

To SAGE Secretariat, WHO

Dear Professor Helen Rees, Dear Dr. Jean Marie Okwo-Bele,

On behalf of the Civil Society Constituency of the GAVI Alliance, we would like to thank SAGE and its members for the guidance and leadership provided throughout the Global Vaccine Action Plan process to date. Your high-level stewardship has been a key element in ensuring the technical quality of the GVAP.

Generally, throughout the indicator development process, we feel that there has been a lack of transparency regarding how and by whom these indicators were developed. However, we appreciate the consultative and responsive approach to indicator review.

As you review the M+E framework for the GVAP, we would like to draw your attention to the following requests for re-consideration of proposed indicators for various Strategic Objectives:

- 1) **SO1:** We would like to suggest that the indicator used to measure “vaccine hesitancy” be DTP 1 to measles first dose dropout.
- 2) **SO3:** We would like to request that indicator 3.1 (reduction in coverage gaps between lowest and highest wealth quintile) be expanded to other characteristics of inequity as determined by the country context, such as disaggregating by sex, mother’s education level, urban/rural, etc.

We would also like to request in 3.1 that an additional temporal coverage indicator be added to measure the number of countries by region that have sustained DTP3 coverage >80% for each of the previous 3 years.

- 3) **SO4:** (Strong immunisation systems are an integral part of a well-functioning health system) We are concerned that we will fail to measure this Strategic Objective given the current indicators proposed. Currently, SO4 combines three different ideas that need to be measured: strength of the immunisation system, strength of the health system, and the integration/coordination of the two. The current proposed indicators (DTP1 to measles first dose dropout rate; immunization coverage data assessed as high quality by WHO and UNICEF) would measure only the strength of the immunisation system and data quality within that system. In effect, we would fail to measure 2/3 of the stated SO.

We would like to request that SAGE include an appropriate indicator to measure the strength of the health system and a separate indicator to measure the degree to which the immunisation system and health system are integrated/coordinated.

We would also like to propose an indicator replacement for SO4. Instead of measuring DTP1 to measles first-dose dropout rate (which we propose be used to measure vaccine hesitancy), we would like to see this indicator changed to measure DTP1 to DTP3 dropout rates. Please see Annex 1 at the end of this letter for supporting information.

- 4) **SO5:** In SO5.1, we would like to request that an indicator be added to track reduction in vaccine prices. We suggest that the indicator used to track GAVI Strategic Goal 4 (the market shaping goal) could be used in this instance: Change in the total cost of vaccines to fully immunise a child with pentavalent, pneumococcal and rotavirus vaccines.

We would also like to use this occasion to raise the issue of accountability of non-state actors to the GVAP (including industry, international organisations, donors and funding mechanisms [including GAVI] and civil society). How will each of these groups agree to a set of commitments and how will their performance against these commitments be measured and reported?

We would like to conclude with two process requests going forward. We kindly request that a civil society representative be included in both the M+A working group and on the GVAP annual accountability report editorial committee, and that these representatives be nominated through a consultative process led by the GAVI CSO Constituency. We would also like to request that annual GVAP reports include an analysis of pricing in relation to vaccination.

Thank you for your time, consideration and continued stewardship.

With our thanks,

GAVI CSO Constituency

GAVI CSO Steering Committee, including specific institutional support from:

Médecins Sans Frontières (MSF)

Save the Children UK

Catholic Relief Services

John Snow Incorporated/MCHIP

ACTION

This letter incorporates feedback from the GAVI Alliance Secretariat

GVAP proposed indicator for monitoring drop-out rates: pros and cons of different options
(prepared by MCHIP 30 September 2012)

A set of indicators has been proposed to monitor the implementation of the Global Vaccine Action Plan (GVAP). The indicators will be discussed at the November 2012 meeting of the WHO Strategic Advisory Group of Experts (SAGE). As an indicator for the GVAP strategic objective, “Strong immunization systems are an integral part of a well-functioning health system,” DTP1 to measles first dose (MCV1) drop-out rate is being considered in the draft M & E plan.

Selecting the most appropriate drop out rate is important, since a focus on drop out at higher levels (global and regional) will continue to validate the importance for national and sub-national levels to actively monitoring their own drop out data to improve their programs. A high drop out rate is generally considered to be a composite indication of multiple failures in the immunization services, reflecting problems in the system, supply, demand, and quality of services.

For over a decade, most countries have been monitoring drop-out rates based on DTP1 to DTP3. The proposal to replace that indicator with DTP1 to MCV1 raises a number of concerns. A comparison of the pros and cons of the two indicators is provided below. A general premise here is that in order to get an estimate of the full magnitude of the problem, underestimating the drop out rate should be avoided.

DTP1 – DTP3 drop out rate (“DTP” refers to vaccine products containing the DTP antigens, for example pentavalent vaccine)

Pros:

1. Measures the ability of the immunization system to reach a child multiple times with the same antigen(s), specifically DTP-containing vaccine.
2. DTP1-DTP3 drop out measures the same delivery system multiple times, thereby giving insight into factors that may hinder caregivers to continue utilizing a delivery system.
3. Drop out between DTP1 and DTP3 is also a better indirect measure of timeliness of coverage during the first year of life than DTP1-measles because many countries currently give MCV1 starting from 12 months. And the number of countries shifting the starting age for MCV1 from 9 to 12 months is expected to increase, as coverage rates at 9 months of age reach high levels.
4. DTP1 and DTP3 are given only through routine immunization and not as supplemental doses. Therefore they describe the routine immunization system.
5. DTP-containing vaccine is a proxy for pentavalent vaccine, which most (but not all) countries use. DTP1-DTP3 drop out rates also provide essential managerial and effectiveness information relevant to pneumococcal conjugate vaccine, which follows the same vaccination schedule as DTP and which an increasing number of countries will be introducing during the GVAP timeframe.
6. The DTP1-DTP3 drop out rate provides information that bridges two broad areas of the GVAP: strengthening routine immunization and introduction of new vaccines.
7. While DTP3 is not the final antigen/dose in the immunization schedule, it has been noted for years that in countries with weaker immunization programs, DTP3 coverage is actually lower than measles coverage. (See Figure 1 and Tables 1 and 2 for data from the African Region.) Thus in countries with weaker systems, the drop out rates for DTP1-DTP3 would, paradoxically, be higher than for DTP1-measles and therefore give a better idea of the magnitude of the drop out rates. More than 60% of surviving infants in AFR live in countries where measles coverage is higher than DTP3 coverage. For AFR and SEAR as a whole,

measles coverage is higher than DTP3 (75% vs. 71% in AFR; 79% vs. 75% in SEAR). For other WHO regions, DTP3 is either slightly higher or the same as measles coverage. Globally measles coverage is higher than DTP3 coverage (84% vs. 83%).

8. DTP1-DTP3 drop-out is one of the key indicators in the GAVI monitoring and evaluation plan. As such, its value has already been debated and accepted by the GAVI Board and is part of country reporting to GAVI.
9. The Reaching Every District (RED) strategy and all countries now use coverage with DTP1 and DTP3, as well as the drop out between them, to guide program strategies.
10. Other than for short periods of time or in small geographic areas if service is disrupted, it is impossible to have a true negative drop-out rate with DTP1-DTP3. A negative drop-out rate can only be due to data quality problems.

Cons:

1. DTP3 is not the final antigen or dose in the official infant vaccination schedule when it is optimally implemented.
2. The measurement points for DTP1 and DTP3 fall relatively close together (2-4 months) when the official vaccination schedule is optimally followed, thereby focusing on obstacles in service delivery and uptake over a shorter period.
3. The DTP1-3 indicator does not give any operational information as to the progress of the measles and rubella initiative.

DTP1-measles first dose (MCV1) drop out rate

Pros:

1. Measles is the final antigen/dose in the infant vaccination schedule of most countries. Therefore in places where measles vaccine is given after DTP3, DTP1-measles drop out describes a longer period of time than DTP1-DTP3 drop out.
2. DTP1-measles is thought by some to be a better measure of overall program effectiveness whereas DTP1-DTP3 is considered by some to be a better measure of delivery effectiveness.
3. Adding an indicator on DTP1-measles introduces a measles-related indicator to GVAP monitoring, thus spanning the GVAP goals pertaining to disease elimination and extending immunization benefits to all. In that the global measles and rubella strategic plan calls for attaining high levels of population immunity through both routine immunization and SIAs, it would be useful to have a measles related indicator in the GVAP monitoring plan.

Cons:

1. It is easier to achieve single dose versus triple dose coverage, i.e., measles vs. DTP3; thus the DTP1-measles drop out rate may be artificially low, obscuring the dip in coverage between successive doses of DTP (and other vaccines such as PCV given at the same time) and thus minimizing the magnitude of the challenge facing the routine immunization program.
2. Because measles is easily recognized and feared by communities, demand for measles vaccine may be higher than for DTP, resulting in a lower drop-out rate for DTP1-measles than DTP1-DTP3 that does not capture the challenges of delivering multiple doses of the same vaccine.
3. DTP1-measles compares apples to oranges, since the service delivery systems may differ for the first dose of DTP and the first dose of measles.
4. Measles vaccine is given both through routine immunization and SIAs. There is the possibility that some supplemental doses are inappropriately counted as being given through the routine delivery service. This will become more complicated with plans to start recording measles doses administered during SIAs. Since SIAs are not conducted every year, data interpretation from year to year will become even more difficult.

5. It is possible to have negative drop-out rates for DTP1 and measles because of the different service delivery strategies. (See attached data.)
6. Monitoring DTP1-measles drop out is not included among the global indicators specified in the global measles and rubella strategic plan for 2012-2020, so DTP1-measles drop-out represents a new dimension to measles monitoring.
7. Is not clear what operational information DTP1-measles provides the measles and rubella initiative that would facilitate better programming and strategy development.

Figure 1

Comparison of 2011 DTP3 and measles coverage in the WHO/AFRO region, by category of DTP3 performance

(WHO/UNICEF estimates posted 14 July 2012)

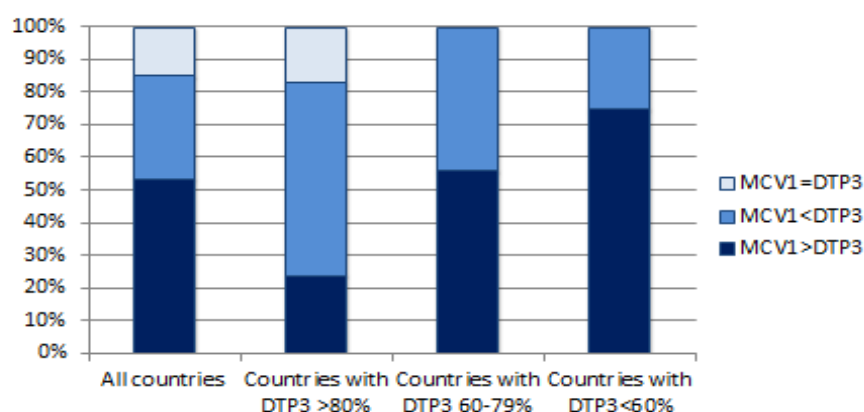


Table 1. Number of AFR Countries by Level of DTP3 Coverage and Drop Out Rates

Category of country, by DTP3 coverage	DTP3 > MCV1		DTP3 < MCV1		DTP3=MCV1
	Number of countries (%)	Mean difference and range in percentage points	Number of countries (%)	Mean difference and range in percentage points	Number of countries (%)
DTP3 ≥80% (N=29)*	17 (59%)	8 (1-28)	7 (24%)	3.3 (1-7)	5 (17%)
DTP3 60-79% (N=9)**	4 (44%)	13 (8-16)	5 (56%)	4.8 (1-10)	0 (0%)
DTP3 <60% (N=8)***	2 (25%)	5 (1-9)	6 (75%)	12 (6-24)	0 (0%)
All countries (N=46)	23 (50%)	8.4 (1-28)	18 (39%)	6.6 (1-24)	5 (11%)

*Algeria, Angola, Benin, Botswana, Burundi, Burkina Faso, Cap Verde, Comoros, Congo, Eritrea, Gambia, Ghana, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Namibia, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, Swaziland, Tanzania, Togo, Uganda, Zambia, Zimbabwe

**Cameroon, Cote d'Ivoire, DRC, Guinea-Bissau, Mali, Mauritania, Mozambique, Niger, South Africa

*** CAR, Chad, Equatorial Guinea, Ethiopia, Gabon, Guinea, Liberia, Nigeria,

Source: WHO Coverage Estimates, accessed September 15, 2012

Table 2. Number of AFR Countries and Percent of Surviving Infants, by Level of DTP3 Coverage and Drop Out Rates

Category of country, by DTP3 coverage	DTP3 > MCV1		DTP3 < MCV1		DTP3 = MCV1	
	Number of Countries (#)	Percent of surviving infants (%)	Number of Countries (#)	Percent of surviving infants (%)	Number of Countries (#)	Percent of surviving infants (%)
DTP3 ≥80% (N=29)	17	24.7%	7	11.2%	5	6.1%
DTP3 60-79% (N=9)	4	5.0%	5	20.0%	0	0%
DTP3 <60% (N=8)	2	1.8%	6	31.2%	0	0%
All countries (N=46)	23	31.5%	18	62.4%	5	6.1%

Source: WHO Coverage Estimates, accessed September 15, 2012