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13th meeting of the European Technical Advisory Group of Experts on Immunization (ETAGE)

Copenhagen, Denmark, 10–12 October 2013

ABSTRACT

The European Technical Advisory Group of Experts on Immunization (ETAGE) met on 9–11 October 2013 to review and discuss immunization activities and developments in the WHO European Region and provide advice to the WHO Regional Office on appropriate activities. The main topics for discussion included operationalization of the monitoring and evaluation/accountability framework for the Decade of Vaccines Global Vaccine Action Plan (GVAP); development of a Regional Vaccine Action Plan (RVAP); planning for inactivated polio vaccine (IPV) introduction; progress toward measles and rubella elimination in the Region; implementation of the *Package of accelerated action for measles and rubella elimination*; development of standards for adult immunization practices; and sustaining immunization investments in countries "graduating" from support provided by the GAVI Alliance.

Keywords

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Rubella – prevention and control
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Abbreviations

AEFI	adverse event following immunization
CRS	congenital rubella syndrome
ETAGE	European Technical Advisory Group of Experts on Immunization
GAVI	GAVI Alliance
GVAP	Global Vaccine Action Plan
HCWs	health care workers
IPV	inactivated poliovirus vaccine
JRF	WHO/UNICEF Joint Reporting Form
M&E/A	monitoring and evaluation / assessment
MR	measles and rubella
NITAG	National Immunization Technical Advisory Group
NIP	national immunization programme
OPV	oral polio vaccine
OPV2	oral poliovirus vaccine for wild poliovirus type 2
RC	Regional Committee for the WHO European Region
RCC	Regional Commission for the Certification of poliomyelitis eradication
RVC	Measles and Rubella Regional Verification Commission
RVAP	Regional Vaccine Action Plan
SAGE	Strategic Advisory Group of Experts on Immunization
SIA	supplementary immunization activity
TIP	Tailoring Immunization Programmes
UNICEF	United Nations Children's Fund
VPD	Vaccine-preventable diseases
VPI	Vaccine-preventable Diseases and Immunization Programme of the WHO Regional Office for Europe
WHA	World Health Assembly
WHO	World Health Organization
WPV	Wild poliovirus

Executive summary

The thirteenth meeting of the European Technical Advisory Group of Experts on Immunization (ETAGE) was held on 9–11 October 2013 in Copenhagen, Denmark to review and discuss immunization activities and developments in the WHO European Region and provide advice to the WHO Regional Office for Europe (the Regional Office) on appropriate activities. The first day of the meeting on 9 October was a closed session.

The main topics for discussion in the open sessions included operationalization of the monitoring and evaluation/accountability framework for the Decade of Vaccines Global Vaccine Action Plan (GVAP); development of a Regional Vaccine Action Plan (RVAP); planning for inactivated polio vaccine (IPV) introduction; progress toward measles and rubella elimination in the Region; implementation of the *Package of accelerated action for measles and rubella elimination*; development of standards for adult immunization practices; and sustaining immunization investments in countries "graduating" from support provided by the GAVI Alliance (GAVI).

The GVAP monitoring and evaluation /accountability (M&E/A) framework was developed as the means to monitor progress towards achievement of the GVAP goals and strategic objectives. The GVAP includes specific global targets for each of its five goals, and global-level indicators for each of its six strategic objectives. These will form the basis for the RVAP, which will be supplemented with indicators and targets tailored to the regional context and its available mechanisms and structures. The global monitoring and evaluation process will be feasible if further actions are taken at national and regional levels to enhance monitoring. National immunization technical advisory groups (NITAGS) can play an important role in this process, not to control activities but to help define policy and advise decision-makers. It needs to be understood at all levels that the GVAP process will improve the quality of data and thereby provide added value for decision-makers and immunization programmes.

Objective 2 of the Global Polio Endgame Initiative (GPEI) is to strengthen immunization services in "focus countries", introduce IPV and withdraw oral poliovirus vaccine for wild poliovirus type 2 (OPV2) globally by the end of 2016. Currently, 11 countries in the European Region have OPV only in their immunization schedules (7 of which are eligible to receive GAVI support to introduce IPV); 8 countries have both IPV and OPV (of which 1 is GAVI supported) and 34 countries have only IPV. Introduction of IPV and other new vaccines in the European Region is forecasted to accelerate from approximately 10 vaccine introductions per year from 2000–2012 and 47 introductions in 2013 to 79 in 2014 (14% IPV) and 123 in 2015 (43% IPV).

GAVI has agreed to play a leading role in IPV introduction in eligible countries. NITAGs are expected to play a central role in introduction, scheduling, and prioritizing with respect to cold chain capacity and other issues. For GAVI-eligible countries not choosing the standalone IPV vaccine, the Regional Office will be involved in a review of financial sustainability of introduction. Timing to ensure product availability will also need to be discussed.
ETAGE applauded the *Package of accelerated action for measles and rubella elimination*, while also recognizing the challenges to achievement of the 2015 elimination goal in the European Region, including increasing immunization gaps in some countries, lack of case-based surveillance, continuing outbreaks and in some cases insufficient outbreak response. Increasing political commitment at country level is crucial to achievement of the elimination goal. Some NITAG representatives present at the meeting suggested ways to increase political commitment in their respective countries, for example by shifting focus from the dangers of the diseases to the benefits of elimination.

Equitable access to good health throughout the life course is a priority of the European policy framework Health 2020 that has been neglected by immunization services geared only toward children. The Regional Office requested ETAGE's advice on the development of standards for good practice in adult immunization that would facilitate: identification of historic gaps in childhood immunization programmes, improvement and promotion of routine adult immunization (leading to increased demand), and preparedness for non-routine vaccination in the event of a disease outbreak. The focus of standards would be on immunization practices, not on the choice of which vaccinations to offer.

Six countries in the European Region (Armenia, Azerbaijan, Georgia, Kazakhstan, Republic of Moldova and Uzbekistan) are scheduled to graduate from GAVI support for immunization programmes within the coming few years. The WHO Regional Office has initiated a number of activities to help them prepare for and cope with graduation issues, including a desk review to identify challenges, a workshop on graduation issues for all graduating countries, development of transition plans with national authorities and assistance with performance monitoring. The

GAVI Alliance Executive Board was expected to decide on proposed adjustments to current policies that would help address the challenges faced by graduating countries.

Introduction

The European Technical Advisory Group of Experts on Immunization (ETAGE) meets annually to review the progress of the Vaccine-preventable Diseases and Immunization Programme (VPI) towards the European Regional disease prevention goals and to provide guidance on related activities. The previous ETAGE meeting was held at the WHO Regional Office for Europe, Copenhagen, Denmark, on 3–4 October 2012.

Professor Pierre Van Damme chaired the meeting, Professor Christian Perronne was vice-chair, and Ms Catharina de Kat-Reynen was rapporteur.

Objectives of the meeting

1. Request advice and guidance from ETAGE members on the following key topics and issues:
    - operationalization of the monitoring, evaluation and accountability framework for the Global Vaccine Action Plan (GVAP);
    - development of a Regional Vaccine Action Plan (RVAP);
    - planning for inactivated polio vaccine (IPV) introduction;
    - development of standards for adult immunization practices; and
    - sustaining immunization investments in countries graduating from GAVI support.

2. Provide updates on:
    - progress toward measles and rubella elimination in the Region;
    - implementation of the *Package of accelerated action for measles and rubella elimination*;
    - progress towards maintaining the polio-free status of the European Region;
    - Strategic Advisory Group of Experts on Immunization (SAGE) recommendations;
    - outcomes of the WHO European Regional Committee (RC).

3. Provide insight and activity reports, as required by ETAGE, from the different sub-teams and technical officers of the Vaccine-preventable Diseases and Immunization Programme.

Opening remarks

Dr Guenael Rodier, Director, Division of Communicable Diseases, Health Security and Environment (DCE), opened the meeting and welcomed ETAGE members, representatives of partner agencies, representatives of NITAGs from newly independent states and staff from WHO headquarters on behalf of the WHO Regional Director.

Dr Rodier summarized the outcomes of the WHO Regional Committee meeting, during which the Global Vaccine Action Plan was discussed, among other topics. Regional implementation of the GVAP has to be in line with its global vision but also the regional priorities outlined in Health 2020, including strengthening health systems and focusing on health promotion through

the life course. Dr Rodier expressed his concern that the Region is not on target to achieve elimination of measles and rubella by 2015 and is still at risk of importing wild poliovirus.

Dr Dina Pfeiffer, Programme Manager, welcomed the participants on behalf of the WHO/Europe Vaccine-preventable Diseases and Immunization (VPI) programme team.

Professor Pierre van Dam welcomed all participants on behalf of the ETAGE members and co-chair. He extended a special welcome to the NITAG representatives, underlining the importance of their input in the meeting.

Report on responses to recommendations of the 12th ETAGE meeting

The previous ETAGE meeting concluded with eight recommendations. In light of a report presented by the VPI Programme Manager on all ETAGE recommendations made to date, Professor van Dam reminded the Group to be prudent in making new recommendations and to update rather than make new recommendations where possible.

Responses to recommendations of the 12th ETAGE meeting

- The Tailoring Immunization Programmes (TIP) toolkit was successfully implemented in Bulgaria and Sweden, leading to adjustments in national immunization policy; and several more countries have requested support for its implementation.
- The Vaccine-preventable Diseases and Immunization programme (VPI) continues to develop strategies, including updated surveillance guidelines and recently published guidance on conducting serosurveys, to identify needs and develop approaches to immunize susceptible groups.
- WHO and the majority of countries with NITAGS are working to maintain a high level of political commitment within national immunization programmes for the measles and rubella (MR) elimination target and maintenance of the Region's polio-free status.
- WHO has been facilitating the sharing of information with and among NITAGs.
- An ETAGE working group on development of the Regional Vaccine Action Plan still needs to be established. This topic was scheduled for discussion at the meeting.
- The Regional Office reported that countries in the Region are strict with their schedules and want to increase the timeliness of their vaccinations rather than relax the age limits in the schedules. This needs to be taken into consideration in making recommendations.
- Strengthening of adverse events following immunization (AEFI) monitoring is in progress.
- Rubella immunization strategies and preparedness for rubella outbreaks was to be discussed at length during the meeting.

Session 1. GVAP monitoring and evaluation /accountability Framework and adaptation to regional needs

The Global Vaccine Action Plan was adopted at the World Health Assembly (WHA) in 2012 in a resolution that also called for annual monitoring and evaluation of its implementation, and presentation of an annual report on progress and challenges to the WHA each year.

The GVAP monitoring & evaluation / accountability (M&E/A) framework was developed as the means to monitor progress towards achievement of the GVAP goals and strategic objectives. It was proposed at the WHO World Health Assembly in May 2013, where it received support from and input from Member States.

The framework is based on three principles: use of existing structures and processes as far as possible, consideration of the reporting burden on Member States, and alignment with other monitoring and accountability frameworks and initiatives.

The annual review of GVAP implementation through the M&E/A framework entails the following steps and tight timeline.

- Member States collect and report data through the WHO/UNICEF Joint Reporting Form (JRF) to WHO regional offices.
- The regional offices review data, correct errors or inconsistencies and report to the global level (by 15 July).
- The GVAP monitoring and evaluation Secretariat compiles information from regional offices and other partners and independent experts and presents a Secretariat report to a SAGE working group (by 15 August).
- The working group reviews data and submits a global report on progress toward GVAP targets along with its own recommendations to SAGE (by 17 October).
- SAGE finalizes the report and presents it (by 8 November) to the WHO Executive Board for its January meeting the following year.
- The World Health Assembly reviews the report at its subsequent May meeting, and submits it to the independent Expert Review Group (iERG) for the UN Secretary General's Global Strategy for Women's and Children's Health.

The final progress report identifies successes, challenges and areas where additional commitment, resources, efforts or corrective actions by countries, regions, partners, donor agencies or other parties are needed to achieve the Decade of Vaccines (DoV) goals and strategic objectives.

Operationalizing the GVAP M&E/A framework at regional level

The GVAP includes specific global targets for each of its five goals, and global-level indicators for each of its six strategic objectives. These will form the basis for regional vaccine action plans, supplemented with indicators and targets tailored to the regional context and the available mechanisms and structures.

The Regional Vaccine Action Plan (RVAP) currently being developed for the WHO European Region will include a M&E/A framework based on and fully aligned with the principles and timeline of the global framework. The first year of GVAP implementation reporting (2013) will take place at global level; regional offices will become involved starting in 2014.

The first year of regional reporting will provide more clarity on which indicators should be added to the regional framework to reflect the regional context, how to strengthen advisory boards, what can be improved, and what can be learned from other regions.

Principles

In addition to fulfilling the stated principles of the global framework, the regional framework should:

- enable the identification of successes, challenges and further actions required in implementing the GVAP;
- enable documentation and sharing of best practices;
- have a timeline that is aligned with its parental framework;
- have minimum reporting requirements that sufficiently reflect regional progress in achieving the GVAP goals;
- be developed through a consultative process.

Process and tools

At country level, each national immunization programme will work with its national immunization technical advisory group (NITAG), if available, to assess progress achieved during the previous year against the defined set of global and regional indicators (based on routine reporting plus additional studies conducrted as needed). The Regional Office will compile, clean and validate the data received from ministries of health and work with a dedicated ETAGE working group for further analysis and finalization of the Regional Report and recommendations, which will then be submitted to the GVAP Secretariat and ETAGE. Data will be derived from the JRF and national, sub-regional or regional level assessments, reviews, reports and studies.

Timeline

Critical deadlines in the reporting schedule include: submission of the JRF by Member States to the Regional Office by 15 March, submission of the VPI report to the ETAGE working group by the end of May, and submision of the final report including ETAGE's feedback and recommendations to the GVAP Secretariat by 15 August.

Indicators

Most of the indicators to monitor progress toward GVAP´s strategic objectives can be obtained from the JRF, either directly or with some extra work. Others, related for example to equitable access, will require studies to acquire the data. Countries will not be expected to report on the sixth global indicator, related to research and development of vaccines.

Further pilot testing is needed to improve the indicators proposed for the second strategic global objective ("Individuals and communities understand the value of vaccines and demand immunization both as a right and a responsibility"). A standard variable to compare countries may not be possible, but it is most important that countries are prompted to actively monitor perceptions and trends over time.

Additional objectives and indicators relevant to the European Region may be identified and added during the RVAP development process.

The monitoring and evaluation process will be feasible if further actions are taken at national and regional levels to enhance monitoring. Internal and external advocacy at national level for timely and complete reporting is needed. Some countries have not yet established a NITAG; and existing NITAGs need to be empowered and strengthened. The Regional Office needs to strengthen its data analysis capacity and should provide more capacity-building assistance to Member States to improve data quality, especially with respect to introduction of electronic registrations and estimation of target populations.

Two contributing factors to data quality need to be strengthened at all levels: making use of data in the decision-making process and provision of feedback (on completeness and timeliness) to the levels providing the data.

Discussion

It is important to consider how data collection works at local level, and especially the feasibility of acquiring the required data on time at the regional level. This is a key issue because timely reporting is crucial to the GVAP monitoring and evaluation process.

The NITAG representatives present (Armenia, Azerbaijan, Belarus, Kazakhstan, Kyrgyzstan, Republic of Moldova, Ukraine and Uzbekistan) did not see the GVAP requirements as an extra burden and believed that the timeline is feasible. However, if the JRF is modified, they would need to know this well in advance in order to adjust reporting at sub-national level. The Republic of Moldova explained that data received from different sources in the country do not always coincide, which can lead to errors in estimating target populations.

Half of the 53 Member States in the European Region have generally not been able to submit their data by mid-march. The challenges that countries face in collecting the data (e.g. difficulty in ascertaining denominator data, decentralization) reflect the problem that the data is not being used in decision-making. Rethinking the way data is obtained (e.g. high level of aggregation) is needed to reduce the burden of data collection, while also giving more power to analyse the data and adapt programmes accordingly. Higher-quality data is the main objective of the monitoring and evaluation process and a source of added value for countries, which should be made clear in RVAP and GVAP objectives.

Since national data come from various sources and many countries wait to submit the JRF form until the whole package is complete, it was suggested that the immunization section be decoupled from the other sections of the form (communicable diseases, etc.) and have its own deadline.

ETAGE remains concerned about the burden of parallel reporting to ECDC and WHO. After four years of ETAGE recommendations, this issue has still not been resolved, and it is especially important now with the current lack of human resources for reporting in many countries. Although the issue has essentially been resolved in regards to disease surveillance reporting, there are still concerns for other types of reporting (e.g., vaccination coverage).

NITAGs will be instrumental in reviewing data and providing feedback to national authorities. The Regional Office will continue to encourage and motivate countries that do not yet have a NITAG to establish one as soon as possible. It is important to define the NITAGs' role carefully so that they monitor progress but are not put in an implementation role. Evaluating performance should be limited to assessing the progress achieved toward GVAP implementation.

Validation of data at the regional level will be a collaborative effort with UNICEF, looking at data of previous years, surveys, etc. There is currently a lack of human resources at regional level to carry out this work.

Session 2. Planning for inactivated polio vaccine introduction (IPV), as a part of the Polio Eradication and Endgame Strategic Plan 2013–2018

Overview of the current status of IPV use in Member States

Objective 2 of the Global Polio Endgame Initiative is to strengthen immunization services in 'focus countries', introduce IPV and withdraw oral poliovirus vaccine (OPV) for wild poliovirus type 2 (OPV2) globally by the end of 2016. Important points to remember in this regard are that wild poliovirus (WPV) eradication and OPV2 withdrawal/IPV introduction are parallel processes with independent timelines, the OPV2 withdrawal date is determined by six prerequisites, IPV introduction can begin as soon as feasible, and IPV introduction is a risk mitigation strategy not conventional disease control.

Currently, 11 countries in the European Region have OPV only in their immunization schedules (7 of which will be eligible to receive GAVI support to introduce IPV), 8 have both IPV and OPV (1 of which is GAVI supported, and 5 of which use a combination vaccine product that includes IPV) and 34 have only IPV. The 4 OPV-only countries that are not GAVI supported all purchase vaccines themselves, in two cases procured through UNICEF. Kazakhstan is considering a full IPV schedule. Ukraine has funding for only 65% of its vaccination needs.

GAVI Alliance support

In June 2013, the GAVI Executive Board agreed to play a leading role in the introduction of IPV into routine immunization services in the 73 countries eligible for or graduating from GAVI support and it requested the GAVI Secretariat to present a long-term strategy for this support. However, it stipulated that funds required for IPV procurement and roll-out in GAVI-supported countries should not be taken from existing GAVI resources.

The challenges of the Endgame Strategy are unique and flexibility in GAVI policies are therefore being considered, including a possible extension of the application window for IPV support and waiver of co-financing requirements for IPV vaccines.

In the coming year, GAVI will be communicating with countries to determine demand and country readiness, helping countries determine introduction dates and revised forecasts, and providing technical assistance and support for introduction, based on upcoming SAGE guidance related to the recommended immunization schedule.

Update on WHO/Europe support to Member States for IPV introduction

Throughout the past year the Regional Office has been in discussion with Member States on IPV introduction. A side session was organized at the Regional Committee meeting in September 2013, and the Regional Director subsequently sent a letter to the 11 remaining countries that have OPV only in their immunization schedules, encouraging them to introduce IPV. Of the 8 official and 1 unofficial responses received thus far, most have expressed interest in IPV introduction. Some already had planned dates for introduction (Albania, Serbia and Tajikistan), some were waiting for the SAGE decision on the preferred immunization schedule, and some asked for technical assistance. Follow up letters will be sent from GAVI to request more information.

Feedback received from the countries revealed an interest in low-dose combination products or a more affordable IPV standalone product. Some countries face ongoing regulatory and scheduling issues.

Globally, introduction of IPV and other new vaccines is forecasted to accelerate from approximately 10 vaccine introductions per year in 2000–2012 and 47 introductions in 2013 to 79 in 2014 (14% IPV) and 123 in 2015 (43% IPV).

NITAGs are expected to play a central role in introduction, scheduling, and prioritizing with respect to cold chain capacity and other issues.

Political commitment is the first step, but other issues are also important, including communication messages, training for administration of injectable vaccines and public acceptance of multiple injections (as many as three injections at one visit). The next steps for the Regional Office include preparing briefing notes for the 2014 World Health Assembly and attending upcoming NITAG meetings and national regulatory meetings. VPI will also be involved in a review of financial sustainability of introduction for some countries. Timing to ensure product availability will also need to be discussed.

Discussion

Outbreak response

Supplies of live polio vaccines in countries that use predominantly IPV have run out. ETAGE advice was requested related to the need for long-term planning for the complete shift to IPV and the recommended use of monovalent or bivalent OPV in the event of an outbreak of wild poliovirus. Among the 30 Member States that have no OPV stockpiles, bivalent OPV is licensed only in Belgium and France, where it is produced. Most of these countries have national response plans in place, but they stipulate use of IPV as the first option to respond to an outbreak.

Should WHO promote the registration of bivalent OPV for outbreak response and recommend that all Member States incorporate bivalent OPV as the vaccine of choice in outbreak response plans? ETAGE noted that it does not have the mandate to decide these questions, but they will be conveyed to SAGE and the working group for discussion at the November meeting.

Licensing for routine use

Newly independent states and middle-income countries often use prequalified products but do not license them. Only Azerbaijan and Kyrgyzstan have made use of expedited licensing procedures for routine use. The Regional Office recommends that countries review regulation procedures and consider this approach.

Scheduling of IPV vaccine

For practical and programmatic reasons it is important to investigate whether there will be sufficient acceptance among health care workers (HCWs) and parents for administration of a standalone injectable vaccine for young children alongside one or two other injectables at the same visit. Cost is also an important issue, since combination vaccines may be prohibitively expensive for some countries.

From the UNICEF Supply Division perspective, the current tender is for standalone IPV. Because of the lack of WHO-prequalified combination products, standalone IPV will remain the option for GAVI-graduating and -eligible countries in the short term.

Countries need to keep in mind that IPV is being introduced as insurance against the re-emergence of WPV2. In a non-outbreak setting, one dose of IPV is considered sufficient to offer protection from WPV2 when administered in addition to bivalent OPVs, because type 2 has not circulated for over 10 years and is considered "eradicated".

Countries all have different preferences and schedules. If the SAGE recommendation could include options rather than a single recommended schedule and the working group could indicate the expected impact of different options, regarding mitigating risk and producing enough immunity to reach the eradication goal, this may help countries to choose their own methods of introduction, related to the type of vaccine they will use.

SAGE attempts to allow flexibility in determining the recommended schedule, but it needs to decide on the best option and be clear about why this is best, and what is lost with other scenarios. Before making any decision it will consider the situations of countries in the four tiers of the GAVI pricing matrix.

GAVI support

GAVI is looking to provide support for IPV introduction in all 73 supported countries. It has not yet decided whether graduating countries (of which there are currently six in the European Region) would be required to co-finance IPV introduction. The current expectation is that co-financing will not be required for any of the 73 countries until 2018, and this might be extended to 2020, at least for countries that will not be graduating. GAVI's proposal to provide cash grants in lieu of supply is valuable, but existing combination vaccines are expensive, so cash support will still not be enough for some countries to introduce them.

Countries need clarity as soon as possible on: SAGE's scheduling recommendation (especially options to avoid the three-injection problem); on whether GAVI funding will be available for combination vaccines; and whether UNICEF Supply Division can provide any kind of combined product at a public-health price for middle-income countries. These decisions will help countries plan how to introduce IPV. SAGE's background paper on these issues will be translated and circulated to countries as soon as possible.

Communication

There is a great need to clarify the proposed introduction of IPV, why it is expected to work, and why it is different from historical combination schedules of IPV/OPV. Communication with decision-makers at national level, HCWs and parents has been a weak link, and GAVI, WHO and partners are struggling to fill this gap. In the European Region it is especially important to address misconceptions and misrepresentations.

NITAGs can play an important role in IPV introduction. Strategies being put in place are insurance against things going wrong, which is more difficult to communicate than the need for high immunization coverage. It is therefore critical to provide NITAGs with consistent and comprehensive information.

Session 3. Update on progress in Region toward meeting elimination target for measles and rubella by 2015

Rubella

Rubella has been reduced dramatically in the European Region, from a high of over 600 000 cases in 2000 to a low of under 10 000 in 2011. Although rubella cases were reported in various parts of the Region, the resurgence in 2011 and 2012 took place largely in Poland and Romania – and predominantly among males because of gender-specific targeting of immunization activities in the past.

Measles

Overall, the measles vaccination programme has had a tremendous impact on the European Region, with measles cases down 98% from almost 350 000 cases in 1993 to a low of 6936 in 2009. Compared to most other WHO regions, the European Region continues to perform well with coverage of the first dose of measles-containing vaccine (MCV1) at 94% in 2012. However, the number of measles cases has rebounded since 2010, with large outbreaks occurring in the past few years in several Member States, primarily in western and central Europe.

While fewer Member States attained 95% coverage with MCV1 in 2012 compared to 2010 (31 and 28 respectively), the number of Member States with less than 90% coverage also decreased in the same period (from 10 in 2010 to 7 in 2012).

Age groups

Although vaccination coverage for measles-containing vaccines (MCV) has been greater than 90% in the European Region since early 2000, coverage throughout the 1980s and to a less extent in the 1990s was subopitmal (below 95%), resulting in a large number of un- or under-vaccinated children who are now young adults. Among the measles cases reported for 2010 to (August) 2013:

- over half of the cases were 10 years and older;
- 1 in 3 patients with were aged 20 and older (these adults emerged as a susceptible group they were not targeted when vaccination programmes were first implemented in their countries or because of poor coverage during certain years);
- there was a large variation in age distribution of cases by country – with a larger proportion of adult cases in Georgia and Germany and a larger proportion of children in Turkey and United Kingdom.
- few cases had had 2 doses of MCV, and many adult cases had unknown vaccine status.

These statistics point to both multiple cohorts of poor immunization in the past (adult cases) and recent problems with immunization programmes (outbreaks among children).

Genotyping

- In 2011 and 2012: D4 was the predominant endemic genotype in the Region, with scattered clusters of B3, D8 and D9.
- In 2013: D8 was the dominant genotype.

Progress toward elimination

Thanks to a broad commitment to immunization programmes, the European Region has achieved a number of successes in pursuit of measles and rubella elimination in recent years.

- All Member States now include 2 doses of measles-containing vaccine in their regular vaccination schedules.
- All Member States have adopted a rubella immunization programme.
- Regional immunization coverage levels remain high.
- 44.6 million doses of measles-containing vaccines were administered in supplementary immunization activities (2005–2012).
- 67 national and subnational laboratories have been fully accredited.
- Surveillance tools for evidence-based decision-making have been produced and made available , e.g. immunization registries, genotyping data, seroprevalence studies, vaccine supply.

However, challenges remain that threaten achievement of the 2015 elimination target:

- suboptimal coverage and immunization gaps (e.g. eight countries administer the second dose at 10 to 12 years of age and WHO recommends that this be moved down to a younger age);
- insufficient case-based surveillance to enable verification of elimination (most countries collect this data, but some do not report it to WHO – in 2012, 13 countries did not report national case-based data for measles and 29 for rubella);
- continued outbreaks, with no comprehensive response;
- complacency of HCWs, the public and politicians – measles/rubella elimination is not a priority;
- lack of resources for lower- and middle-income countries that are not GAVI eligible to address gaps in coverage and respond to outbreaks.

The root causes of these challenges differ per country, and may include lack of awareness and misconceptions; transition of health care systems; and outbreaks in health care settings, schools and among specific population groups.

What WHO is doing

The *Package for accelerated action for elimination of measles and rubella in the WHO European Region* was presented to the Regional Committee in 2013. It identifies priority areas in which the Regional Office and partners will strengthen technical support to Member States as they seek to eliminate measles and rubella, and sets indicators and milestones by which progress resulting from the efforts of all stakeholders can be measured.

The top priorities for the Regional Office will be to help strengthen vaccination systems, improve surveillance, heighten outbreak response and preparedness, optimize communications, information and advocacy, strengthen resource mobilization and partnerships (such as the MECACAR collaboration with countries of the Middle East and Caucasus and the central Asian Republics) and coordinate the verification process for measles and rubella elimination.

The Regional Office began implementing the Package in 2013, with technical missions to improve surveillance and subregional response to measles outbreaks, implementation of the

Tailoring Immunization Programmes approach in pilot countries, impact assessment of selected NITAGs, publication of several guidance documents and many more initiatives. At the time of the meeting, 37 national verification committees had been established, 16 were pending and 35 annual reports had been received for the period 2010–2012.

Discussion

2015 target

Despite the decreasing likelihood that the Region will attain elimination by the end of 2015, moving the target date would not be advisable. Among other consequences, such a move could eliminate the urgency to act.

Outbreaks

Some countries have not responded adequately to outbreaks, and challenges have also been encountered in acquiring vaccines. All Member States should have preparedness plans and buffers to address initial outbreaks. Central stockpiling of MR vaccine would make it possible to get vaccines quickly to countries, but this task is not within the Regional Office´s mandate or capacity. Preparedness needs to be a political priority in every Member State.

Since the root causes of immunity gaps differ per country, the Regional Office plans to map the main obstacles in each country and identify priority countries where the risk of outbreaks is highest.

Health care workers (HCWs)

In the European Region, HCWs significantly influence immunization behaviour, but their training and commitment related to vaccines and immunization are not optimal. For this reason, the Regional Office has produced a number of job aids in four languages to inform HCWs and help them answer parents' questions and concerns. Supplemental training is also needed, such as an online in-service training course on immunization that would count towards licensing. Accreditation of such a course would require collaboration with education institutions or professional organizations such as ESPID that are already working on this in various countries. A teaching package on immunization for middle school level biology instruction could also be very effective in raising awareness.

The Regional Office has already begun engaging with associations to create links to the national and local levels. Much more work can be done to support HCWs, pending availability of resources in the Office.

Package of accelerated action

The intention of the Package is to highlight innovative activities and prioritize those that need to be taken immediately to reach the target. It is also intended to stimulate Members States´ engagement in parallel initiatives. In addition, ETAGE and the Regional Office need to put pressure on the ministries of health to prioritize and take ownership of measles and rubella elimination.

European Immunization Week (EIW)

It has proved difficult to measure the impact of EIW, because activities vary extensively across the Region. However, the VPI programme plans to do more to collect feedback on

communication products and tools developed at regional level. In general, more funding and resources are needed to conduct external evaluations of the campaign and communication materials.

Campaign messaging

Various experiences have shown that fear is not an effective motivator and that direct confrontation with the anti-vaccination lobby can be counterproductive. It may be more effective to highlight the social responsibility aspect.

Political commitment

The NITAG representatives discussed how to place immunization targets higher on the political agenda in their countries:

- Armenia and Belarus – There is high public acceptance of immunization and it is already well integrated in government policy.
- Azerbaijan – It is most important to educate parents, as health care workers are well prepared professionally.
- Denmark – Emphasis should shift to the benefits to be gained once measles and rubella are eliminated.
- Kazakhstan – The public is tired of being scared about complications, so the focus should be on positive examples and working with primary health care workers, school teachers, etc.
- Ukraine – Emphasis should be on the importance of herd immunity and coverage of at least 95% of every community.

Session 4. Towards developing strategies for adult immunization practices

Thanks to successful routine vaccination programmes for children, measles and rubella cases have been reduced dramatically. However, with systems tailored to reach children, the importance of adult immunization has been overlooked. For example, over one third of measles cases in the first half of 2013 were above 20 years of age, there is evidence that pertussis is increasing among adults, and uptake of influenza vaccine among health care workers remains low.

Developing strategies for adult immunization is in line with the Health 2020 priority of maximizing health through all stages of life. Various WHO position papers recommend vaccinations in adulthood, in addition to those recommended for international travel. Adoption of these recommendations at country-level varies across the Region, but most Member States recommend rubella vaccine for unvaccinated women of childbearing years, seasonal influenza for certain target groups, hepatitis B, and tetanus and diphtheria boosters.

Accurate data on uptake is not readily available, but it is believed that uptake among adults is poor. The envisaged strategies would therefore aim to address: barriers to adult vaccination, standards for practice, drivers of public demand, vaccine delivery systems, funding and costs, and coverage monitoring.

The Regional Office proposed that, as a first step, standards be developed that would provide guidance to reach a certain level of quality practice for adult immunization. The standards would cover: vaccine availability, assessment of patient vaccination status, effective communication with patients, correct administration and documentation of vaccines, implementation of strategies to improve vaccine uptake and partnerships with the community. These standards could be adapted by countries to suit their immunization programmes' needs, with the expected outcomes of improved practice and promotion of the use of adult immunization.

The standards can be tailored in such a way as to identify roles for the various sections of the target audience, e.g. vaccinating health care providers, non-vaccinating health care providers and public health authorities. Advice from ETAGE was requested on the best way to develop the standards, whom to share them with for review, and how ETAGE can best participate in the process.

Discussion

ETAGE recognizes that adult immunization is an emerging area. The idea of life-long immunization needs to be promoted and its purpose clearly defined. Putting guidelines for good practice in place would facilitate identification of historic gaps in childhood immunizations, improvement and promotion of routine adult immunization (leading to increased demand), but also preparedness for non-routine vaccination in the event of a disease outbreak. The standards would provide guidance on immunization practices, not on which vaccinations should be offered.

Issues to be addressed in developing the standards include clear definition of the target group, infrastructure requirements, equitable access, cold chain implications, the role of insurance as well as who will implement the system, who will be accountable and who will evaluate it. A checklist could be developed to help countries implement an adult immunization programme.

Standards established in the United States by the Centers for Disease Control and Prevention can be used to clarify the intended direction. But the developed guidelines have to be flexible enough for the varied contexts in the WHO European Region.

Session 5. Graduation challenges – sustaining immunization investments in countries graduating from GAVI support

GAVI revised its eligibility policy in 2010 based on 2009 data on gross national income per capita. Based on this new policy, eight countries in the European Region were declared eligible for GAVI support in one of three categories: low income (Kazakhstan, Tajikistan), intermediate (Uzbekistan) and graduating (Armenia, Azerbaijan, Georgia, Republic of Moldova, Ukraine).

Placement in each of these categories has policy implications that are intended to move the countries toward financial sustainability of their immunization programmes. Minimum co-financing of vaccines is required for low-income countries (US$ 0.20 per vaccine), to ensure that financing in not a bottleneck for maintenance of routine vaccination or introduction of new vaccines. Intermediate countries contribute a bit more (remaining at US$ 0.20 in the first year and then increasing 15% per year). Once a country moves into the graduating category, it is given a "grace period" of one year in which the co-financing level does not change. Thereafter, co-financing increases linearly for four years up to the full projected price when support ends. Graduating countries are not eligible for new GAVI support, however, they can continue to

apply for pneumococcal vaccines through GAVI and UNICEF at the terms and conditions of the Advance Market Commitment (AMC).

Economic growth since 2009 has been positive for each of the eight GAVI-supported countries in the WHO European Region, and none are expected to move into a lower category in the near future. Armenia, Azerbaijan, Georgia, Republic of Moldova and Ukraine will therefore be required to pay the full price for vaccines by 2016. Uzbekistan will become a graduating country in 2014 and will thus pay the full price after 4 years of support. Kyrgyzstan may cross the eligibility threshold for becoming a graduating country in the coming five years; while Tajikistan is expected to remain in the low-income category for at least the next five years.

Estimated financial burden after graduation is calculated based on the projected average prices per vaccine for new vaccines procured through the UNICEF Supply Division. Currently these are: Hib-containing pentavelent – US$ 1.95, rotavirus – US$ 2.54, pneumococcal – US$ 3.50 and HPV – US$ 4.50.

The WHO Regional Office has initiated a number activities to help countries prepare for and cope with graduation from GAVI support.

- A desk review was conducted to identify challenges that could threaten the sustainability of investments in immunization and propose solutions to secure them. Based on the findings, graduating countries (excluding Uzbekistan which was not yet a graduating country at the time) and required support were ranked according to need. Priority areas included financial stress on the national immunization programme (NIP), current and future financial affordability of vaccines and external threats to financing. Georgia was ranked most in need of support primarily due to uncontrolled privatization of its health care system that is seriously affecting the immunization programme, followed by Republic of Moldova, Armenia and Azerbaijan.
- A workshop on graduation issues organized in 2012 enabled all graduating countries to review challenges, share experiences, identify lessons learnt and agree on approaches to improve financial and programmatic sustainability of NIPs. WHO established and continues to facilitate a platform for sharing learning on these topics.
- Missions to five graduating countries were conducted in 2012 and 2013 together with WHO headquarters, UNICEF Supply Division, and the GAVI Secretariat to analyse the current situation and prospects related to graduation and recommend ways to address identified challenges. After the missions a transition plan for each country was developed with national authorities, and assistance has been provided to monitor implementation of the plans and report on progress on a quarterly basis.
- WHO is working with partners and countries on an ongoing basis, for example to continually monitor performance and update fiscal space analyses, determine access to GAVI prices for vaccines after graduation, expand the Sustainable Immunization Financing project to Europe, and consider options for further support to graduating countries.

Maintaining funding especially for newly introduced vaccines is a major concern, however the multi-country assessment revealed that financial affordability is not the only threat to the sustainability of NIPs. Other country-level challenges include insufficient advocacy to mobilize

additional resources, a weak planning and budgeting process, and difficulty in accessing quality-assured vaccines at an optimum and affordable price (due to limited understanding of the vaccine market and specificities of vaccines).

Plans for continuing support from the Regional Office include monitoring performance of graduating countries in meeting financial resource mobilization requirements, strengthening of national procurement systems, development of a "training for graduation" curriculum, increased collaboration with other technical units within WHO to create a system-wide approach and response, sharing experiences and lessons learnt with partners, and keeping the GAVI Board informed of and vigilant regarding graduation challenges.

Policy changes planned by GAVI to enhance support to graduating countries

GAVI recognizes the need to adjust policies to address the challenges faced by graduating countries. The eligibility policy is based solely on gross national income; and while the 17 currently graduating countries (out of 73 countries receiving support globally) are capable of making co-payments, they do not all of have strong immunization performance. Because vaccine support and financial support are not aligned, graduating countries do not have access to GAVI financial support to address health system barriers to immunization.

At its November 2013 meeting, the GAVI Alliance Board was to decide on proposals to:

- extend the grace period to allow countries moving into the graduation category to apply for new support;
- align cash support with the graduation phase through access to (modest) graduation grants;
- scale up technical support in programmatic areas to graduating countries;
- provide access to GAVI prices for countries that did not introduce new vaccines while receiving GAVI support.

Discussion

ETAGE recognizes that GAVI has been a catalytic platform for introducing new antigens in immunization programmes and for strengthening immunization programmes in the different countries. It also notes that clarity is needed for countries identified as graduating from GAVI support. Although some form of continued co-financing is expected, these countries are now facing several challenges related to graduation and therefore require assistance and guidance.

Ministries of health sometimes do not realize the long-term budgetary impact of introducing new vaccines until they approach graduation. It was suggested that GAVI provide longer-term analysis to help decision-makers understand the level of resources that will be needed to sustain programmes after graduation.

ETAGE recognizes the Regional Office's work in conducting trainings, helping to develop transition plans, and providing costing and cost-effectiveness data to help graduating countries understand where they are now and what to expect in future. This critical evidence has fed back into GAVI policies and gives a concrete view of the challenges countries face and their responses. The focus for this Region in the coming years will be to ensure that all countries are supported to sustain their current vaccines after graduation. With 6 of 17 globally graduating countries located in the European Region, experiences gained here will provide valuable lessons for other regions and will help define the whole graduation process.

As a follow up, the graduation process will be on the agenda of the next ETAGE meeting.

NITAG involvement

NITAGs will play an important role in collecting relevant data on the burden of vaccine-preventable disease and the impact of immunization programmes in reducing this burden. This evidence is the driving force for demonstrating the importance of these programmes and for convincing policy-makers in the ministry of health and other ministries to make more of the country's own resource available for immunization programmes.

Vaccine prices

Graduating countries will require assistance in understanding the complexities of the vaccine market, negotiating with private companies and using the UNICEF procurement system. More transparency regarding vaccine pricing is also needed. Many countries cannot share the prices they pay for vaccines because of confidentiality clauses in their procurement contracts. Considering the number of graduating countries in the European Region, vaccine pricing and procurement issues will be a critical area for the Regional Office to focus on in the coming 3–7 years. Both WHO and GAVI will play a critical role as intermediaries to ensure sustainability over time.

Assistance provided to graduating countries is also important for middle-income countries facing similar challenges.

In April 2014, SAGE will discuss the possibility of reducing the recommended number of doses of HPV vaccines from 3 to 2. This will have implications for cost, administration and immunization schedules.

Introduction of IPV is a special case, as it is being introduced through the Endgame Strategy and has not been the choice of individual countries. Some countries for whom financial sustainability projections were based on zero financial burden for IPV may be asked to co-finance IPV after 2018. International donors will therefore need to take responsibility for supporting IPV in these countries.

A NITAG representative from Uzbekistan explained that the country will not be able to sustain the costs of pneumococcal and IPV vaccines after graduation without additional donor support.

Session 6 Regional Vaccine Action Plan (RVAP)

Rationale for and process of the RVAP development in the European Region

The sixty-fifth World Health Assembly in 2012 endorsed the Global Vaccine Action Plan and requested WHO regional offices (and Member States) to translate the GVAP into regional (and national) immunization plans, and to apply the vision and strategies of the GVAP into their broader and immunization plans according to the epidemiologicial situation in their respective territories.

The Regional Office sees development of a RVAP as an opportunity to revitalize the immunization agenda in the Region. The Regional Office will develop the policy document in close consultation with ETAGE, Member States and partners and will present it to the WHO

Regional Committee in September 2014. It will be aligned with the GVAP and regional Health 2020 goals and objectives, and will provide clear strategy guidance for the VPI programme and national counterparts in achieving set targets in the period 2014–2020.

The purpose of this ETAGE session was to brief and receive feedback from ETAGE members on the development process and to brainstorm on: regional priorities and challenges to be reflected in the regional plan, how to ensure key stakeholder engagement and how to better communicate and advocate for the developed RVAP.

Discussion

GVAP is not an operational plan but a policy document. For consistency, the Regional Office decided to use the same title even though the document will outline vision and strategies based on regional priorities and challenges rather than a set of key activities. The Regional Office will encourage strong ownership and buy-in from countries during the development process and in implementing the Plan at national level. Operational activities will need to be defined after the vision has been laid out.

ETAGE will be asked to provide feedback at all stages in the development process as well as to assist in advocating for and communicating the finalized document to Member States and partners.

Similar policy development initiatives in other WHO regions

GVAP encompasses five goals, each of which has six strategic objectives that can be adapted at regional level. Many regions have specific issues that are not included in GVAP and that will therefore be encompassed in regional adaptations of the Plan. Specific action in pursuit of the objectives is to be determined at country level.

The **Region of the Americas** already has a vision and strategy for 2007–2015. Due to the Region´s success in achieving high immunization coverage, countries are reluctant to put this issue high on the agenda, so GVAP is seen as way to revitalize commitment. The GVAP monitoring framework was discussed during the regional technical advisory group (RTAG) meeting in July 2013 and is expected to be endorsed at the Regional Committee meeting in September.

The strategic areas in this Region of maintaining past achievements, introduction of new vaccines and completion of the unfinished vaccination agenda are similar to those in the GVAP. But the GVAP can also help tackle regional specificities, such as vaccine hesitancy, shared responsibility to vaccinate vs. individual right to access vaccines, integration of immunization in the health system, regional production of vaccines at affordable prices, use of electronic registries, etc.

The Regional Office will lead discussions with Member States to develop and define indicators to track progress towards achieving regional goals and targets. The JRF will be the primary reporting mechanism for GVAP monitoring. Challenges are similar to those in other regions, including insufficient data quality, adherence to reporting timeline and the need for surveys and additional data collection for indicators not currently covered in the JRF.

A draft RVAP for the **Western Pacific Region** was discussed and revised by the regional technical advisory group (RTAG) and is under consultation with Member States and WHO country offices. The TAG secretariat also prepared a draft regional monitoring and evaluation

framework for implementing GVAP at regional level that includes specific goals and targets. The RVAP and framework for monitoring and evaluation are expected to be endorsed at the 2014 Regional Committee meeting.

Regional goals for the **African Region** to be included in the revised regional strategic plan will be discussed at a ministerial-level meeting in June 2014 and presented to the Regional Committee in 2015.

The **South-East Asia** and **Eastern Mediterranean** regions are updating their regional immunization plans.

Outline of regional priorities and challenges that the RVAP will be built on

The RVAP will lay out the broad areas or principles that will guide the VPI programme's vision for the next seven years. The RVAP has to be aligned with the Health 2020, GVAP and other regional commitments (e.g. measles/rubella elimination).

Health 2020's strategic objectives are to improve health for all and reduce health inequalities and to improve leadership and participatory governance.

GVAP's five goals are to: achieve a world free of poliomyelitis; meet global and regional elimination targets; meet vaccination coverage targets in every region, country and community; develop and introduce new and improved vaccines and technologies; and exceed the Millennium Development Goal 4 target for reducing child mortality. Goals 1–4 are the most applicable to the European Region, as child mortality due to vaccine-preventable diseases is not high in this Region.

To reach these five goals, six strategic objectives have been defined: all countries are committed to immunization; individuals and communities demand immunization as a right; benefits of immunization are equitably distributed; strong immunization systems are part of well-functioning health systems; national immunization programmes have sustained access to funding, supply and technologies; and research and development are conducted to maximize benefits. The final objective is mostly relevant at the global level, but all others will drive the RVAP document and vision.

Based on these parent documents and regional priorities, the RVAP vision will encompass four components: equity in immunization across populations; demand-driven delivery of services as a basic right; expansion of immunization throughout the life course; and the aspiration target of a Region free of the vaccine-preventable disease burden. The vision will reflect the view that building public demand for immunization is as important as providing equitable access to it.

Discussion

ETAGE is pleased to offer assistance and be actively involved in this development process at all stages, through regular consultations with VPI and engagement in country-level consultations.

Conclusions and recommendations

Conclusions

ETAGE acknowledges the important role played by NITAGs and welcomes participation in the meeting by NITAG representatives from Armenia, Azerbaijan, Belarus, Denmark, Republic of Moldova, Kazakhstan, Kyrgyzstan, Ukraine and Uzbekistan.

Operationalization of the monitoring, evaluation and accountability framework for the Global Vaccine Action Plan (GVAP)

- ETAGE notes that the GVAP timeframe for operationalization of the framework appears to be feasible for most countries. However, the information needed to complete the JRF and other reports comes from multiple sources; and there is concern about the quality of the data produced. Strengthening reporting to meet the requirements as well as avoiding parallel reporting activities will require greater organization in Members States and will be a collaborative effort at various levels.
- Indicators need to be well defined, and standardized if possible. ETAGE recognizes that the first year of reporting within the GVAP framework will involve a learning curve and lessons learnt will contribute to improvements in subsequent years.
- ETAGE notes that NITAGs can play an important role in implementation of the GVAP framework: not to supervise activities but to profit as the end user of the data, which will allow them to define policy and advise decision-making authorities.
- ETAGE notes that the whole GVAP process should create added value for the beneficiaries of the immunization programme – this message needs to be understood by all and thus better communicated.

Planning for inactivated polio vaccine (IPV) introduction (to mitigate risks associated with withdrawal of type 2 component of OPV)

- ETAGE notes that there is great need to clarify to national authorities, health providers and parents the purpose of IPV introduction as envisioned in the Endgame Strategy, why it is expected to work, and why this approach is different from historical combinations of IPV/OPV. If people do not understand the principles involved, implementation will not achieve what is being sought.
- For the IPV introduction process, each country might be starting from a different point based on the historical context. Member States are accordingly requesting tailored support from the Regional Office. WHO, UNICEF and others are working to produce Frequently Asked Questions (FAQs) and other documents, but additional resources will need to be invested in communication on all topics related to introduction.
- ETAGE notes that the challenges for IPV introduction also include licensing of vaccine products and mobilization of sufficient resources. The long-term involvement of GAVI will be decided by the GAVI Board in November 2013. This decision will be instrumental to achieving the Endgame Strategy for polio eradication.

Progress toward measles and rubella elimination in the Region and implementation of the Package of accelerated action for measles and rubella elimination

- ETAGE is concerned about persistent immunization gaps, the lack of case-based surveillance, continuing outbreaks of measles and rubella and the lack of an adequate response to these outbreaks in the European Region. Moreover, ETAGE notes that these factors threaten the 2015 measles and rubella elimination target for the Region. To reduce complacency and mobilize the necessary resources to address gaps (also in middle-income and high-income Member States), measles and rubella elimination will need to become a high priority for decision-makers. It is necessary to look at what ETAGE and the Regional Office can do to put pressure on the ministries of health to make elimination a priority.
- ETAGE is enthusiastic about the efforts initiated by the VPI programme under the framework of the *Package of accelerated action for measles and rubella elimination*. The Package encompasses many activities and tools which can be used at country level to enhance elimination efforts, such as the *Guide to tailoring immunization programmes* and *Guidelines for measles and rubella outbreak investigation and response*. At the same time, ETAGE recognizes that ownership in each country is also needed.
- ETAGE recognizes that this effort will also include strengthening relations between organizations, services that provide immunization and educational institutions.

Development of strategies for adult immunization practices

- ETAGE recognizes that adult immunization is an emerging area. Immunization does not end after childhood: it is necessary to extend the concept to one of lifelong immunization. If adult immunization is recommended, a tailored infrastructure needs to be in place for delivery. Topics to be considered are how to reach adult populations, cold chain issues, how to document their immunization status, who in each country is responsible for the adult immunization, the role of health insurance, etc. A set of standards (that emphasizes the role of all providers, even non-vaccinating providers) to be developed by WHO/Europe would provide a checklist that countries could review and that would assist them in the implementation of an adult immunization programme.
- ETAGE recognizes that there is need for targeting schools, universities and employers with information on the cost–effectiveness of increasing immunization uptake among young adults.

Graduation challenges – sustaining immunization investments in countries graduating from GAVI support

- ETAGE notes that GAVI has been a catalytic platform for introducing new antigens in immunization programmes and for strengthening immunization programmes in eligible countries.
- ETAGE is concerned that countries identified as graduating from GAVI support face challenges in maintaining the sustainability and quality of their immunization programmes. More clarity is needed regarding post-process, and graduating countries (as well as middle-income countries) need assistance and guidance in areas such as

understanding vaccine market dynamics, impact of national procurement systems and regulations on vaccine supply, in order to access quality-assured vaccines at an affordable and optimum price after graduation. ETAGE is accordingly concerned about the lack of transparency regarding vaccine prices and appreciates the work initiated by WHO in this area.

- ETAGE appreciates VPI's ongoing work together with partners and Member States to identify graduation challenges, facilitate inter-country collaboration, and facilitate the development, monitoring and review of transition (graduation) plans.
- ETAGE acknowledges the important role NITAGs will play in mobilizing the financial resources required and in strengthening the programme functions in addressing the graduation challenges. Collecting country-specific data on the burden of vaccine-preventable diseases and the impact of the immunization programme in reducing this burden is needed to demonstrate the importance of the programme. This evidence is the driving force for convincing policy-makers and ministers of health and other ministries to allocate more of their countries' own resources to immunization programmes. WHO/Europe is already assisting countries in using costing and cost–effectiveness data to understand where they are now, where they are heading and what to expect in future.
- With 6 of 17 globally graduating countries located in the European Region, ETAGE notes that experiences gained here will be watched by, and provide valuable lessons for, other regions.

Development of a Regional Vaccination Action Plan (RVAP)

- ETAGE supports development of the RVAP, which will set out the Regional Office's vision and strategies for the coming seven years in line with the applicable goals and objectives of the GVAP. The RVAP will be a policy document intended to be operationalized at the country level.
- ETAGE is pleased to offer assistance and to be actively involved in the development process at all stages, through regular consultations with VPI and participation in country-level consultations.

Recommendations

1. ETAGE advises the VPI to provide technical assistance to national and supranational regulation authorities in licensing products pertinent to the polio Endgame Strategy.
2. Due to the threat to the 2015 measles and rubella elimination goal for the WHO European Region, ETAGE encourages Member States to formulate or revisit their current action plans for measles and rubella elimination and to urgently address immunity gaps in their populations.
3. Recognizing that most Member States have not developed a framework to provide immunization services to adolescents and adults, ETAGE encourages Member States to include adequate practices and facilities for adult immunization in their health care systems.
4. ETAGE urges VPI to assist GAVI-graduating and lower middle-income Member States in ensuring access to quality-assured vaccines at an affordable and optimal price.

5. ETAGE recommends that WHO support the development of generic training materials on immunization for schools, as school populations are highly receptive to the immunization topic.
6. ETAGE recommends that WHO support the development of training materials on immunization for continuous medical education schemes. Accreditation of this material could take place through national or international medical professional organizations or national licensing schemes.

Annex 1. Agenda

Wednesday, 9 October 2013 – closed session

Thursday, 10 October 2013

Session 1
Opening remarks, *Dr Guenael Rodier, WHO Regional Office for Europe* Operationalizing Monitoring, Evaluation and Accountability Framework for Global Vaccine Action Plan (GVAP) • Monitoring, Evaluation and Accountability Framework for the GVAP and operationalizing the GVAP at regional level, *Dr Kamel Senouci, WHO headquarters* • Operationalizing Monitoring, Evaluation and Accountability Framework at the European Region of WHO, *Dr Nizake Cakmak, WHO Regional Office for Europe*
Session 2
Planning for inactivated polio vaccine introduction (IPV), as a part of Polio Eradication and Endgame Strategic Plan 2013-2018 • Overview of current status of IPV use in Member States, *Dr Abigail Shefer, WHO Regional Office* • GAVI Alliance support in the European Region in introducing IPV in GAVI-eligible countries, *Dr Stephen Sosler, GAVI Alliance* • Update on WHO Europe support to MS for IPV introduction, *Dr Abigail Shefer, WHO Regional Office for Europe*
Session 3
Update on progress in Region toward meeting elimination targets for measles and rubella by 2015 • Overview of the Package of Accelerated Action for measles and rubella elimination, reviewing milestones and timeline for key outputs, *Dr Abigail Shefer, WHO Regional Office for Europe*
Session 4
Towards developing strategies for adult immunization practices, *Dr Mark Muscat, WHO Regional Office for Europe*

Friday, 11 October 2013

Session 5
Graduation challenges – Sustaining immunization investments in countries graduating from GAVI support • Graduation challenges, *Dr Nizake Cakmak, WHO Regional Office for Europe* • Policy changes planned by the GAVI Alliance to enhance support to GAVI graduating countries, *Dr Stephen Sosler, GAVI Alliance*
Session 6
Regional Vaccine Action Plan (RVAP) – introduction, *Dr Dina Pfeiffer, WHO Regional Office for Europe* • Rationale for and process of the RVAP development in the European Region, *Dr Nizake Cakmak* • Similar policy development initiatives in other WHO regions, *Dr Kamel Senouci, WHO* • Outline of the RVAP and regional priorities and challenges that the RVAP will be built upon, *Dr David Mercer, WHO consultant*

Annex 2. List of participants

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REGIONAL OFFICE FOR EUROPE

WELTGESUNDHEITSORGANISATION
REGIONALBÜRO FÜR EUROPA

ORGANISATION MONDIALE DE LA SANTÉ
BUREAU RÉGIONAL DE L'EUROPE

ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ
ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

13th European Technical Advisory Group of Experts on Immunization (ETAGE)

Copenhagen, Denmark, 9–11 October 2013

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