World Health Organization
REGIONAL OFFICE FOR Africa

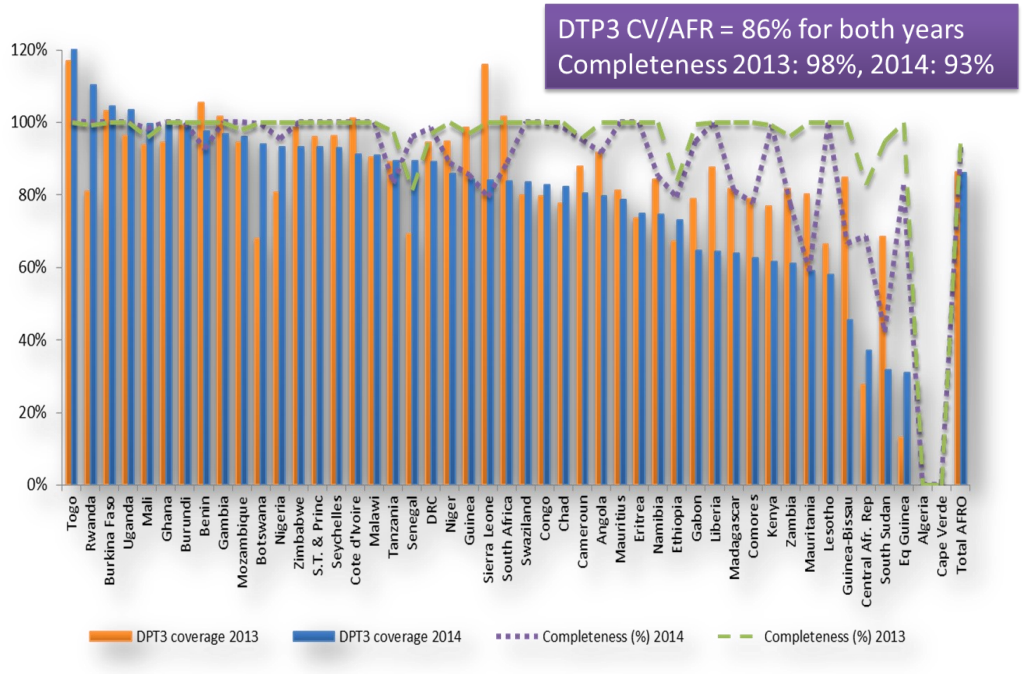
IMMUNIZATION VACCINES & EMERGENCIES

40 YEARS 1974-2014

MONTHLY IMMUNIZATION UPDATE IN THE AFRICAN REGION

November 2014 (Vol 2, issue N° 11)

DTP3 coverage and data completeness by country in the AFR Jan-Sept 2013-2014



Source : WHIO AFRO, IVE Cluster. Compiled from Monthly districts routine immunization reports from Member States

Highlights

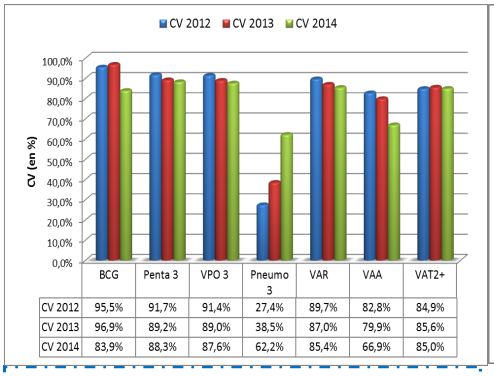
Data reported in this issue covers the period January - September 2014 and 2013. Data completeness was 93% compared to 98% the same period last year. Guinea Bissau, Mauritania & South Sudan reported a completeness < 70%. .

The reported regional DTP3-containing vaccine & Measles coverage rates were 86% for both antigens in 2014 & 2014. Seventeen countries reported DTP3 coverage ≥ 90% among which 4(Burkina Faso, Rwanda, Togo & Uganda) with coverage >100% and 4 (CAR, Equatorial Guinea, Guinea Bissau & South Sudan) with coverage <50%.

Out of a target population of ~ 24.5 million eligible children for the period, more than 21 million were vaccinated with 3 doses of DTP-containing vaccine. More than 160,000 additional children were vaccinated in the region compared to the same period last year. An increase in the number of vaccinated children was reported in 17 countries with a significant increase reported in Nigeria > 60.000, Ethiopia >130.000. and Uganda >100.000. The highest number of under-immunized (> 100. 000), were reported in Kenya Madagascar, South Sudan & Tanzania.

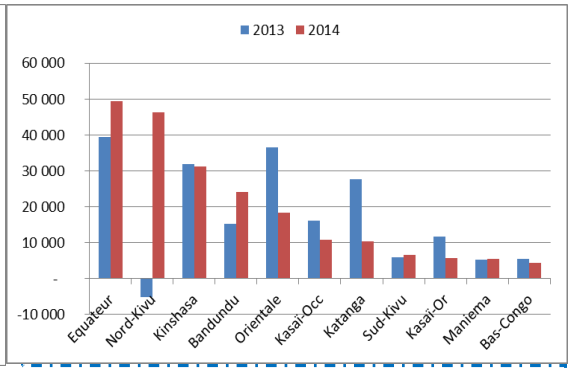
RI performance for the DRC for Jan– September 2014 & EVM September 2014

DTP3 HepB-Hib3 Coverage per antigen Jan –Sept 2012-2014

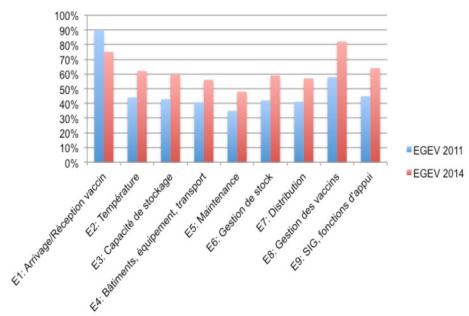


	BCG	Penta 3	VPO 3	Pneumo 3	VAR	VAA	VAT2+
CV 2012	95,5%	91,7%	91,4%	27,4%	89,7%	82,8%	84,9%
CV 2013	96,9%	89,2%	89,0%	38,5%	87,0%	79,9%	85,6%
CV 2014	83,9%	88,3%	87,6%	62,2%	85,4%	66,9%	85,0%

Unimmunized children with DTP3 HepB-Hib3 per province 2013-2014



Comparative results of EVM in DRC in 2013 & 2014



Results of the 2014 EVM in DRC per administrative level

	Moyenne	National	Coordinations	Antennes	Zones de santé	Aires de santé
E1: Arrivage/Réception vaccin	75%	75%				
E2: Température	62%	52%	69%	65%	66%	58%
E3: Capacité de stockage	60%	69%	54%	61%	68%	48%
E4: Bâtiments, équipement, transport	56%	54%	59%	57%	64%	45%
E5: Maintenance	48%	65%	55%	52%	49%	21%
E6: Gestion de stock	59%	67%	66%	70%	58%	33%
E7: Distribution	57%	60%	66%	54%	57%	46%
E8: Gestion des vaccins	82%	75%	89%	87%	79%	80%
E9: SIG, fonctions d'appui	64%	51%	81%	71%	62%	54%

Highlights

- The DRC set 2 priority areas for 2014 : Strengthening the RED approach and improving data quality. Micro planning was conducted in the districts and immunization activities implemented accordingly. But the programme experienced vaccine shortage due to delay in the disbursement of government funds for purchase and distribution of vaccines. A strike action by health workers in the Nord Kivu province also affected immunization. As a result, reported data for the period showed coverage has stagnated for most antigens.
- **Effective Vaccine Management (EVM) evaluation** was conducted in September 2014. The report showed an improvement in vaccine management indicators compared to 2011, but most of the criteria did not reach the required levels of satisfaction as shown in the graph.

This assessment led to the development of an improvement plan with Vision 2020 and 5 Strategic Areas:

◊ Optimize the supply chain ;
◊ Strengthen effective vaccine management ;
◊ Rehabilitate cold chain with solar energy options;
◊ Improve distribution and transportation systems for uninterrupted availability of vaccines;
◊ Modernizing information system for the traceability of vaccines;

EPI review in Congo in October – November 2014
Preliminary results of the coverage survey

- 70% of children and 74.5 % of mothers had documents mentioning vaccination received.
- Coverage with cards only were: BCG (94.7%); Polio 3 (56.9%); Penta 3 (59.5%); Measles (52.8%) Yellow fever (52.6%) and Tetanus Toxoid 2 in mothers 56%.
- Coverage with card and history were: BCG (98.1%); Polio 3 (85.2%); Penta 3 (86.4%); Measles (77.6%) Yellow fever (77.6%) and Tetanus Toxoid 2 in mothers 94% .
- Proportion of children fully immunized (card + History) was 75%. Only 1.4% of children had received no vaccine (zero dose).
- Dropout rate between Penta 1 and Penta 3 was 5.5% and between Penta 1 and measles : 14.7%. The majority of children (90.5%) were vaccinated in the health facility.

The main reasons for non immunization of children are summarized in the table hereunder:

Reasons of non vaccination of children	%
Conflict between the occupation of the mother and Immunization	40,0%
Vaccinator absent or unavailability of vaccine	15,3%
Ignorance of the need for immunization	12,0%
Fear of adverse effects following immunization	7,3%
Ignorance of the need to come back	6,7%
Lack of confidence in vaccination (rumors or beliefs)	6,0%
Remoteness of the place of vaccination and high transportation costs	4,0%
Inconvenient immunization schedules and waiting too long	2,7%
Poor reception by the vaccinators	2,7%
Misinformation about the contra-indications (sick child)	2,0%
Ignorance immunization timeline	1,3%

Highlights

- After 5 years of implementation of the recommendations of the last review of the EPI in 2010, it seemed appropriate for the Congo, to conduct a comprehensive EPI review to have accurate and relevant information on routine immunization in order to enhance the quality of immunization services and update the multiyear plan to align it with the GVAP.
- The review was conducted by a team of external experts and analyzed the 8 components of the immunization systems (Service delivery, vaccine supply & quality, communication, logistics & surveillance, Financing, capacity building & management). The review included a coverage survey whose preliminary results are summarized here.

2014 Inter -Country EPI Mid-Level Management (MLM) course for lusophone countries
Maputo, Mozambique, 17-26 November 2014

Group picture and a view of the participants in one of the sessions of the MLM course

The general evaluation of the course was satisfactory with an index of satisfaction of more than 75% for each item as shown in the graph. A participation/facilitation certificate was granted to each participant/facilitator.

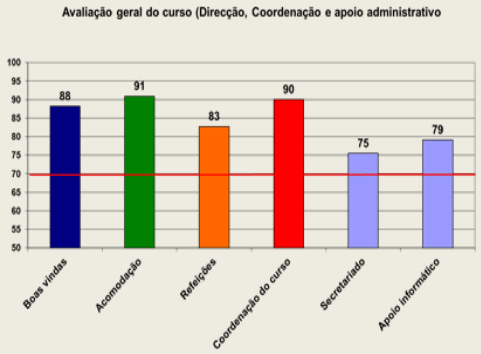
Key recommendations from the course were:

To Governments

- ♦ Include similar courses in all public health education programs; and support health education institutions to review their programs to include content of MLM course;
- ♦ Contribute to the funding of the course to allow a greater number of participants for each country;
- ♦ Organize MLM courses at country level

To WHO & Partners

- ♦ Increase the duration of the course so that each module is administered in one day;
- ♦ Increase the frequency of the inter country MLM course.
- ♦ Improve the translation of the modules in Portuguese;



Highlights

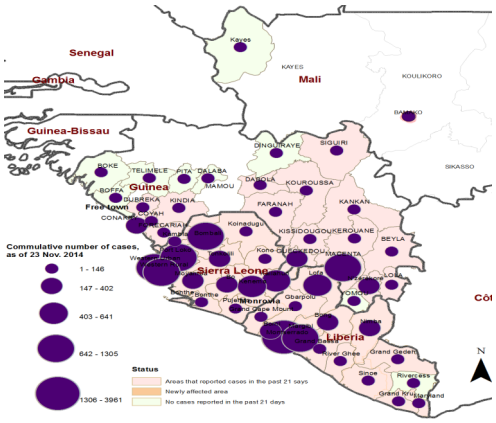
To extend the MLM course to Lusophone countries and to ensure the sustainability of EPI training, WHO/AFRO-IVE organized the Lusophone inter country MLM course. The course targeted national EPI managers, logisticians, WHO/UNICEF and other key immunization partners as well as teachers/ professors from health pre-service training institutions. This inter country MLM course took place in Maputo, Mozambique and comprised of a training of trainers session (14-16 November) and an EPI managers session (17-26 November).

The objectives of the MLM course were to train MLM trainers, to equip EPI professionals and teachers with managerial skills related to each component/ operational of immunization programmes and to validate the content and proofread the 16 revised AFRO MLM modules newly translated into Portuguese .

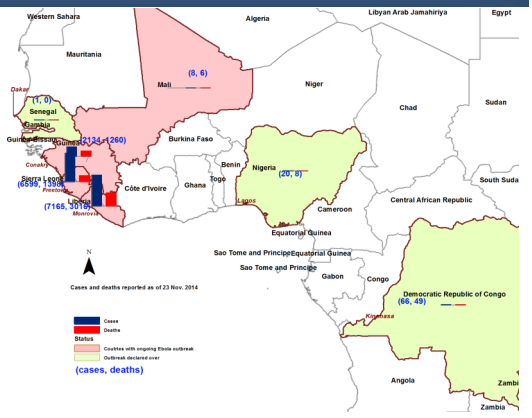
The course was attended by 28 participants and 11 co-facilitators. Participants came from Angola, Cape Verde , Guinea Bissau, Mozambique and Sao Tome & Principe.

The Course was conducted in two successive sessions: three days for training of trainers (ToT) and nine days for EPI managers training. The ToT session focused on MLM lesson plan design and the EPI Managers training session covered the main managerial functions related to immunization components and operations.

Updates on Ebola Virus Disease (EVD) in the AFR and development of Ebola Vaccines



Geographic distribution of EVD in the AFR & cumulative cases per country as of 23 November 2014



Geographic distribution of EVD in the AFR as of 23 November 2014

Countries	Cumulative number		Health Care Workers	
	Cases	Deaths	Cases	Deaths
Guinea	2134	1260	97	56
Liberia	7168	3016	342	172
Sierra Leone	6599	1398	136	105
Nigeria	20	8	11	5
Senegal	1	0	0	0
DR Congo	66	49	8	8
Mali	8	6		
Total	15996	5737	594	346

Situation as of 23 November 2014: A total of 15 996 EVD cases including 5 734 deaths have been report-ed from six West African countries (Guinea, Liberia, Sierra Leo-ne, Nigeria, Senegal and Mali).

- WHO declared end of Ebola out-break in Senegal, Nigeria and DR Congo.
- In the 3 most affected countries (Guinea, Liberia and Sierra Leone), most of the affected districts reported new cases in the past 7 days with the majority of the cases coming from Sierra Leone (Port Loko, Western Area Rural, Western Area Urban, Tonkolili and Bombali) and Liberia (Montserrado and Bong).

Highlights

Without a vaccine or treatment, the out-break of Ebola affecting Guinea, Liberia and Sierra Leone with spread to Senegal, Nigeria and Mali has led to a global public health crisis requiring an unprecedented global and humanitarian response. The WHO is leading a response to this out-break by supporting the accelerated de-velopment of products against EVD, which include therapeutics (medicines, convales-cence blood, convalescence plasma), vaccines and other biologicals. The pro-cess involves identification of products, development, testing . Licensure and use.

Currently there are three candidate vac-cines in clinical trials.

The rVSV-ZEBOV, is a recombinant stoma-titis virus carrying the glycoprotein of Zaire Ebola virus. Developed by NewLink Pharmaceuticals and the Public Health Agency of Canada, the vaccine induces EVD-specific immune responses

The GSK ChAd3-ZEBOV, utilizes a chim-panzee adenovirus, which does not repli-cate in humans to carry the glycoprotein of Zaire Ebola Virus. Both candidate vac-cines produced 100% protection after one dose in nonhuman primates post-lethal challenge and are available in GMP-grade.

The phase 1 clinical trials of GSK ChAd3-ZEBOV, involving 80—100 participants each is ongoing in Oxford, UK and Bama-ko, Mali. Phase 1 clinical trials of rVSV-EBOV are planned for Germany, the US, Gabon and n Kenya. The trial in Gabon has began. And we will soon have preliminary safety data in humans.

Initial safety data from phase show no safety concerns

9th African Vaccine Regulatory Forum (AVAREF) meeting, Pretoria, South Africa 3-7 November 2014.

Photograph of participants of the 9th Annual AVAREF meeting taken after the official opening by the WHO Representative for South Africa, Dr. S Barber.

The 9th annual meeting of the African Vaccine Regulatory Forum (AVAREF) took place in Pretoria 3-7 November 2014. It brought together representa-tives of the NRAs and Ethics committees of 23 Member States of the WHO AFR. Also present were regulators from the European Medicines Agency, Health Canada and US FDA. Vaccine manufac-turers/developers/sponsors of clinical trials presented their pipeline of prod-ucts, clinical trial designs and plans. Among the topics discussed were R&D of therapies and vaccines against EVD, TB, malaria and HIV. The first 2 days were devoted to the response of AVAREF to the accelerated development of vaccines and therapies against EVD. The rest of the meeting discussed ethics and regu-lation of vaccines against the rest of the diseases.

Highlights

Manufacturers/sponsors and scientists involved in the R&D of 3 lead vaccine candidates against EVD presented product characteristics, preliminary safety and immunogenicity data, clinical designs and plans for phase 2 and 3 studies planned for countries of the African region includ-ing affected countries.

In a closed session, AVAREF members discussed their response to the challenge to support the accelerated development of the lead candidate vaccines, in an effi-cient manner and ensuring the safety of participants in the clinical trials and the generation of reliable data for licensure and use of the products.

Countries of AVAREF prioritized accelerat-ed development of vaccines and thera-peutics against Ebola Virus Disease.

AVAREF members agreed to guidelines for bio repositories for specimens; use joint reviews and mechanisms to promote harmonization, adopt ethics standards including indicators of performance; use standard WHO guidelines for review of HIV vaccine submissions