Coverage of third dose of DTP containing vaccine in AFR, 2014 vs 2015

Source: WHO/UNICEF estimates for 2015, July 2016 release
http://apps.who.int/immunization_monitoring/globalsummary/timeseries/tswucoveredt3.html

Highlights

According to the 2015 WUENIC, the Regional coverage for DTP3 containing vaccine increased from 74% to 76% between 2014 and 2015. Around 24.96 million children were vaccinated with DTP3 in 2015 compared to 23.98 million in 2014.

Sixteen countries reached a DTP3-containing vaccine coverage ≥90% in 2015 compared to 18 in 2014.

In 14 countries coverage was sustained at >90% for the last 2 consecutive years, while it dropped in 4 (Ghana, Kenya, Malawi, Zimbabwe) and increased in Namibia and Zambia.

The coverage increased in 17 countries including in 4 of the 6 priority countries (Ethiopia, Chad, Nigeria & DRC) that received direct support from the Regional Office. Coverage in CAR, Equatorial Guinea and South Sudan remained below 50% for both years and even decreased in South Sudan and Equatorial Guinea. The conflict in CAR and in South Sudan with insecurity areas and inadequate implementation of RED approach in Equatorial Guinea are the main causes of the sub optimal performances observed.
**Coverage of first dose of Measles Containing Vaccine (MCV1) in AFR, 2014 vs 2015**

**Highlights**

The regional coverage for MCV1 increased from 72 to 74% and MCV2 from 11 to 18% with only 23/47 countries having introduced this vaccine.

Analysis of the WUENIC 2015 show that 12/47 countries in the region have reached 90% coverage for the 1st dose of measles containing vaccine (MCV1) compared to 14 in 2014

11 countries have sustained 90% coverage during 2 consecutive years: Algeria, Botswana, Burundi, Cape Verde, Gambia, Lesotho, Mauritius, Rwanda, Sao Tome et Principe, Seychelles, Tanzania and Zambia. Eritrea, Ghana and Zimbabwe who had a coverage≥90 in 2014 had a slight drop this year

MCV2 coverage ≥90 were observed in only 3 countries (Algeria, Capo Verde and Seychelles)

Three countries (CAR, Equatorial Guinea and South Sudan) reported MCV1 coverage below 50% for both years.

**Comparison between 2015 DTP3 national official reported coverage (JRF) and WUENIC**

**Highlights**

Comparative analysis of 2015 DTP3 administrative data (JRF) and WUENIC show similar coverage in 27 countries with 14 having met the GVAP target of 90%.

The WUENIC for Lesotho and Botswana, was higher than the administrative data, highlighting possible underreporting from national administrative system.

Equatorial Guinea had the same level of coverage for the 2 source but below 20% while in South Sudan, the WUENIC showed a coverage lower than the reported by 19 points.

However, in 17 countries, there was a gap between these 2 sources of data (Administrative data > WUENIC). The highest gap (≥20 points) was observed in South Africa, Mali, Niger, and Chad. Moderate gap (>10 and <20) was observed in Democratic Republic of the Congo (the), Benin, Uganda, Madagascar, Angola, Nigeria, Liberia and South Sudan. Minor gap (≥3 and <=10) was observed in Ethiopia, Côte d’Ivoire, Guinea-Bissau, Guinea and Zimbabwe. Majority of these countries developed data quality improvement plans which are being implemented. This will surely contribute to reduce the gap between the 2 sources of data.

The figure shows a good positive correlation between country reported data in the JRF and the WUENIC for 2015 with a P value <0.001. This implies that the administrative reported data can be reliably used for decision making on a monthly basis and for programme review and planning prior to the release of the WUENIC later the following year. Caution should be taken for countries which persistent data quality issues.
Countries with highest number of DTP3 under immunized children, 2014-2015 (WUENIC)

**Highlights**

The 2015 WUENIC data show that an estimated 7.84 million children were not reached with DTP3 in 2015 compared to 8.2 million in 2014.

Around 75% of these children are located in the 10 countries shown in the beside graph with 53% of these children located in 4 countries only (Nigeria, Ethiopia, DRC and Angola).

These countries are among the AFR priority countries that are supported in the development and implementation of national immunization coverage improvement plans with specific strategies to reach the unreached children. These are collaborative efforts with other immunization partners need to be strengthened as well as close monitoring done through regular teleconferences and field visits.

### Routine Immunization coverage per country in AFR, all antigens in 2015 (WUENIC)

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<tr>
<th>County</th>
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| **Number under/unvaccinated with DTP3 containing vaccine in AFR:** | 8 234 679 | 7 840 969
Highlights

Analysis of data as reported in the 2015 Joint Reporting form (JRF) show that 17/47 countries (36%) in the region reported at least one episode of stock out of one or more vaccine at national level for a duration of at least one week.

For some countries, there was also shortage at district level.

BCG vaccine has been the most affected antigen for stock out (18 countries), followed by OPV (7 countries), DTP-HePb-Hib and Tetanus (6 countries).

Most of the stock outs at district level were due to unavailability of vaccines at national level.

Recurrence of these vaccine shortage stock outs at district level in some countries probably may have contributed to the interruption of vaccination sessions and therefore to the non achievements of the set objectives.

Tailored corrective measures should be implemented to improve vaccine management in those countries.

Funding of immunization programmes by Governments in the AFR in 2015

Five countries reported funding 100% of their immunization programmes with one funding ≥ 90%.

More than half of the countries (28) are funding <50% of their immunization programme among which 10 funding even <20% leaving a lot of unmet needs and challenges to reach all target groups.

Eight countries did not provide this information in their 2015 JRF.

This picture is almost the same as last year and this situation highlights the need for strong country ownership of immunization programmes in the African region.

This is reflected in the Addis Ababa declaration of the 2016 Ministerial conference on Immunization, which now needs to be implemented.
Coverage and equity: % of district with at least 80% of third dose of DTP containing vaccine by country in the African Region (JRF 2015)

Highlights

GVAP recommends that by 2020, coverage should reach at least 90%, at national level and at least 80% in every district or equivalent administrative unit for all vaccines.

The 2015 data reported by countries show that only 7/47 countries have reached ≥80% coverage in each district. Another 13 countries were close to reaching the target with 80-99% of districts having reached 80% coverage.

But more than half of the countries in the Region are lagging behind with almost 34% of countries still having ≤60% districts reaching 80% coverage.

The data shows that some districts have poor access compared to others, emphasizing geographic restricted inequity. Those countries should strengthen activities to equitably reach all children and increase coverage.

Third annual meeting of the MenAfriNet data management group

Ouagadougou 18-22 July 2016

Highlights

The 1st two meetings of MenAfriNet took place in Atlanta and Niger respectively.

The 3rd annual meeting was organized by WHO in Ouagadougou from 18 to 22 July 2016 with 26 participants from MOH & WHO of the following countries: Burkina Faso, Mali, Niger, Togo and Chad; as well as IST West, AMP, MenAfriNet Data team (CDC, AMP, WHO/AFRO and IST). At the end of the 5-day workshop, the following was achieved:

- Each of the 5 countries and the DMT conducted an evaluation of their 2015-2016 Data management plan and developed their new plan of action for August 2016 to December 2017;
- 4/5 countries further included surveillance and laboratory activities in this process;
- The DMT conducted an evaluation of the current DMS and came up with a road map for system upgrade, generic system development and deployment of the revised module.
- The data sharing mechanism was adopted and clear recommendations and actions adopted.

Background

MenAfriNet project was launched 3 years ago following the success of the men A vaccine introduction in the African Region. Funded by the Bill and Melinda Gates foundation, it comprises CDC, AMP, WHO and the Ministries of Health of 5 countries, Burkina Faso, Mali, Niger, Togo and Chad.

The main objective was to support the case based surveillance of meningitis in those countries and progressively in the remaining AFR countries within the meningitis belt by ensuring active case search, laboratory capacity, data management and use of quality data for decision making, research, communication etc.

MenAfriNet has different technical groups (surveillance, laboratory, data management, communication and research).

The Data management team (DMT) is building a robust data management system and coordinating support to countries in data collection, collation, compilation, analysis and sharing. The team chaired by WHO, includes specialists from WHO, CDC and AMP. It has monthly calls and meets on a yearly basis to evaluate the annual plan, assess the data management systems and analyze feedback from users for improvement and to develop a new POA.
Regional Immunization Technical Advisory Group (RITAG) Meeting, Brazzaville: 5-8 July 2016

Highlights
The newly constituted Regional Immunization Technical Advisory Group (RITAG) had its 1st meeting in Brazzaville, from 5th to 8th July 2016. The meeting was officially opened by Dr Joseph Cabore, Director of Programmes Management (DPM), on behalf of the Regional Director, Dr. Matshidiso Moeti. Present during the opening were Cluster Directors and staff of the WHO from the RO, ISTs, HQ, and immunization partner’s. The primary goals of the meeting were to brief the new RITAG members on the regional priorities for immunization and to seek their advice on current specific challenges. Some of the current priority areas in immunization were discussed in sessions of the meeting after the briefing sessions. In these sessions, the progress made was summarized, challenges highlighted and the RITAG members given the opportunity to discuss and to provide advice. At the end, a number of key recommendations were made.

Key recommendations
Some of the key recommendations in specific immunization areas include:

- **Immunization coverage and equity**: Countries, especially those reporting high immunization coverage, to triangulate available data to improve the accuracy of population immunity estimates.
- **In the context of decreased polio funds**: Maintain essential polio programme functions to ensure that the polio-free status remains, WHO/AFRO to work with partners to mobilize additional resources to fill funding gaps, including the development of detailed advocacy plans to increase country ownership and leadership, and monitoring government commitments.
- **Yellow Fever**: Steps should be taken to reduce response time between identifying cases and implementation of outbreak response interventions, Maintain high immunization coverage in Routine Immunization during outbreaks, Review the efficacy and feasibility of the use of fractional doses in situations where stockpiles of vaccine are low.

Practical Guidance on the Use of Ebola Vaccine in an outbreak response:
Call for comments by 30 September 2016

Background
The unprecedented Ebola virus disease (EVD) epidemic in West Africa which started in 2013 exposed global weaknesses to effectively prevent and manage emerging infectious disease outbreaks in timely manner. On 8 August 2014 (epidemiologic week 32 of the outbreak), the World Health Organization declared the Ebola outbreak a Public Health Emergency of International Concern (PHEIC) under the International Health Regulations (IHR) (2005) and the outbreak was graded 3 in line with the WHO Emergency Response Framework (ERF).

As part of the measures to control this and future EVD outbreaks, the WHO and its international partners and affected countries worked on a comprehensive Ebola research and development effort for effective vaccines, therapies and rapid diagnostic tests.

Several Ebola vaccine clinical trials were launched; however there was lack of guidance for the use of Ebola vaccines in an outbreak response and lack of clarity on vaccination strategies, vaccine supply and logistics. To help address these needs the *Global Ebola Vaccine Implementation Team (GEVIT)* was created under WHO leadership in order to facilitate the collaborative planning for the potential use of Ebola vaccines.


Highlights
This draft guidance is the result of a collaborative effort of a multi-partner initiative also known as the Global Ebola Vaccine Implementation Team (GEVIT). We hope that once this is finalized, it will serve as a “Blueprint” to governments and partners as they plan to use the potential effective and safe Ebola vaccines in an outbreak response.

All comments received by the published deadline will be considered in the preparation of the next version of this draft.

Comments are expected by no later than 30 September 2016 using the forms posted on the website and sent to prezio-sim@who.int with subject line “Comments on draft GEVIT Practical guidance on use of Ebola vaccine”. Inputs can either be provided to the entire document or only to certain parts. They can be submitted in English or French. Inputs received will contribute to the further development of the guidance document.