Pan American Health Organization
Regional Office of the
World Health Organization

Ministries of Health of the Region of the Americas

Organization of the Vaccination Week in the Americas (VWA) 24-30 April 2004

General Guidelines

Quito, Ecuador, 28-30 January 2004

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Vaccination Week in the Americas
24-30 April 2004

General Guidelines

The Vaccination Week in the Americas (VWA) is a regional instrument for intensifying the Expanded Program on Immunization (EPI), making vaccination a priority on the political agenda in all the countries, promoting Pan-Americanism, revitalizing transborder efforts, strengthening the primary care network, and meeting the goal of reducing inequities and reaching traditionally excluded populations with quantifiable results.

1. Background

Kicking off with the slogan "*Vaccination: An Act of Love,"* the First Vaccination Week in the Americas was held in June 2003. Nineteen countries[1] participated in this initiative proposed by the Ministers of Health of the Andean Area and supported by their counterparts from Central and South America, Mexico, and several countries of the English-speaking Caribbean. The basic objectives of the initiative were to reduce inequities through immunization and promote Pan-Americanism. The countries prioritized areas with at-risk populations and intensified activities along their borders. Other objectives included maintaining measles elimination and keeping vaccination a high priority on the political agenda of the countries.

The goal was to immunize 14,085,451 children under 5 with a number of antigens (in accordance with each country's needs) and 3,000,000 women of childbearing age (WCBAs) with Td. A total of 13,583,888 children under 5 (97% of the goal) and approximately 2,700,000 women were vaccinated. Some countries vaccinated men and women under the rubella elimination plan, while others carried out integrated efforts that included activities such as the administration of vitamin A and parasiticides.

PAHO's Public Information Office (PIN) designed a regional communication strategy bearing the slogan "*Vaccination: An Act of Love*." The strategy involved the creation of posters, and TV and radio spots featuring international artists as champions of Health in the Americas--material that was distributed to the countries in different languages and adapted to the local situation. The reach of the communication campaign was measured through a survey of mothers and responsible adults in households situated in the areas targeted by the intervention. Approximately 80% of the community

[1] Argentina, Bahamas, Bolivia, Brazil, Colombia, Costa Rica, Chile, Ecuador, El Salvador, Guatemala, Honduras, Jamaica, Mexico, Nicaragua, Paraguay, Peru, Suriname, Uruguay, and Venezuela.

interviewed demonstrated a high degree of knowledge about the VWA in scattered, remote, and urban fringe areas.

Active participation in border areas was observed, with the revival of transborder agreements in several countries. A variety of vaccination strategies was used, among them, fixed vaccination posts, mobile teams for remote areas, the strategic location of vaccination posts at population crossroads, with intensive regional and local communication operations, specific tasks, and the creation of joint vaccination, monitoring, and supervision teams.

The political commitment and allocation of resources by the countries, interagency coordination, social mobilization, and the general communication strategy, as well as technical and economic assistance from PAHO, UNICEF, CDC, the International Federation of Red Cross and Red Crescent Societies, and the Andean Health Agency were key to the success of the First Vaccination Week in the Americas.

2. Vaccination Week 2004

The second regional vaccination event is scheduled for the week of 24 to 30 April 2004, with the majority of the countries of the Region participating. The VWA has political backing from the PAHO Directing Council, which called for the establishment of an annual Vaccination Week in the Americas (Resolution 132.R7 of 132nd Executive Committee), in addition to endorsements from MERCOSUR, the Andean Health Agency, and RESSCAD.

2 a. Rationale

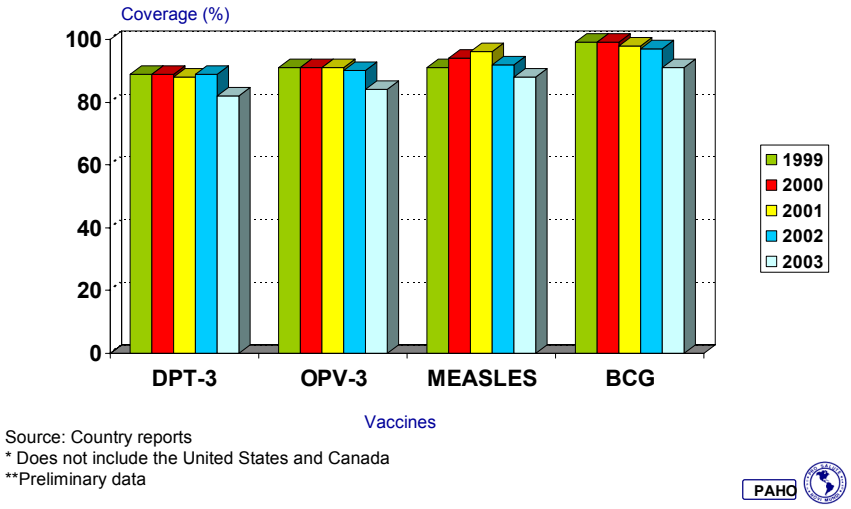
Given the Expanded Program on Immunization's high degree of coverage, approximately 85-90% of children under 1 year of age have access to vaccination in the Americas (Figure 1). However, universal vaccination coverage has yet to be achieved. One of the best indicators of access is coverage with DPT3, which in 2002 was 89%. Comparing this figure with the percentage of municipalities with vaccination coverage of over 95% (Figure 2), it can be seen that only 55% of municipalities in the Region can boast that figure, meaning that a high proportion have yet to reach optimal coverage levels.

The question is, where is the population that is not being vaccinated or is not receiving the full immunization schedule located? The PAHO study on exclusion in health in Latin America and the Caribbean[2] shows that exclusion in health is highly correlated with poverty, marginality, racial discrimination, and cultural patterns, including language, geographic isolation (especially residence in rural areas), lack of

[2] Exclusión en Salud en países de América Latina y el Caribe. Serie No. 1 Extensión de la Protección Social en Salud, 2003. OPS/OMS (English translation soon to be available)

basic services, and low levels of education or information among users of the health services. Lack of equity in access to health services and their use is the primary cause of the unjust inequalities in health outcomes. Inequity, understood as the existence of unjust avoidable differences in access to goods, services, and opportunities, generates exclusion in health.

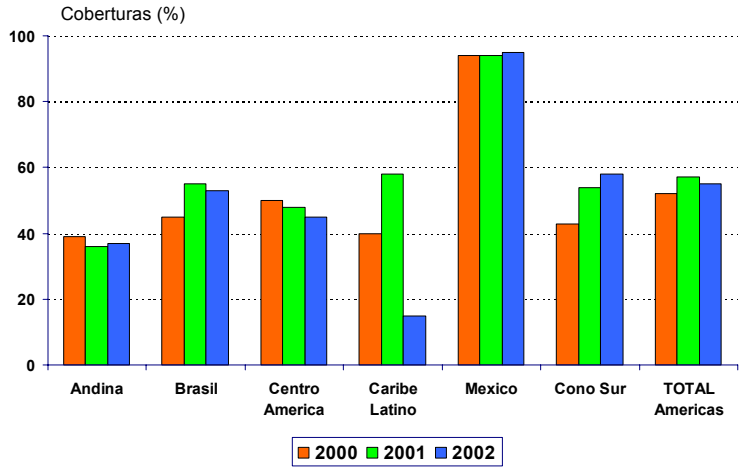
Figure 1. Vaccination coverage for children <1 year
Region of the Americas*, 1999-2003**



Source: Country reports
* Does not include the United States and Canada
**Preliminary data

PAHO

Figure 2. Percentage of municipalities with DPT3 immunization coverage >95% in the Latin American Region. 2000-2002



Immunization

With the present strategy, the EPI of the Region of the Americas seeks to reach traditionally excluded populations such as urban slum dwellers, indigenous groups, ethnic

minorities, residents of rural, hard-to-reach or border areas, and other groups at risk, with the object of reducing inequities in access to vaccination and decreasing the risk of transmitting vaccine-preventable diseases.

2 b. Principles

Equity, access, and Pan-Americanism are the underlying principles of the Vaccination Week in the Americas.

2 c. Purpose

- Promote equity and improve access to vaccination;
- Protect groups at risk of epidemics;
- Promote communication and cooperation among countries;
- Promote Pan-Americanism;
- Keep EPI a high political priority in the Region.

2 d. Goals

- Vaccinate children <5 and WCBAs who have never before been reached by the program (0 doses);
- Reach the <5 population and WCBAs with incomplete immunization schedule;
- Develop micro plans for completing vaccination series after the VWA;
- Maintain measles elimination in the Region;
- Support the implementation of plans for the elimination of rubella and CRS;
- Improve epidemiological surveillance.

3. Vaccination Scenarios during the VWA

Countries who have programmed activities for 2004 such as measles follow-up campaigns, additional doses of polio vaccine, accelerated rubella and CRS control, and vaccination of the elderly, are invited to commence or finish them during the week of 24-30 April.

Recommendations for the rest of the countries of the Region are to intensify vaccination activities targeting all children under 5 and WCBAs, ideally countrywide; if this is not possible, prioritize the following at-risk areas and groups:

- Municipalities with low coverage;
- Marginal urban areas, especially those with periurban slums;
- Border areas with high levels of population exchange or other risk factors;
- Indigenous groups;

- Ethnic minorities;
- Remote areas;
- Tourist areas;
- Workers (health, education, transportation, sex trade).

4. Organization of the Vaccination Week

Each country should form a Steering Committee and an Operations Committee for organizing the VWA at the national, regional, and local levels.

The Steering Committee should be headed by the Minister of Health and should include among its members the Ministers of Education and the Treasury, as well as other high-level country authorities. It should also be spearheaded by the First Lady of the Nation and representatives of international cooperation agencies. Interagency Coordinating Committees play a key role in providing technical and financial assistance for the Vaccination Week.

The Operations committee, headed by the EPI Administrator, should enlist the participation of all technical agencies of the various institutions and sectors in the country to obtain support and the human, physical, logistical, and financial resources necessary for this activity.

The technical teams of the ministries of health are responsible for planning, implementing, supervising, and evaluating vaccination and epidemiological surveillance activities, in addition to designing national and local mass media campaigns. Authorities at all levels and the community at large should participate.

During the programming of the Vaccination Week it is essential to secure financial backing to guarantee the availability of biologicals, syringes, and other supplies to meet the established goals.

5. Transborder Coordination

One of the most important outcomes of the first Vaccination Week was the active participation of border areas in the implementation or reactivation of transborder agreements and their joint commitment to the permanent integration of vaccination activities with other health activities, in keeping with the epidemiological profile on the border.

The Plan for the Vaccination Week will consider developing joint local plans in border areas, which will involve:

- The definition of joint activities and roles;
- Information dissemination and communication;

- The drafting of a budget of needs and potential sources of financing;
- Epidemiological surveillance, active case-finding;
- Analysis units;
- Cross rapid coverage monitoring;
- Diplomatic activities, launchings, official ceremonies;
- Performance evaluation.

6. Role of PAHO/WHO

PAHO/WHO's role is to provide assistance to the countries for the Vaccination Week in the Americas each year, as requested in Resolution 132.R7 of the 132nd Executive Committee (2003), which is comprised of the Ministers of Health of the Region. The activities include:

- Regional interagency coordination: UNICEF, USAID, CIDA-Canada, CDC, International Red Cross, Rotary Club International, World Bank, IDB, NGOs, etc.

- Regional public awareness campaign to complement the country campaigns, through TV, radio, the press, posters, and videos.

- Technical assistance to the countries through the regional team and the Representative Offices in the countries.

- Technical assistance for planning, mobilizing resources, and evaluating activities.

- Participation in coordination meetings and support for border activities.

- Technical support for evaluating the dissemination of information to the local level.

7. Interagency Coordinating Committee

The Interagency Coordinating Committee at the regional level and in each country has a key role to play in meeting the objectives of the VWA, providing political and technical support.

The ministries of health called the ICC together to determine the contribution of the different cooperation agencies in the countries. For the Vaccination Week, it is recommended that at least two ICC meetings be held to present the Plan of Action and obtain resources.

8. Proposed Indicators

Operational Indicators:

Children <5 and WCBAs who had not been reached by the program (0 doses) and were identified and vaccinated during the VWA:

1. Percentage of children <1, 1, 2-4, and <5 vaccinated who had had 0 dose prior to VWA/Number of children from these groups programmed for the Vaccination Week.

   Number of children with DPT1/Children programmed or found during rapid coverage monitoring (RCM)

   Anticipated value: <5%

2. Percentage of vaccinated women who had had 0 dose of Td prior to VWA/Number of women estimated for Vaccination Week (Td).

   Number of WCBAs with Td1/WCBAs programmed (estimated or by RCM)

   Anticipated value: <5%

3. Percentage of children behind in their vaccinations who were brought up to date (continued or finished) during the VWA (OPV or DPT)

   Number of DPT2 and DPT3/ Total children vaccinated during the VWA

   Anticipated value: <5%

4. Percentage of supervision with at least one rapid coverage monitoring (RCM)

   Number of supervision activities with RCM/Supervision activities programmed.

   Anticipated value: 100%

5. Percentage of RCM that found MR vaccination coverage of <95%.

   Anticipated value: 0

6. Percentage of mothers interviewed in the selected areas who knew about the VWA

   Number of mothers who knew about the VWA/Total mothers interviewed.

   Anticipated value: <80%

7. Percentage of municipalities with monitoring plan to complete immunization schedule after the VWA

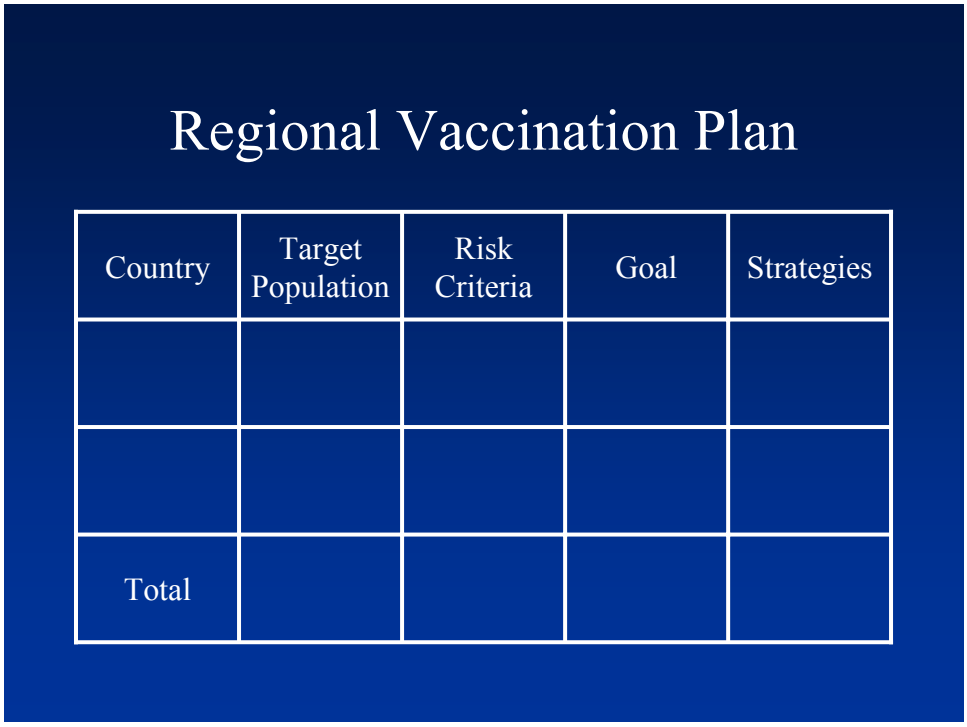
Number of municipalities with a plan/ Total municipalities or areas that participated in the VWA

Surveillance Indicators:

Number and proportion of suspected measles/rubella and AFP cases that were identified during active community case-finding and were known to the system.

9. Activities

During planning for the Vaccination Week, each country should identify the populations to be vaccinated, indicating the risk criteria used in their selection. The target population, goal, and vaccination strategies to be implemented by the country should be specified.



Once the target population has been identified, the next step is to program the biologicals and other supplies that will be needed, as well as all other necessary components, such as cold chain, training, human resources, operating costs, supervision, monitoring, mass communication, and evaluation.

Regional Vaccination Plan

C'try	Biologicals & supplies	Cold chain	Training	Operatio-nal costs	Supervisión & monitoring	Epidemio-logical surveillance	Social Communi-cation	Evaluation
Total								

Coverage monitoring and active case-finding:

For coverage monitoring, the Program's existing forms will be used, adapting them to the specific characteristics of the Vaccination Week in each country.

Rapid coverage monitoring (persons eligible for vaccination during the VWA), see Annex 1a, 1b, and 1c.

During house-to-house vaccination, an active search in the community will be conducted for suspected measles/rubella cases to evaluate the quality of the system for reporting suspected cases through the proportion of cases known to the system. (See Annex 2).

A community survey will be used to determine how much information the population has about the Vaccination Week. (See Annex 3)

10. Evaluation of the Vaccination Week

The VWA will be evaluated in terms of the achievement of goal established by the countries and through selected indicators, including the administration of the survey on the degree of local knowledge about the VWA.

The impact of the VWA will be assessed through an operations research study, with the participation of CDC, in marginal areas of large cities in three countries of the

Region, each of them representative of a subregion (Southern Cone, Andean Area, and Central America).

11. References

Sucre Agreement on the Interruption of Indigenous Transmission of the Measles Virus in the Andean Countries, 23 Abril 2002.

Declaration of the II Meeting of Ministers of Health of South America, Lima, 30 November 2002.

PAHO-ORAS Work Agreement, 29 November 2002

Report of the Technical Advisory Group on Vaccine-Preventable Diseases. Washington, D.C., 23 November 2002.

Resolution 132.R7 of PAHO's 132nd Executive Committee, 2003

Statements of MERCOSUR, Andean Health Agency, and RESSCAD

Annexes

Annex 1

RAPID COVERAGE MONITORING (RCM) DURING THE VACCINATION WEEK IN THE AMERICAS

Monitoring will be conducted when the district, municipality, parish, or health facility indicates that it has finished vaccinating all the target population in its jurisdiction or area of influence to confirm that all children have been vaccinated. The areas for monitoring will be selected on the basis of criteria established for previous similar activities.

RCM will be used for the M/MMR vaccine and/or the third dose of DPT or the Pentavalent vaccine in children who should have been vaccinated with DPT3 and M/MMR, according to their age. See instruments.

The results obtained by the health facilities, towns, communities, parishes, municipalities, and districts will be consolidated, employing each country's unit of analysis to allow comparison with the administrative coverage. It is suggested that each country adapt the model table attached.

Administrative Coverage and RCM for DPT/Pentavalent and M/MMR by health facilities, municipalities, parishes, towns, or districts. Country, April 2004

Districts/ Municipalities/ Parishes (Unit of Analysis)	Health Facilities/ Communities/ Towns	Administrative Coverage						Rapid Coverage Monitoring					
		Population		Vaccinated		Coverage (%)		Child-ren <1 a.	Vac. DPT3/ Penta 3	Child-ren 1 a.	Vac. MMR	%	
		<1 a.	1 a.	DPT3/ Penta	MMR	DPT3/ Penta	MMR					DPT3/ Penta	MMR
1	To												
	S												
	G												
Total District/Municipality/Parish 1													
2	T												
	Or												
	R												
	Z												
Total District/Municipality/Parish 2													

Annex 1a

RCM OF VACCINATION WITH DPT/PENTAVALENT VACCINE (in children 6 months & 6-11 months)

Department/Province/Region:_____ **District/Municipality/Parish:**_____
Health facility: _____ **Date of Monitoring:** _____
Supervisor: _____ **Individual in charge of monitoring:** _____

In the area of influence of a district, municipality, parish, or health facility, a minimum of four sectors should be selected by the individual in charge of the monitoring, on the belief they are less likely to have been visited by the vaccinators (remote, far from the main streets, high % of uninhabited houses, doubts about the quality of the vaccination, etc.).

Visit the 25 **relevant houses** moving in a single direction—clockwise, for example (If there are more than 25 relevant houses, visit the first 25, and if there are fewer, continue down the next block until 25 have been surveyed).

Selection criteria - Relevant houses are houses with children aged 6-11 months, 29 days and competent informants.

House No.	(A) Number of resident children aged 6-11 months and 29 days	(B) Number of children aged 6-11 months and 29 days vaccinated with DPT3/Penta (*)	(E) Reason given by the mother/father for not vaccinating the child(ren): (1) No vaccinators came; (2) Vaccinators came when they were out and did not return; (3) Parents refused vaccination because the child was sick;(4) Parents refused vaccination on the advice of their pediatrician or other physician; (5) Parents refused vaccination on religious grounds; (6) Vaccinators refused to vaccinate the child; (7) It was not vaccination day; (8) Vaccines ran out; (9) Other
1			
2			
3			
4			
5			
…			
23			
24			
25			
Total			

(*) Note here after viewing the vaccination card. A child is considered unvaccinated if he is at the age at which he should receive the appropriate dose and it was not administered to him during the event.

Coverage achieved on the blocks:

$$\frac{\text{(A) Total children aged 6-11 months and 29 days vaccinated with DPT3/Penta} \times 100}{\text{(B) Total children aged 6-11 months and 29 days found}}$$

Annex 1b

RCM OF VACCINATION WITH MEASLES OR MMR VACCINE

Department/Province/Region:_____ **District/Municipality/Parish:**_____
Health facility: _____ **Date of Monitoring:** _____
Supervisor: _____ **Individual in charge of monitoring:** _____

In the area of influence of a district, municipality, parish, or health facility, at least four sectors should be selected that the individual in charge of monitoring believes are less likely to have been visited by the vaccinators (remote, far from the main streets, high % of uninhabited houses, doubts about the quality of the vaccination, etc.).

Visit 25 relevant houses, moving in a single direction—clockwise, for example (if there are more than 25 relevant houses, visit the first 25, and if there are fewer, continue down the next block until 25 have been surveyed).

Selection criteria - Relevant houses are houses with children aged 12-23 months, 29 days with competent informants.

House No.	(C) Number of resident children aged 12-23 months and 29 days	(D) Number of children aged 12-23 months and 29 days vaccinated with M/MMR (*)	(E) Reason given by the mother/father for not vaccinating the child(ren): (1) No vaccinators came; (2) Vaccinators came when they were out and did not return; (3) Parents refused vaccination because the child was sick;(4) Parents refused vaccination on the advice of their pediatrician or other physician; (5) Parents refused vaccination on religious grounds; (6) Vaccinators refused to vaccinate the child; (7) It was not vaccination day; (8) Vaccines ran out; (9) Other
1			
2			
3			
4			
5			
…			
21			
22			
23			
24			
25			
Total			

(*) Note here, after viewing the vaccination card, that a child is considered unvaccinated if he is at the age at which he should receive the corresponding dose and it was not administered to him during the event.

Coverage achieved on the blocks:

$$\frac{\text{(A) Total children aged 12-23 months and 29 days vaccinated with M/MMR} \times 100}{\text{(B) Total children aged 12-23 months and 29 days found}}$$

Annex 1c

RCM OF VACCINATION WITH DPT/PENTAVALENT VACCINE[3]
(in children <1 year)

Department/Province/Region:_____ **District/Municipality/Parish:**_____
Health facility: _____ **Date of Monitoring:** _____
Supervisor: _____ **Individual in charge of monitoring:** _____

In the area of influence of a district, municipality, parish, or health facility, at least four sectors should be selected that the individual in charge of monitoring believes are less likely to have been visited by the vaccinators (remote, far from the main streets, high % of uninhabited houses, doubts about the quality of the vaccination, etc.).

Visit 25 relevant houses, moving in a single direction—clockwise, for example (if there are more than 25 relevant houses, visit the first 25, and if there are fewer, continue down the next block until 25 have been surveyed).

Selection criteria - Relevant houses are houses with children aged 6-11 months, 29 days with competent informants.

House No.	(A) Number of resident children aged 2–11 months and 29 days	Number of children aged 2–11 months and 29 days vaccinated in a timely manner in keeping with their age with DPT/Pentavalent (*)			(E) Reason given by the mother/father for not vaccinating the child(ren): (1) No vaccinators came; (2) Vaccinators came when they were out and did not return; (3) Parents refused vaccination because the child was sick;(4) Parents refused vaccination on the advice of their pediatrician or other physician; (5) Parents refused vaccination on religious grounds; (6) Vaccinators refused to vaccinate the child; (7) It was not vaccination day; (8) Vaccines ran out; (9) Other
		DPT			
		I (B)	II (C)	III (D)	
1					
2					
…					
25					
Total					

(*) Note here after viewing the vaccination card. A child is considered unvaccinated if he is at the age at which he should receive the appropriate dose and it was not administered to him during the event.

Coverage obtained with RCM:

$$\frac{\text{(D) Total children aged 6-11 months and 29 days vaccinated with DPT3/Penta X 100}}{\text{(B) Total children aged 6-11 months and 29 days found}}$$ ☐

Timeliness of vaccination:

$$\frac{\text{(B + C + D) Total children aged 2 to 11 months and 29 days vaccinated with DPT I, II, and III X 100}}{\text{(A) Total children aged 6-11 months and 29 days found}}$$ ☐

Projected Coverage:

$$\frac{\text{(B + C + D) Total children aged 2-11 months and 29 days vaccinated with DPT I, II, and III X 100}}{\text{Total population under 1 year}}$$ ☐

[3] The results of this monitoring are not applicable to other sectors or to the total area of influence of the health facility/town/community/ parish/municipality/district. However, they yield information that is very useful for evaluating vaccination efforts. If all children visited have been vaccinated, this would suggest that the vaccination has been carried out properly or that there is adequate capture and monitoring. But if the results are lower than 95%, a mop-up or repeat campaign should be conducted in this sector.

Annex 2

ACTIVE SEARCH IN COMMUNITY
SUSPECTED MEASLES/RUBELLA CASES

Country _____
Department/Province/Region _____
District/Municipality/Parish _____ Town _____

No.	Full name	Residence	Date of symptom onset	Date of rash onset	In the system		Date of sample collection	Remarks
					Yes	No		
Total								

Annex 3

INTERVIEW GUIDE TO EVALUATE KNOWLEDGE ABOUT THE VWA

Instructions for the interviewer: *Interview at least 10 mothers with children under 5, who are outside a health facility (in a plaza, a market, a bus stop, etc); avoid choosing conglomerates. It is suggested to interview one out of every 3 or 5 mothers found in each place.*

Ask the following questions and, according to the responses, mark as appropriate:

1. Do you live with children under 5?

   Yes ☐ No ☐

   If the answer is No, stop the interview and exclude it from the analysis.

2. Have you recently heard anything about a special vaccination activity in your community?

   Yes ☐ No ☐

   If the answer is No, stop the interview. If the answer is positive, continue.

3. Can you tell us what type of vaccination activity you have heard about?

   Campaign or Vaccination Campaign ☐ Vaccination Week ☐

   Other ☐ Which one?_____

4. How did you hear about this activity? Mark all answers mentioned.

   a. Radio ☐ d. Health facility ☐
   b. Television ☐ e. Press ☐
   c. Loudspeaker ☐ f. Schools ☐
   g. Other ☐ Specify _____

5. Upon learning about the Vaccination activity, did you:

Review your child's vaccination card? ☐

Take your child for vaccination? ☐

Other ☐ What? _____