Vaccine 27 (2009) 3131–3136

Contents lists available at ScienceDirect

Vaccine

journal homepage: www.elsevier.com/locate/vaccine

Review

National immunization advisory committees of the World Health Organization's European Region

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ARTICLE INFO

Article history:
Received 20 November 2008
Received in revised form 20 February 2009
Accepted 19 March 2009
Available online 8 April 2009

Keywords:
Advisory Committee
Immunization
Vaccine

ABSTRACT

This study sought to understand the prevalence, structure and decision-making process of national immunization advisory committees (IACs) among the 53 member countries of the World Health Organization (WHO)'s European region. Of the 47 countries responding to the electronically administered questionnaire, 37 (72%) have an IAC. The majority of committees have a legislative basis while just over half have formal terms of reference. Fewer than half have experts in health economics. The vast majority of countries do not allow the public to attend committee meetings nor distribute publicly the minutes of their meetings. Countries should partner with financial experts early in the process of immunization policy decision-making and should examine their policies regarding conflicts of interest and public access to meetings, as financial strategy and public trust are essential to the successful implementation of new vaccines.

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1. Introduction

In 1974, the World Health Organization (WHO) initiated the Expanded Programme on Immunisation (EPI) with the goal to make vaccines available to all children throughout the world. The EPI was designed to provide guidance and support to improve vaccine delivery. A standardized immunization schedule was established on the basis of a review of immunological data. In the late 1980s, hepatitis B and haemophilus influenzae, type b (Hib) vaccines were added to the EPI's list of recommended vaccines. However, despite widespread morbidity and mortality related to these diseases, few countries worldwide implemented these vaccines. With higher use among wealthier countries, low uptake was attributed to economic constraints [1]. Since that time, new financing mechanisms have

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0264-410X/$ – see front matter © 2009 Elsevier Ltd. All rights reserved.
doi:10.1016/j.vaccine.2009.03.052

been developed through large donors to remove these financial barriers resulting in wider uptake, however, still not at the pace desired [2,3].

With the recent release of several new vaccines and even more in development, the focus of international infectious disease control specialists has shifted to identifying other barriers in the implementation of new vaccines and to the maintenance of national childhood immunization programs. One area of interest is on the decision-making process within national immunization programs and the individuals central to the process.

Many developing countries have established an Interagency Coordinating Committee (ICC) to meet a requirement for financial support from the Global Alliance for Vaccines and Immunizations (GAVI) fund [4]. While the goal of the ICC is to bring together domestic agencies and international donors and advisors to coordinate efficient and effective use of resources [5], these committees are often not designed to address the technical aspects of the nation's immunization program.

Separate and distinct from the ICC, technical Immunization Advisory Committees (IACs) are used by many nations to determine the specific vaccines recommended for use in a particular country. These committees generally bring together a panel of experts to access the wide spectrum of issues involved in the decision to recommend a vaccine. The charge of these committees may include additional responsibilities such as information dissemination, advocacy and oversight of immunization programs.

A recent study [6] of IACs in 10 large industrialized nations in Western Europe revealed significant variation in the composition, process for decision-making and authority of these committees. For example, some committees made decisions through member voting while others operated by consensus. The variation was often a function of the political, social and economic environment in which the committee and the specific government operated.

Many countries in the WHO's European Region are now developing their own IACs. The findings from the 10 industrialized nations present only a limited view of the range of IAC functions currently in place across this region that is diverse both economically and politically. The 53 countries of this region extend from Western Europe to western Asia and include newly independent states of the former Soviet Union. The total expenditure on health as a percentage of the gross domestic product for this region varied from 11.3% (Switzerland) to 3.4% (Azerbaijan) in 2006 [7]. As such, a broader review of the different models of such committees would be helpful in understanding the options available to developing programs and in the assessment of the structure of existing programs. Thus, we studied the current status, composition and processes of IACs across the WHO's European Region.

2. Methods

2.1. Sample

To gain an understanding of the process of immunization recommendation development and implementation throughout the WHO's European Region, all 53 member countries were selected to participate.

2.2. Survey instrument

In collaboration with the WHO, we developed a structured questionnaire to be administered electronically. The survey contained 39 items and was designed to be completed in 15 min or less. The survey focused on membership of the IAC, the committees' meeting process and decision-making. The questionnaire was a composite of fixed-choice and short-answer questions.

The survey and accompanying cover letter were translated from English to Russian by a professional translation service. Eleven countries of the former Soviet Union and Eastern Europe (Armenia, Azerbaijan, Belarus, Kazakhstan, Kyrgyzstan, the Republic of Moldova, the Russian Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan) were provided with surveys in Russian and given the opportunity to complete the survey in Russian.

2.3. Questionnaire administration

The first fielding of questionnaires was sent electronically in April 2008 to the EPI manager in each country and, where applicable, to immunization program managers. The e-mail contained an attached personalized cover letter signed by the Director of the WHO European Immunization Program and the survey instrument. The cover letter also specified that the focus of the survey was on the IAC (also known as the technical committee), not the ICC (if present) in each country.

Respondents had the option to return the completed survey by e-mail, fax or complete a web-based version of the survey. Three additional communications were sent to non-respondents in April and May 2008. Not all respondents provided answers to each question. When answers were missing or unclear, follow-up contact was made with countries, and, occasionally, decision rules were employed by the research team to ensure consistency of response.

2.4. Data analysis

Frequency distributions were calculated for all survey items. All free text from short answers was transcribed verbatim from the surveys. Responses in Russian were translated to English by a professional translation service.

Chi-square analysis was conducted to assess differences between countries by economic status for some items. We grouped countries into low and lower middle-income economies versus upper middle and high-income economies as classified by the World Bank 2008 [8] (Table 1). We hypothesized that there would be differences in the immunization decision-making structure among poorer countries and they would be less likely to have a well-established public health infrastructure compared to other countries in the region.

The study was approved by the University of Michigan Medical School Institutional Review Board.

3. Results

3.1. Response rate

Of the 53 countries in the WHO European Region, 47 completed the survey. This yielded an overall response rate of 89%.

The response rate of low and lower middle-income countries was 92% ($N=11$) and that of upper middle and high-income countries in the region was 88% ($N=36$). Eight of the survey responses required translation from Russian to English.

3.2. Presence of IACs

Almost three-quarters of countries surveyed (72%, $N=34$) have a standing advisory committee to make national immunization recommendations. Another 15% ($N=7$) have ad-hoc committees for special issues and the remainder indicated they had no such committee. When compared to low and lower middle-income countries, upper middle and high-income countries in the region were significantly more likely to have a standing advisory committee that makes national immunization recommendations (83.3%

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