

Global landscape analysis and literature review of 2nd Year of Life immunization platform

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Outline

- Background
- Methods
- Results
- Conclusions / recommendations

Background

To gather evidence on current practices, barriers, lessons learned, impact and opportunities to be used as background and rationale for developing global guidance for national program use, when establishing the 2YL healthy child visit.

Scope of work

- Systematic review of published peer reviewed and grey literature, including measles 2nd dose post introduction evaluations (PIEs).
- Analysis of immunization Joint Reporting Form (JRF) data
- Analysis of Demographic and Health Surveys (DHS)
- Online survey - MoH, WHO, UNICEF country office.

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Summary of literature review - exclusion process

Citations found through computer database searches of PubMed, CINAHL, EMBASE and Google Scholar (n= 2,652)

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Citations found through other means (hand reference search, web search, etc.) (n= 463)

Total citations after all searches (n=3,115)

Duplicates removed (n=1,906)

Citations after duplicates removed (n=1,209)

Citations excluded based on relevancy (n=1,052)

Full-text articles assessed for inclusion (n=157)

Relevant Articles (n=72)

Search terms

first (1st) 1000 days of life	interventions
second (2 nd) year of life	health services
children	policy
immunization	expanding
vaccination	expanding coverage
age	increasing coverage
15 month old well-baby	missed
visit	opportunities
18 month old well-baby	timeliness

Articles included from January 2000
to December 2015

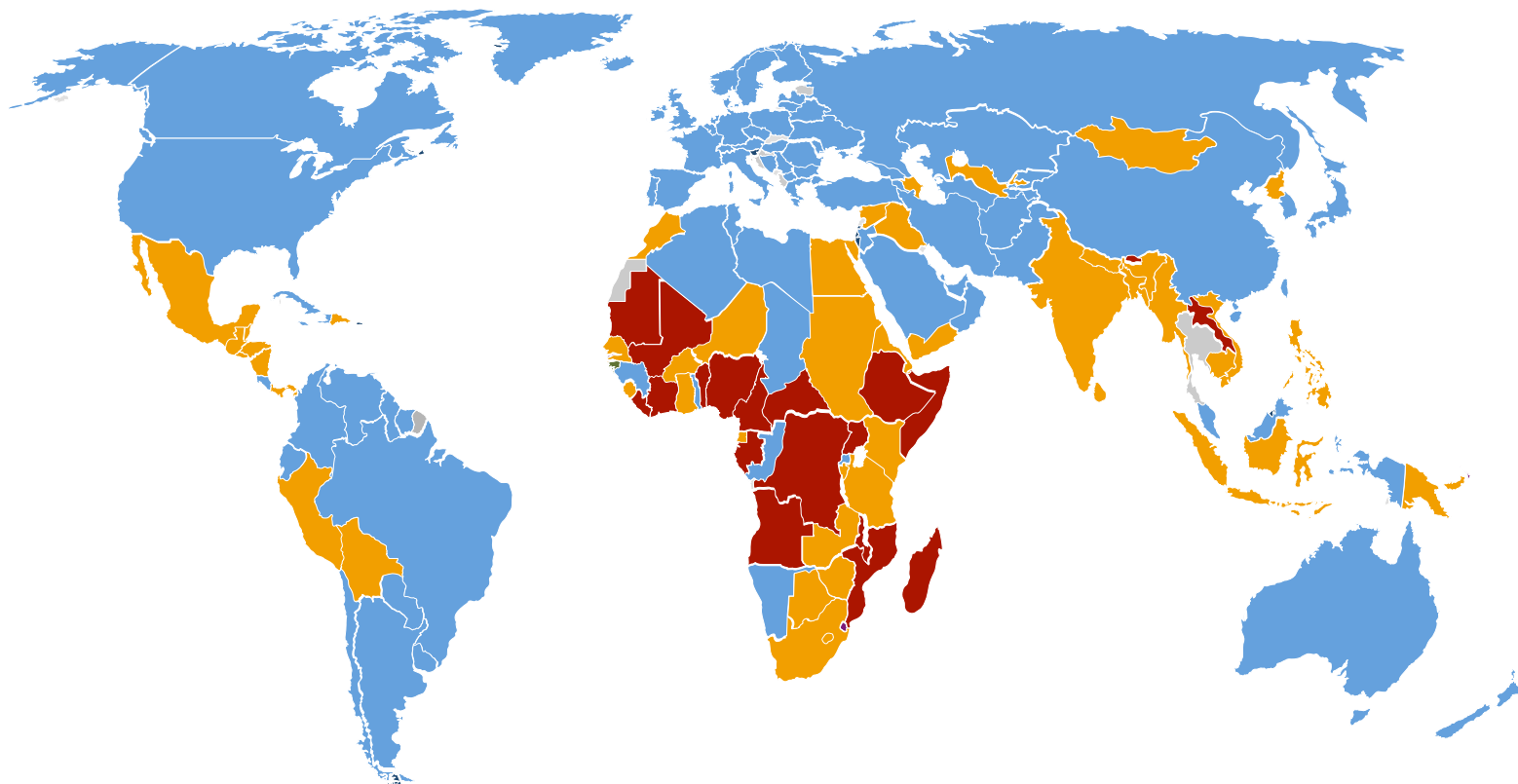
Methods (2)

- **Joint Reporting Forms:** data analyzed for reported schedules, coverage,
- **Demographic Health Surveys (DHS)**
 - From 2010 onwards
 - Children aged 12 – 23 months with immunization cards, date of births and dates of vaccination
 - 43 countries analyzed
- **Online monkey survey**
 - Non-anonymous survey - 135 countries in English and French
 - Sep – Dec 2015, survey was open for three weeks
 - Written national policies or guidelines
 - What is in practice – whether policies exists or not
 - Possible bottlenecks and resources required

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Policies: 191 Countries have services for children in their 2YL (both vaccination and Vitamin A)



Immunization Policies only (164)

Immunization & Vitamin A Policies (55)

Vitamin A Policies Only (27)

No policies (6) or No Information

Source: Literature search, JRF, online survey, MoHs websites

2YL antigens

Current antigens delivered

- Booster doses e.g. DTP4, PCV, Hib
- Measles second dose
- MenAfriVac® in the meningitis belt (9-18 months)

Potential future antigens

- Multiple vaccines under development e.g. malaria (RTS,S), dengue

Number of countries recommending immunizations and Vit-A in 2YL

WHO region (No. of countries)	No. of member states providing				
	Measles containing vaccine	DPT- containing vaccine	Polio	PCV	Vit A
Total (worldwide 194)	147	125	110	75	82
African (47)	24	19	15	7	41
Americas (35)	27	33	31	19	10
Eastern Mediterranean (21)	18	18	19	12	9
European (53)	50	40	38	28	2
South-East Asia (11)	6	3	2	1	10
Western Pacific (27)	22	12	5	8	10

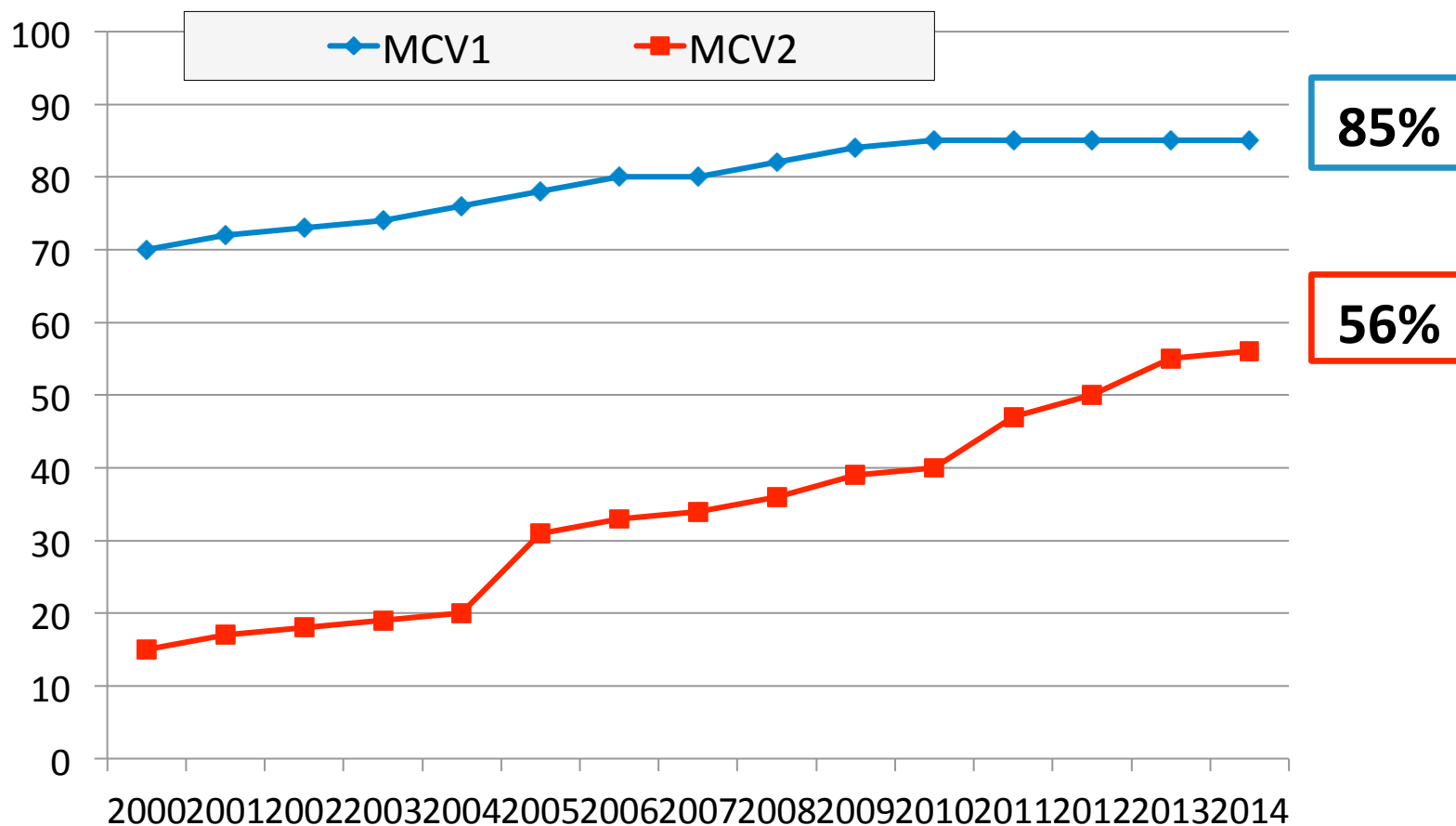
Source: WHO/IVB Database as of Dec 2014,

Date of slide: 18 February 2016

*2YL: 12-23 months

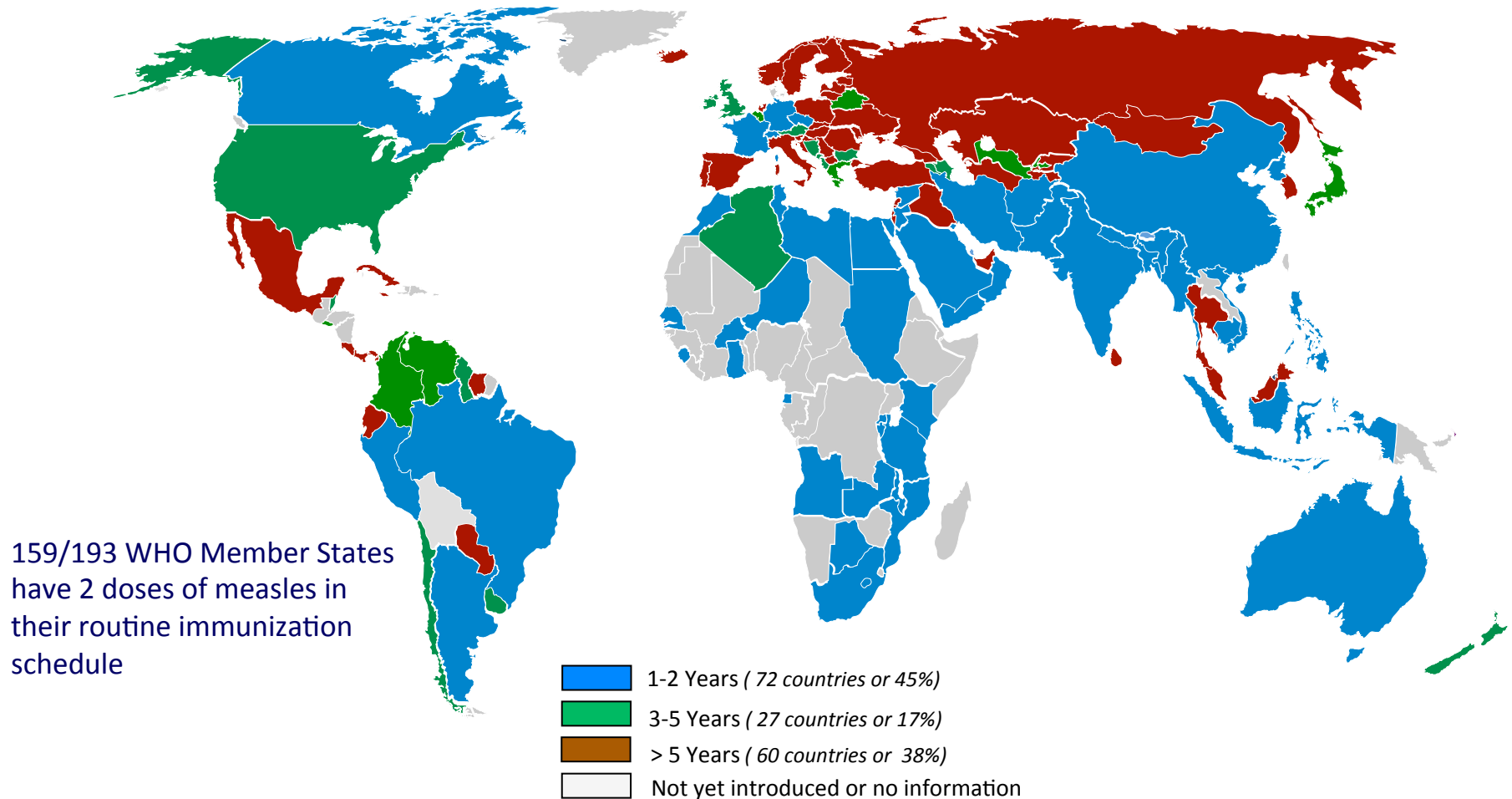
Significant gaps in routine coverage

Global immunization coverage with MCV1 and MCV2, 2000-2014

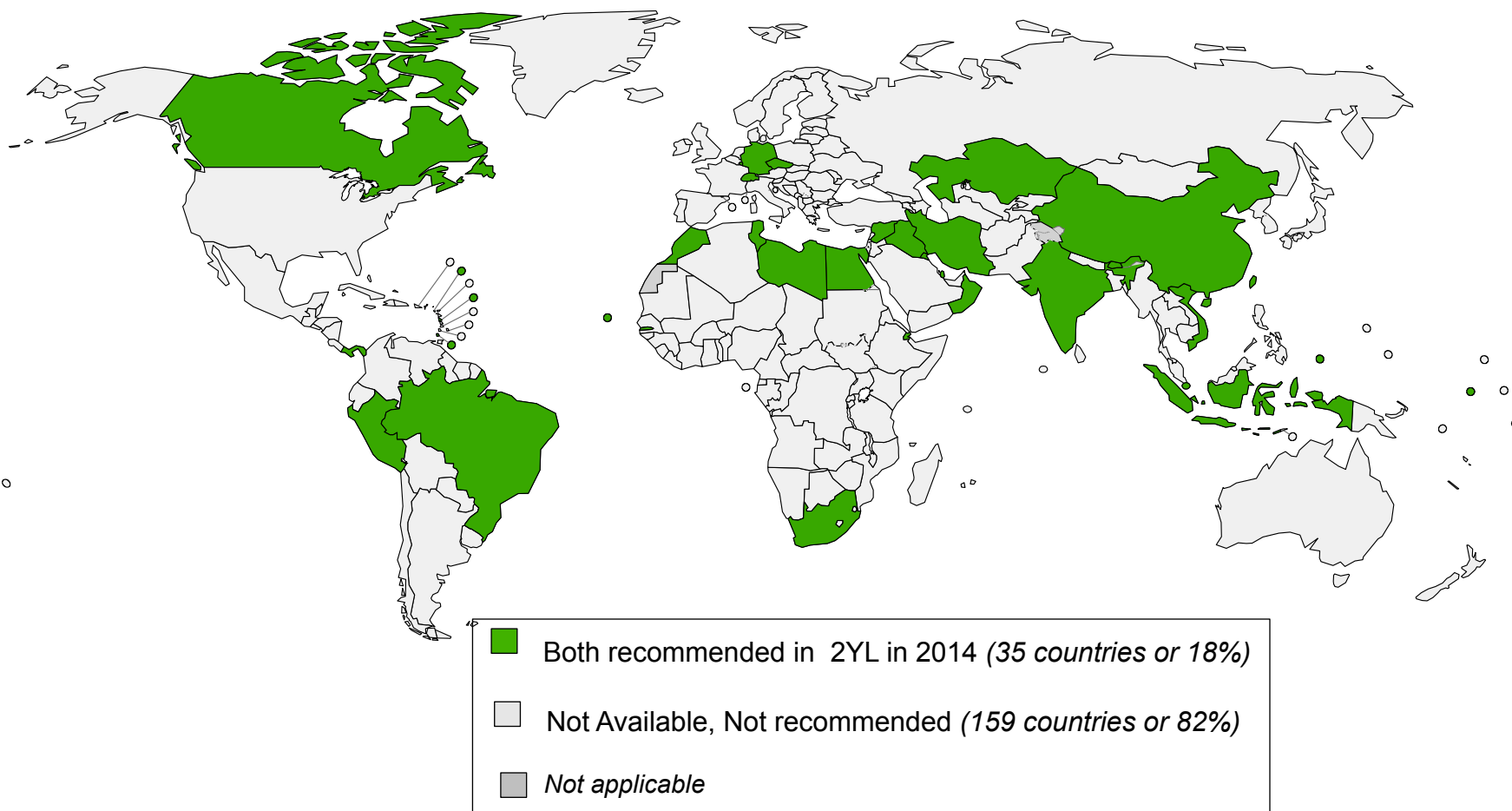


Age of administration measles 2nd dose, 2015

Measles 2nd dose doesn't mean vaccination in 2YL



35 countries recommending both DTPCV4 and MCV2 during 2YL, 2014



Unvaccinated children: WHO measles position paper and practice

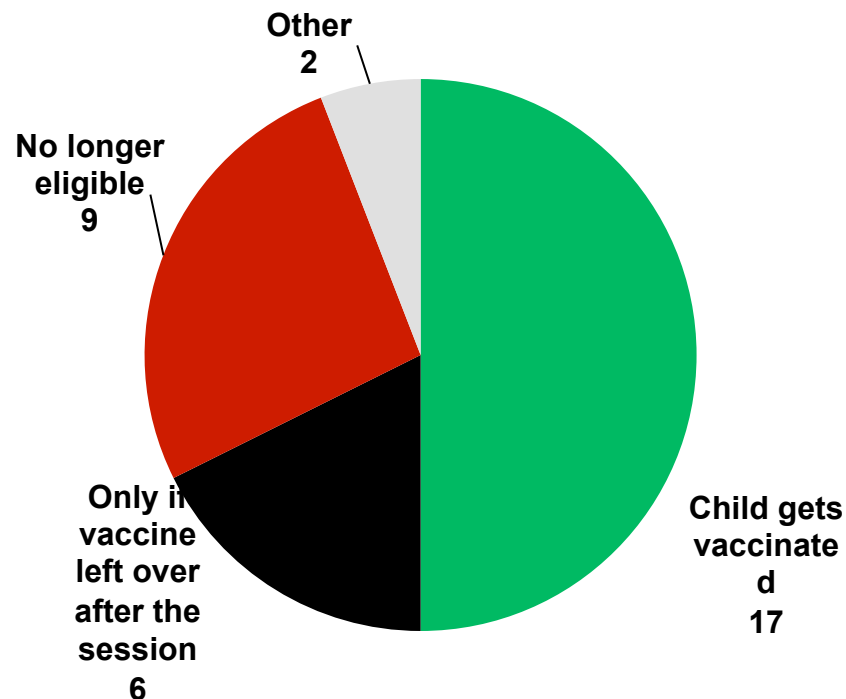
Optimal age for MCV1

In countries with ongoing transmission in which the risk of measles mortality among infants remains high, MCV1 should be administered at age 9 months. In these settings, on-time delivery of MCV1 is important to ensure optimal protection during the susceptible period in infancy. Because many cases of measles occur in children aged >12 months who have not been vaccinated, routine delivery of MCV1 should not be limited to infants aged 9–12 months. All unvaccinated children aged ≥12 months should be offered MCV1 using every possible opportunity when the child comes into contact with children's health services.

Optimal timing of routine delivery of MCV2

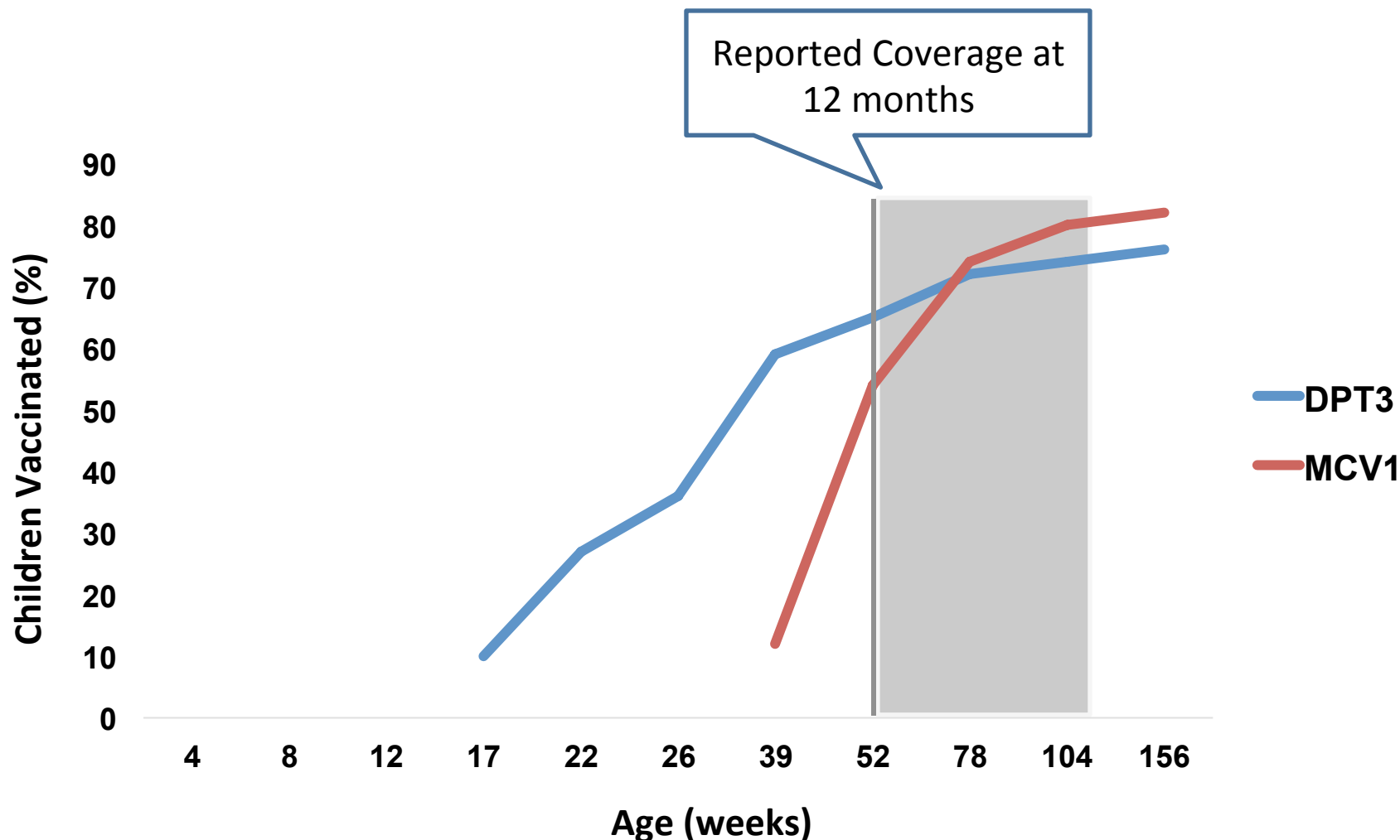
Countries with ongoing measles transmission and MCV1 delivered at age 9 months, should administer the routine dose of MCV2 at age 15–18 months. The minimum interval between MCV1 and MCV2 is 1 month. Providing routine MCV2 to children in their second year of life reduces the rate of accumulation of susceptible children and the risk of an outbreak.

MCV1 at 13 months eligibility & practice (survey in 34 countries)

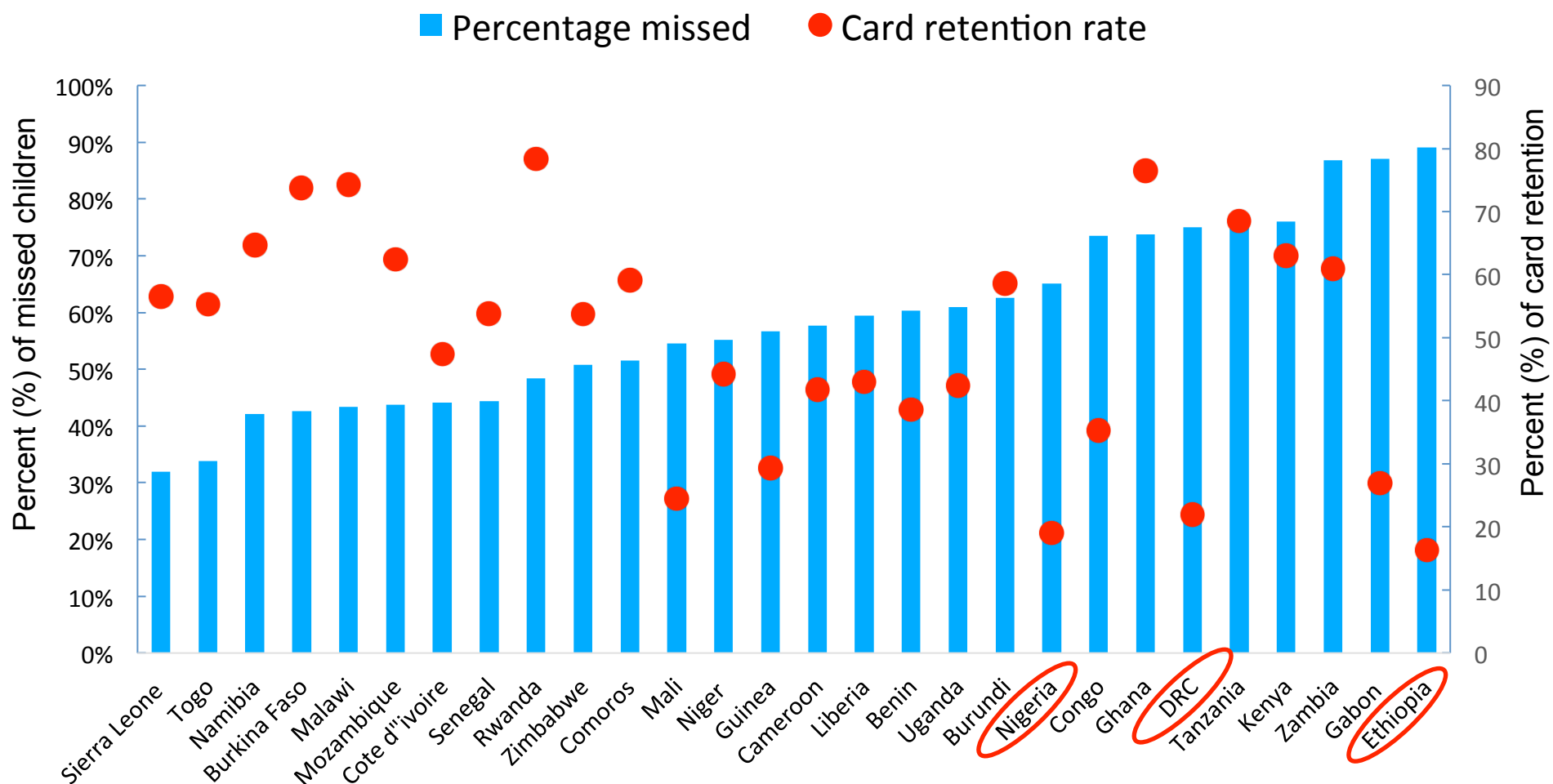


Source: Maya, et.al.; 2012 Survey

Catching-up: coverage rates across 45 low and middle income countries at different ages – DHS data

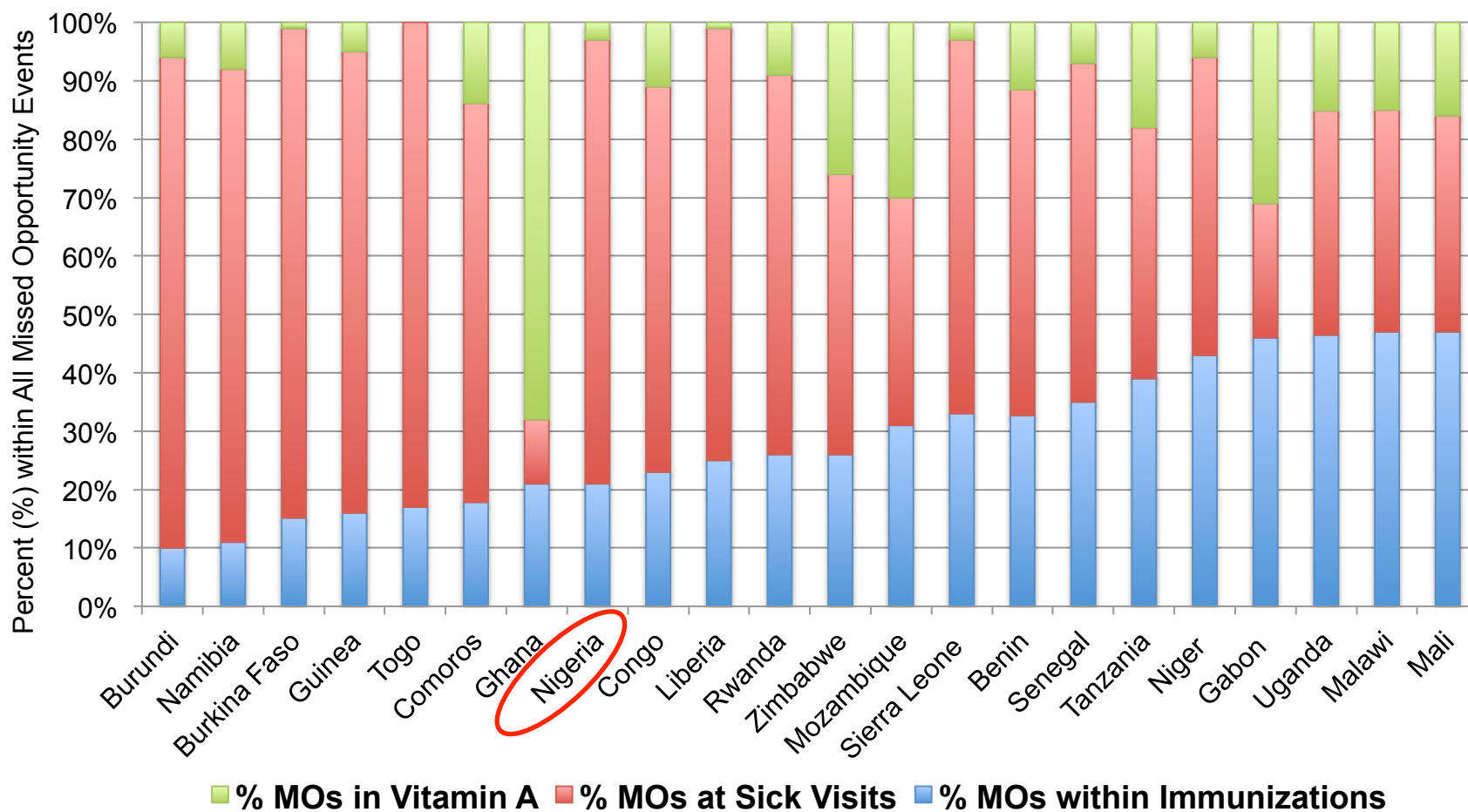


Percentage of non-FIC among 12-23 months of age, and card retention rate – African region



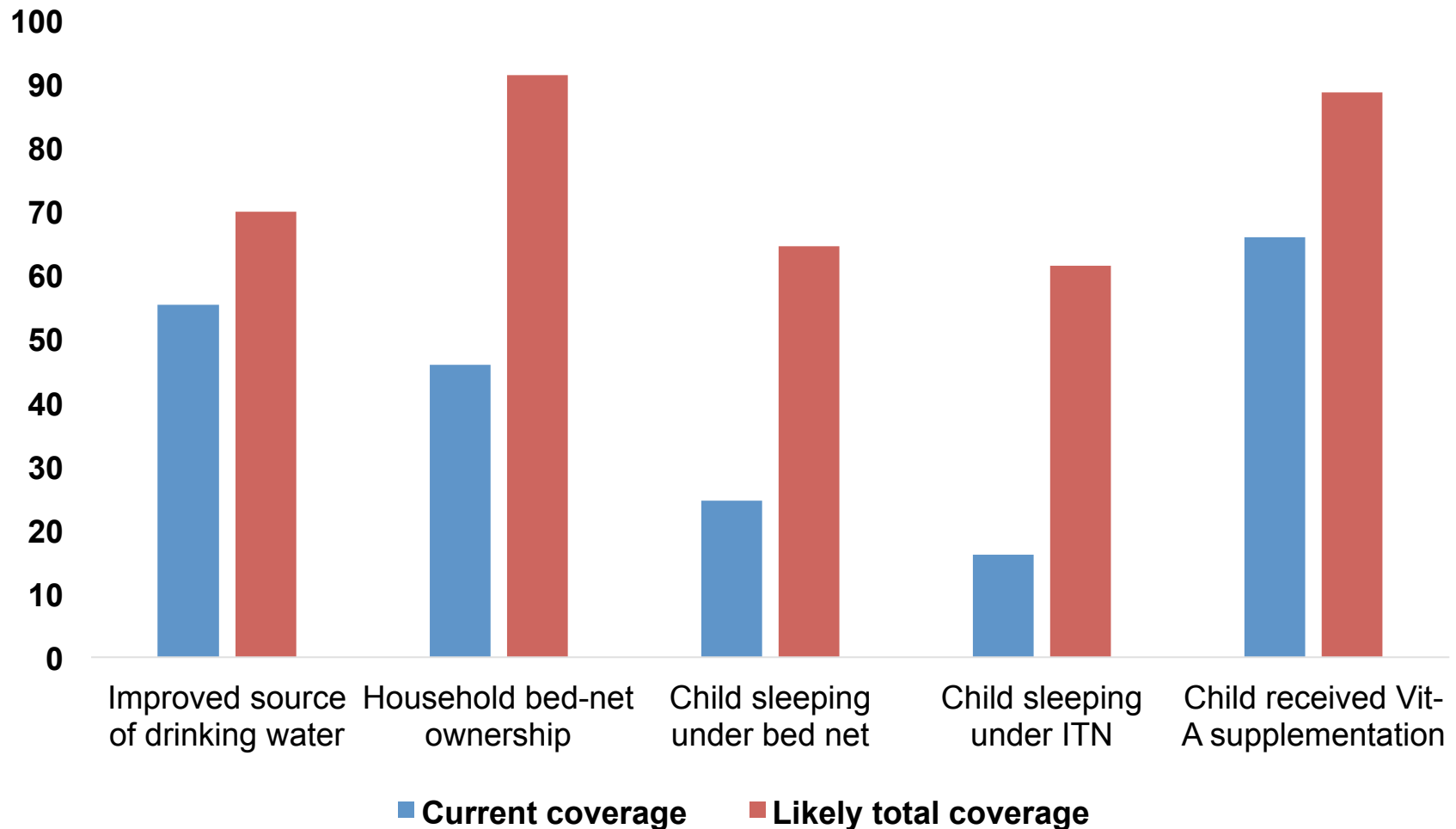
Source: DHS (2010 – 2015) data, children with card

Missed opportunities: non-FIC attending healthcare facilities during 2YL but not being vaccinated



Source: DHS data, children with card

Estimated interventions coverage among households with a child aged 12-23 months if integrated with routine immunization - 28 sub-Saharan African countries



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Conclusions

- Many countries have introduced a 2YL visit, however...
 - There is a large vaccination drop-out to doses given in the first year of life;
 - Opportunities of catching-up missed doses are a major cause of lower 2YL coverage;
 - Frequently vaccines are given at different times during the 2YL, not together;
 - Frequently other health interventions in the 2YL are poorly integrated with the vaccination visit
- MCV2 is frequently closely associated with the 2YL discussion; however, many countries, especially in the Americas and Europe give MCV2 to older children.

Recommendations

- Address the disconnect between existing policies and practice for missed doses during 2YL
- Identify strategies and opportunities
 - To create synergies between current and new antigens
 - For integration with other child health interventions to increase coverage and equity
- Further explore effective delivery platforms e.g. well baby visits – through future studies

Thank you

