

A note from the Chair:

Dear IPAC members and observers,

Welcome to the second IPAC newsletter for 2015. Once again, we have some updates from various working groups that IPAC members are involved in, some items of general interest and we welcome a new IPAC Observer, Laura Conklin, representing CDC. Laura replaces Danni Daniels; we're very grateful for Danni's participation during this changeover period.

Technet21 and document reviews

Thankyou to those who have commented on recent documents, such as the *Guidance Note on Proper Handling of Vaccine Diluents*, and the *Global Routine Immunization Strategies and Practices* (a supplement to the Global Vaccine Action Plan). Such review is a critical part of IPAC's work: to have programmatic experts such as yourselves involved in quality control is a hugely important support to WHO and immunization more generally. I encourage you, wherever possible, to also comment through the Technet forum, to stimulate discussion: both on the document under review and on any broader implications for programmes.

SAGE April 2015 and GVAP

I, and some others from IPAC, attended the April SAGE meeting and was interested to note that

the majority of SAGE discussions were on programmatic issues: as usual, the meeting report is at <http://www.who.int/wer/2015/wer9022/en/>. Programmatic topics included evidence on multiple vaccinations at a single session (introducing a 'Good Practice Statement' rather than the usual systematic review with GRADE) and the call for incorporation of evidence-based pain mitigation in immunization guidance and training. There were clear programmatic implications from discussion of the need to extend the work on Ebola vaccines to a broader approach to emergency deployment of vaccines for emerging infections, the strategy for middle-income countries, review of evidence for maternal vaccination during pregnancy, and the acceleration of polio eradication. The review of evidence on pertussis schedules reaffirmed pertussis immunogenicity as a most important consideration for efforts to standardise the primary infant vaccine schedule.

SAGE's trenchant comments on slow progress against GVAP had been a helpful highlight of the World Health Assembly; I found it interesting that the opening discussion at the April SAGE, relating to GVAP, called for a greater focus on programme issues, and a greater usage of implementation science to bridge the gap between global strategies and field realities.

SAGE has a long forward agen-

da that is circulated regularly, at least a third of which is of direct relevance to IPAC's mandate. One example, that has been on the agenda for several years, is consolidation of evidence on a greatly needed topic: "The Immunization Manager of the 21st Century" – food for thought.

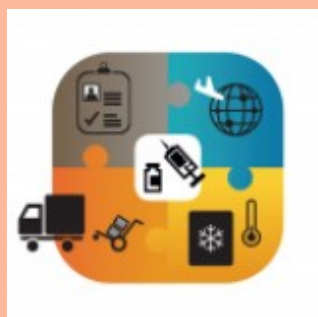
Working groups

IPAC members continue to be asked to join a variety of WHO working groups. I realise this is not always an easy task, both in fitting the work into overloaded schedules, and also in being the 'generalist' voice who contributes the programmatic perspective in balancing the views of disease or other subject specialists. We are very grateful to all who serve in this way.

Best wishes for the winter or summer solstice (depending on your hemisphere) and happy reading.

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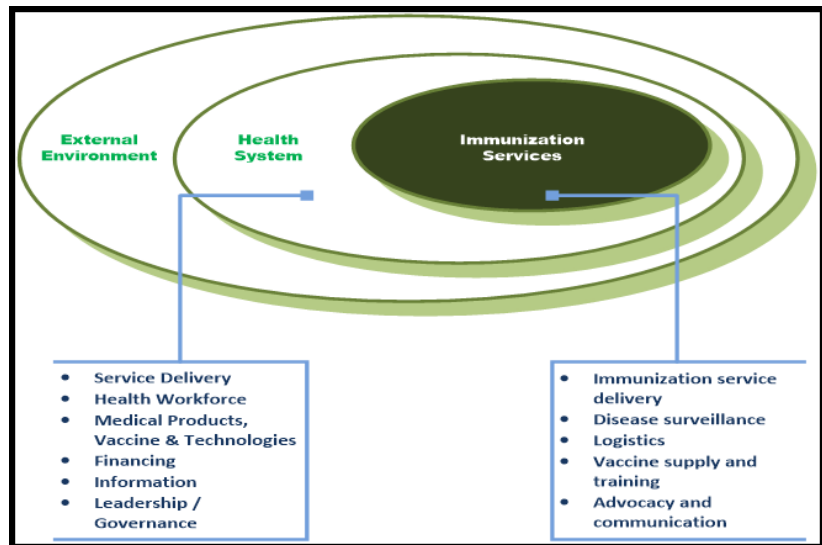
Commentary By Adelaide Shearley

Adequate vaccine supplies at district level but vaccine stockouts persist at service delivery levels: will reducing the numbers of unvaccinated children become a reality?

The immunization program in Zimbabwe was launched more than three decades ago and since then the programme has achieved significant gains in coverage and quality of service provision. The implementation of Reaching Every Community/Child (REC) / Reaching every district (RED) strategy, intensified training and supportive supervision has contributed to significant progress in routine immunization strengthening over the last two decades. However, the country experienced a deteriorating economic and social environment since 2000, negatively affecting quality service delivery.

Barriers contributing to large numbers of unvaccinated children are known (unavailability of vaccines, absence of the vaccinator, inconvenient time for immunization sessions, etc.); what needs to be done is to put in place policies that will deliberately favour and prioritise immunisation and to look beyond 'Coverage' as this indicator is often misleading where the denominator is always problematic. WHO/ UNICEF need to recommit Governments to prioritise immunisation, using their local resources.

Unless and until Governments put in place policies that ensure adequate and sustainable locally mobilised resources for routine immunisation, reducing the numbers of left-outs and partially vaccinated children will be a "Pie in the Sky" for most African Immunisation Programmes. The EPI Managers have brainstormed on strategies of reducing the large numbers of unvaccinated children in most of their meetings and very little has changed over the past years. It is now time to implement the recommendations that came out of several meetings over the past four years (see box).



Immunization and Health System Components

Immunisation programmes thrive well in a sound health system where there is integration, coordination and good leadership where immunisation is prioritised with a clear budget line. All routine immunisation strategies recommended by WHO, do not come with resources, therefore all operational costs should be mobilised locally, through the ICC and other partners with interest in immunisation.

Recommendations made during the Eastern and Southern African countries Meetings:

Develop community-health facility based micro-plans and implement all RED components in their weak performing districts.

Review factors preventing reduction of numbers of unimmunised children in the sub-region in some countries and recommend strategies to address these factors.

Partners should take urgent and concrete steps to support countries to improve performance, including providing technical support to the six focus priority countries (Ethiopia, Madagascar, Mozambique, Somalia, South Sudan and Uganda) in the region to implement, monitor and report progress against performance for their routine immunization improvement plans (RIIP).

Member agencies should support systems strengthening activities at country level, including stronger government ownership and increased funding for the program. Member agencies should provide necessary technical support for the implementation of the full package of the RED strategy, as well as other strategies at country level to improve routine immunization coverage.

Countries should mobilise additional domestic resources by utilising various mechanisms including high level advocacy to political leadership including Parliament and supplementary external financial resources in order to meet vaccines and operational costs as well as Gavi co-financing requirements.

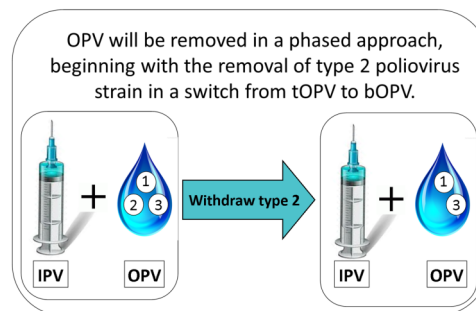
From the Working Group frontlines

Diana Chang Blanc on IPV Introduction status and rational for the withdrawal of type 2 OPV:

A critical part of the strategy for achieving global polio eradication, as outlined in Objective 2 of the Polio Endgame strategy, is the introduction of inactivated polio vaccine (IPV) and the subsequent withdrawal of the type 2 component of oral polio vaccine (OPV)- with the ultimate goal to cease use of all oral polio vaccines in 2019-2020. Withdrawing the type 2 component of OPV a key step to eliminating the rare risks of vaccine-associated paralytic polio (VAPP) and circulating vaccine-derived poliovirus (cVDPV), as OPV type 2 is now the primary driver behind the majority of cVDPV cases. As agreed at the World Health Assembly 2015 the phased withdrawal of OPV will start in April 2016 through the switch from trivalent OPV (tOPV) to bivalent OPV (bOPV), in a globally synchronized manner. Once polio eradication is certified, the withdrawal of all oral polio vaccines is planned for 2019-2020.

SAGE has recommended that in advance of the switch, all countries should introduce at least one dose of IPV to their routine immunization programmes, as a risk mitigation

strategy. As at June 17, 2015, 21 of 126 countries targeted for IPV introduction have completed introduction and the remaining 105 countries have committed or expressed intent to introduce by end 2015 or early 2016. IPV introductions remain on target, although the global supply situation is constrained and the situation is closely monitored by UNICEF and WHO.



With respect to the tOPV-bOPV switch, there are 149 Member States and 7 recognized territories that currently use tOPV alone or in a IPV-OPV sequential schedule, who will be required to participate in the globally synchronized switch. The global switch window will span a two-week timeframe in April 2016 during which countries will select a Na-

tional Switch Day. On this day, the country will a) recall tOPV from the cold chain and initiate its disposal and b) begin administration of bOPV. The two vaccines cannot be administered simultaneously. Countries will subsequently have a two-week period following the National Switch day to dispose of and conduct monitoring of the withdrawal of tOPV stocks. Countries have been oriented to the switch requirements during different regional fora and technical meetings, including EPI managers meetings.

Countries are currently undergoing planning to develop a costed national switch plan by the end of September 2015, which will describe activities for training, supply and distribution management, disposal and monitoring. Countries will need to establish management and operational oversight structures, which includes a National Switch Management Committee and an independent National Switch Validation Committee. It has been strongly recommended that these bodies are developed from existing expert group mechanisms.

Implementation guidelines and support tools are readily available, highlighting the main steps in planning, preparing, implementing and monitoring the switch.

Resource material available at

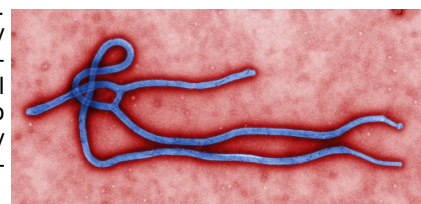
http://www.who.int/immunization/diseases/poliomyelitis/endgame_objective2/en/

Chris Morgan on SAGE Working Group on Ebola Vaccines and Vaccination:

The group presented to the April SAGE a proposed framework for a recommendation on future deployment of vaccines against Ebola. The framework had adopted a scenario-based approach that will aim to define and prioritize target groups for vaccination in different epidemiological scenarios and provide recommendations for the use of vaccines under each scenario, based on the regulatory authorization for use. SAGE requested that the definition and prioritization of target groups

and the vaccination strategies should be based on risk-benefit analysis. Since then, the working group continues to review updates on the epidemic and on vaccine trials, as well as more refined data on topics such as attack rates, varying risks of infection in different groups - including by age, sex, profession (health care, other care), and social drivers of vulnerability. On this last topic, it is increasingly evident how important it is to balance both economic and cultural determinants of behaviour, and to avoid unhelpful generalisation by being as context-specific as possi-

ble, understanding behaviours and practices vary widely within and between settings. It is also clear that there will remain limits to the information available and that the formulation of any recommendation must account for this. There have been several teleconferences and another face-to-face meeting is planned for August.

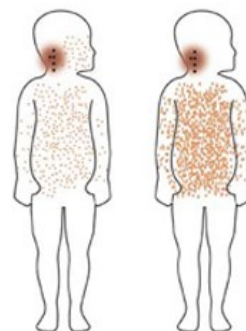


From the Working Group frontlines Continued from page 3

Jean Marc Olive on Measles, Rubella and Routine Immunization WG :

The M&RI Routine Immunization (RI) Work Group objective is to maximize opportunities to both strengthen RI as part of measles/rubella elimination activities and reinforce the important role RI plays in achieving and maintaining measles/rubella elimination.

My 1st contribution to the group has been to participate at the 1st Working Group call where WG's priority areas were presented as an update, particularly: Second Year of Life (2YL), impact of 5d vial on vaccination coverage and opportunities for SIAs to strengthen RI. Planned activities will be another call end of April and the participation to the WHO RI/Measles/NUVI meeting end of June.



Jean Marc Olive on the ad hoc Working Group on Multiple Injections :

With new vaccines being introduced in vaccination programs there is an increasing need to provide clear and sound guidance to countries on how to handle the administration of multiple injectable



vaccines to infants during the same immunization visit. This ad-hoc working group was organized to prepare for SAGE a "Summary of evidence on the administration of multiple injectable vaccines in infants during a single visit". I was invited to this group in March and this year and contributed to the revision of the document.

New from PSPQ By Robin Biellik



At the June 2014 IPAC meeting, the PSPQ Standing Committee (SC) was tasked to review 6 "grandfathered" vaccines that were prequalified before the current PSPQ guidelines were implemented and that are not in compliance with one or more of the PSPQ criteria. For each vaccine, briefing notes were provided by the WHO Secretariat and vaccine supply data were provided by UNICEF Supply Division. In April 2015, the SC reviewed the last 2 vaccines, recommending that prequalification be retained for one vaccine and withdrawn for the other. With this, the SC has now completed reviews of all 6 vaccines.

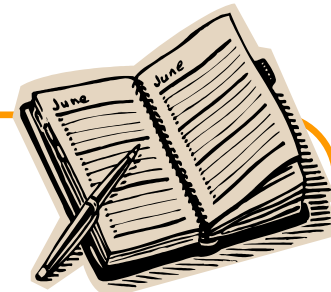
The PSPQ guidelines had been revised in 2014 and the new guidelines are now published and have come into effect from January 2015 onwards.

The revised document can be found at:

http://www.who.int/iris/bitstream/10665/148168/1/WHO_IVB_14.10_eng.pdf

Upcoming Meetings / Events:

- ⇒ **July 14-15: Stakeholder Meeting on Vaccine Doses per Vial, Annecy, France (JSI)**
- ⇒ **September 7-8: WHO Meeting on Optimizing the Hepatitis B vaccination schedules, Geneva, Switzerland**
- ⇒ **October 14-16: IPAC meeting, Geneva, Switzerland**
- ⇒ **October 20-22: SAGE meeting, Geneva, Switzerland**



A final word from the IPAC Secretariat

A formal Evaluation of IPAC is under way and you may already have been contacted to participate by the group tasked with conducting this activity, BigThink Partners (BTP). For those of you who are less familiar with the process leading up to this, I wanted to clarify the stages that led to the selection of BTP and the agreed methodology for the evaluation.

As part of IPAC's transition to a new format, it was considered timely that the Committee's structure, governance, and mandate be re-examined and evaluated in order to ensure its continued relevance and utility. WHO therefore sought out a contractor to carry out a comprehensive evaluation of IPAC, including its evolution and fitness for purpose, in order to make recommendations that will serve to optimize IPAC's current and future value to WHO and the global immunization community.

Following input from IPAC and relevant senior staff of EPI, a Request for Proposals (RFP) was created and advertised in March 2015. The pro-posal from BigThink Partners obtained the highest score from the bid evaluation committee and a contract was awarded to them in mid-May. The objectives of the evaluation remain as follows:

- a) Document lessons learned and optimal practices from IPAC work over the past five years, including description of a limited number of case studies;
- b) Review IPAC's role and function in relation to other expert advisory functions in IVB, assessing in particular what IPAC could do differently to create a stronger community of practitioners that functionally work as peers and contribute to programmatic inputs through working groups.
- c) Assess how well the previous and present IPAC processes support the intended IPAC functions as described in the IPAC Terms of Reference 2013 (including any risks and opportunities associated with IPAC's new operating modality); and

the defined desired outcomes in the current grant supporting IPAC, including:

- * programmatic perspectives being incorporated into global policies and recommendations ; and
 - * adoption and operationalization of evidence-based programmatic guidance / recommendations at country level.
- d) Synthesise findings with recommendations for:
 - i. Improving future IPAC processes and approach to achieving desired outcomes,
 - ii. Defining IPAC's optimal role and contribution to IVB and GVAP, and
 - iii. Communicating and disseminating IPAC outputs.

The principal components of BTP's methodology consist of a desk review, online survey, and one-on-one interviews. The main deliverables and associated timeframes are:

- Agreed survey and interview methodology and related questionnaire frameworks: *Late May 2015*
- Briefing on preliminary findings (via conference call): *Late June 2015*
- Draft report on methods and findings: *Mid-July 2015*
- Final report on methods, findings and conclusions: *Early August 2015*

Should you wish to know more about the IPAC Evaluation, please feel free to contact Anna-Lea. For more information on BigThink Partners, please see

<https://bigthinkpartners.wordpress.com/>.

Wishing you all a very pleasant summer!

The IPAC Secretariat Team