



Establishment of a National Immunization Technical Advisory Group in Côte d'Ivoire: Process and lessons learned

Julia Blau^{a,*}, Papa Coumba Faye^a, Kamel Senouci^a, Simplicie Ncho Dagnan^{b,1}, Alfred Douba^{b,1}, Jeanine Tagliante Saracino^{b,1}, Bradford D. Gessner^a

^a Agence de Médecine Préventive (AMP), s/c Institut Pasteur, 25-28 rue du Docteur Roux, 75724 Paris Cedex 15, France

^b Institut National d'Hygiène Publique, BP V 14, Abidjan, Cote d'Ivoire

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ABSTRACT

In January 2010, Côte d'Ivoire became the first GAVI-eligible country in sub-Saharan Africa to establish a National Immunization Technical Advisory Group (NITAG). The Côte d'Ivoire "National Committee of Independent Experts for Vaccination and Vaccines" (CNEIV-CI) was created to strengthen national capacity for evidence-based policy decisions with regard to immunization and vaccines. The primary reasons for success in Côte d'Ivoire were a strong political will, the availability of sufficient national expertise, a step-by-step country-driven process, and the provision of technical assistance to the Ministry of Health. The challenges included operating within the socio-political crisis, and initial reluctance from some stakeholders due to the potential overlap with other existing committees. The latter rapidly dissolved over the course of numerous meetings held with the SIVAC Initiative to clarify the mandate of a NITAG.

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1. Introduction

Immunization is an important, cost-effective and successful public health intervention [1]. With the increase in resources allocated to immunization through the GAVI Alliance [2], there have been important changes in vaccination programs and policies. Multiple health priorities, limited human resources and logistical capacities [3], and the high cost of vaccines relative to limited public funds have increased the need for evidence-based decision making in immunization programs. Evidence-based decision-making processes can provide more support for immunization programs than other health interventions. Meanwhile, within immunization programs such processes can inform decisions related to new vaccine introduction, prioritization, schedules, target groups and other issues linked to immunization and vaccines.

An important step that countries can take is to establish a national expert group to advise the Ministry of Health (MOH). To

date, most industrialized countries and some developing countries have already constituted National Immunization Technical Advisory Groups (NITAGs) to guide immunization policies [4]. These multidisciplinary national committees include expertise in various areas (epidemiology, economics, public health, anthropology, pediatrics, pharmacology, vaccinology, and infectious diseases) and are responsible for providing recommendations on immunization and vaccines to the minister of health. The World Health Organization (WHO) now recommends that all countries establish national immunization and vaccination committees [5].

To help low- and middle-income countries achieve this goal, the Bill & Melinda Gates Foundation provided funding to the Agence de Médecine Préventive (AMP), in partnership with the International Vaccine Institute (IVI) to develop the Supporting Independent Immunization and Vaccine Advisory Committees (SIVAC) Initiative [6]. This article describes the methodology used by the national authorities in Côte d'Ivoire with the support of the SIVAC Initiative to establish the first sub-Saharan African NITAG in a GAVI-eligible country.

2. Context

2.1. Immunization policies and programs

Côte d'Ivoire is a French-speaking West African country with a 2010 birth cohort of 649,477. Expanded Program on Immunization

* Corresponding author at: Agence de Médecine Préventive (AMP), s/c Institut Pasteur, 25-28 rue du Docteur Roux, 75724 Paris Cedex 15, France. Tel.: +33 1 53 86 89 20; fax: +33 1 53 86 89 39.

E-mail addresses: jblau@aamp.org (J. Blau), pfaye@aamp.org (P.C. Faye), ksenouci@aamp.org (K. Senouci), dagnans@yahoo.fr (S.N. Dagnan), alfreddouba@yahoo.com (A. Douba), saraliantes@yahoo.fr (J.T. Saracino), bgessner@aamp.org (B.D. Gessner).

¹ Tel.: +225 05 66 60 11.

Table 1
Vaccination schedule in Côte d'Ivoire, 2009.

Ages	Vaccine ^a
At birth	BCG + OPV 0
6 weeks	DTP-HepB-Hib1 + OPV 1
10 weeks	DTP-HepB-Hib2 + OPV 2
14 weeks	DTP-HepB-Hib3 + OPV 3
9 months	Measles + yellow fever
18 months	4th dose DTP-HepB-Hib + OPV
Pregnant women	Tetanus toxoid
	1st Dose: at the first contact
	2nd Dose: one month after first dose
	3rd Dose: 6 months after second dose
	4th Dose: one year after the third dose
	5th Dose: one year after the fourth dose

^a BCG: Bacillus Calmette-Guérin (for tuberculosis); OPV: oral polio vaccine; DTP: diphtheria-tetanus-pertussis; HepB: hepatitis B; Hib: *Haemophilus influenzae* type b.

(EPI) services were launched in 1978 and are now delivered through approximately 1500 vaccination centers and involve all levels of the health system structure. Since March 2009, the immunization schedule has included nine vaccine preventable diseases: tuberculosis, diphtheria, pertussis, tetanus, poliomyelitis, measles, yellow fever, hepatitis B and *Haemophilus influenzae* type b (Table 1).

Between 2005 and 2007, administrative coverage rates reported by the MOH steadily improved while a decline in coverage (except for Bacillus Calmette-Guérin [BCG]) was reported for 2008 (Table 2). This can be explained partly by the internal political and military strife experienced by the country since 2000. With the decrease in vaccine coverage, some vaccine-preventable diseases have re-occurred, including 183 measles, 26 wild poliovirus, 22 yellow fever, and 6 neonatal tetanus cases in 2009. The drop in coverage rates which led to outbreaks in polio, yellow fever, measles and tetanus motivated the MOH to increase the number of supplementary immunization activities (SIAs). Despite the increase in SIAs which added to the financial and human cost of routine immunization in the country, no significant improvement was seen in coverage rates. In 2009, the minister of health asked the Inter-Agency Coordination Committee (ICC) to provide him with data on the impact of the SIAs on the coverage rates in the country. However, ICCs address primarily financial and operational issues; consequently, the ICC members created an ad hoc committee to work on the topic. This experience convinced the minister of the benefit of a standing technical consultative organ such as a NITAG to address scientific issues related to immunization policy, including the observed drop in immunization coverage.

2.2. National immunization expertise

Côte d'Ivoire has two medical schools. Additionally, the University of Cocody-Abidjan is one of the primary sponsors of the EPIVAC training course (www.epivac.org) and health professionals also have access to the International Course on Epidemiology and Applied Information Technology [7,8]. The EPIVAC and ICEAIT programs operate in Africa. EPIVAC provides master's level training in

Table 2
EPI vaccination coverage rates in Côte d'Ivoire between 2005 and 2008 (Côte d'Ivoire Ministry of Health, administrative sources).

Vaccine ^a	2005	2006	2007	2008
BCG	61%	77%	85%	91%
Penta 3	56%	77%	80%	74%
OPV3	56%	76%	80%	58%
Measles vaccine	50%	73%	78%	63%
Yellow Fever vaccine	52%	67%	78%	50%

^a BCG: Bacillus Calmette-Guérin (for tuberculosis); OPV: oral polio vaccine.

public immunization program management while ICEAIT provides training in epidemiology with a focus on disease surveillance and outbreak investigation and response. Both courses support NITAG creation by creating a critical mass of local professionals trained in vaccinology and developing a culture of evidenced-based decision making in immunization and disease surveillance. Finally, Côte d'Ivoire has a Pasteur Institute and research facilities. All these structures provide an ample supply of professionals with expertise in immunization issues.

3. Creation of the NITAG in Côte d'Ivoire: a step-by-step country-driven process

3.1. The methodology proposed by the SIVAC Initiative

The SIVAC approach for the creation of NITAGs is based on a country-driven, step-by-step process aimed at ensuring country ownership and sustainability. The specific criteria for country selection include geographic representativeness, routine immunization coverage rates, availability of expertise, and political stability. Information comes from literature reviews, a review of the WHO and UNICEF immunization data, and consultations with WHO regional offices [6]. Once a country is selected, the SIVAC Initiative visits the country to meet with national health authorities and partners to explain the advantages of establishing a NITAG and evaluate the willingness of the country to implement a NITAG. If national authorities express interest, SIVAC makes a second country visit to initiate the development of a concept paper. The first visit allows the country to better understand the concept of a NITAG and the SIVAC approach, while simultaneously allowing SIVAC staff to assess the motivation of the country to create a NITAG. The second visit allows for in-depth work on the creation of the NITAG, based on a concept paper approach. The concept paper, developed by the country, describes the current situation of immunization policies and programs, lists potential partners, describes the envisioned NITAG composition and terms of reference, and proposes priority topics to be put on the agenda. When finalized, the concept paper is then submitted to a large number of experts for discussion and consensus during a national workshop. Based on the final version of the concept paper endorsed by the national authorities, the MOH develops the legal documents related to the establishment of the NITAG. Once the NITAG is legally established in the country, the next steps are to appoint the committee members, identify specific agenda topics, organize formal committee meetings, develop recommendations, and disseminate recommendations to the MOH. After the establishment of the NITAG, the SIVAC Initiative provides support to the country mainly by reinforcing the scientific and technical capacities of the NITAG executive secretariat. Detailed support activities provided by SIVAC are tailored to the country, and are established annually in consultation with the NITAG itself.

3.2. The process in Côte d'Ivoire

SIVAC visited Côte d'Ivoire in January 2009 (Fig. 1) to present the initiative and the concept of establishing a NITAG to the national health authorities, influential national experts, and staff from partner institutions (WHO and UNICEF). The aim of this initial visit was to evaluate the feasibility of establishing a NITAG in the country by assessing the support of the national authorities and the availability of national expertise. SIVAC first met with the director and deputy director of the Cabinet of the MOH, who expressed interest in creating a NITAG. This was followed by a meeting with other senior MOH staff, and staff from the National Institute for Public Hygiene (INHP). Intensive discussion took place on the concept of NITAG independence, the relationships between the NITAG and the

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