:30 Opening Statement by Dr R.H. Henderson, Assistant Director-General
- 13:40 Election of Chairman, Vice-Chairman and Rapporteur
- 13:45 Report by Dr J. W. Lee, Director, GPV
- 14:00 Polio status report – brief introduction by Dr Bjorn Melgaard
- 14:10 Progress in the Polio Eradication Initiative. Dr Harry Hull
- 14:30 Polio financing. Dr Bruce Aylward
- 14:45 Discussion
- 15:15 *Coffee break*
- 15:45 “Accelerating immunization towards the year 2000 and beyond”.
Presentation by Ms Adelaide E. Shearley
- 15:55 Discussion
- 16:15 Report on GPV – financial and global overview
Presentations by :
- Mrs Fabienne Adam and Mr James Cheyne
Mr Michel Zaffran, EPI
Dr P.-H. Lambert, VRD
Ms Tina Villar, VSQ
- 16:55 General discussion on GPV
- 17:35 Closing address by Dr J. W. Lee
- 17:45 Closure

Annex 3:

List of documents

- Agenda
- List of participants
- WHO/GPV/98.01 Programme Report
- WHO/GPV/98.04 Strategic Plan 1998-2001
- WHO/GPV/98.05 Interim Financial Report for the year 1997
- WHO/GPV/98.03 GPV brochure
- Vaccine & Immunization News (VIN), Nos. 5 & 6
- EPI Update, November 1997
- **Polio package**
 - Target 2000: The eradication of poliomyelitis.
 - Global Status Report, 1998
 - Paper on “Resource Requirements”
 - Report of the Dahlem Workshop on The Eradication of Infectious Diseases (Berlin, 16-22 March 1997)
 - Polio: The beginning of the end
 - Vaccine & Immunization News (VIN), No. 7
 - Weekly Epidemiological Record No. 22 (May 1998)
 - Washington Post article

Available in the meeting room

- Recommendations of the SAGE
- WHO/GPV/97.06: Report of the Meeting of Interested Parties for the Global Programme for Vaccines and Immunization, Geneva, 16 June 1997
- Health Trust Fund: Partnership for sustainable primary health care
- Video: WHO polio eradication effort on target

Annex 4:

Terms of reference

For the Meeting of Interested Parties for the Global Programme for Vaccines and Immunization¹

The Meeting of Interested Parties provides a forum for dialogue on, and coordination of, related activities for the Global Programme for Vaccines and Immunization with donor agencies, recipient countries, non-governmental organizations and other interested parties. The main focus of the meeting is on the financial and managerial aspects of GPV to complement the technical and strategic aspects covered by the Scientific Advisory Group of Experts. The SAGE and the MIP will be co-ordinated : one or more representatives of each meeting will attend the other meetings and reports of each will be exchanged.

This meeting is a twin with a similar Meeting of Interested Parties for the Children's Vaccine Initiative. Logistics permitting, the two meetings will be held back-to-back. The meeting will:

1. Review and make recommendations on financial and managerial aspects of GPV based on the programme report.
2. Review and make recommendations on the proposed GPV biennial proposed plan and budget.
3. Provide a forum for information exchange for better co-ordination of support to immunization efforts at country, regional and global levels considering, inter alia, the goals, policies, strategies and activities of the GPV.
4. Consider other topics of interest to the parties involved.

The meetings will normally be held in June each year.

The Meeting of Interested Parties will be open to any interested Government of a WHO Member State. The meetings will also be open to participation by any interested NGO and other interested donor agencies. The WHO secretariat will endeavour to secure appropriate representation from countries, particularly developing countries. The meeting will be chaired by a representative of a government member of the meeting elected for a period of two years, with a

¹ Extract from Defining the roles – draft paper describing governance of the Children's Vaccine Initiative and the Global Programme for Vaccines and Immunization, World Health Organization, Geneva, 23 march 1995.

government representative as vice-chairperson elected in the intermediate year with a view to being elected the chairperson in the following year.

GPV will serve as the secretariat to the meeting. The Meeting of Interested Parties will make its recommendations to the Director General of WHO.