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PAN AMERICAN HEALTH ORGANIZATION (PAHO)

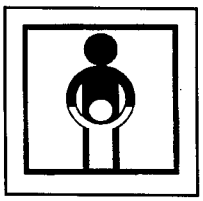
EXPANDED PROGRAM ON IMMUNIZATION (EPI)

10TH CARIBBEAN EPI MANAGERS' MEETING

FINAL REPORT

TOBAGO, TRINIDAD AND TOBAGO

22-25 November 1993



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1. Introduction

The 10th Meeting of the Caribbean EPI Managers took place from 22-25 November 1993 in Tobago, Trinidad and Tobago. The Meeting was officially opened by the Honourable Minister of Health of Trinidad and Tobago, Mr. John Eckstein. Mr. Lenox Denoon, Chairman of the Tobago House of Assembly welcomed the participants, while greetings were extended by Mr. Paul Ellis, PAHO Country Representative in Trinidad and Tobago, on behalf of Dr. Carlyle Guerra de Macedo, the PAHO Director. Representatives of the Canadian Public Health Association, UNICEF and Rotary International also addressed the meeting.

All speakers stressed the leading role that the immunization programs have had in the delivery of preventive care and that the successes of EPI reflect the high level of political commitment and availability of resources for program implementation, both from the governments themselves and several collaborating agencies. The clear and concrete targets that have been established and monitored over the years, both at country level and through these regular annual meetings, have kept the program on track, with its strategies adjusted based on the experiences and lessons learnt from year to year.

There were over ninety participants from the English speaking Caribbean, Suriname, the French and Netherlands Antilles, as well as PAHO consultants from the Center for Disease Control (CDC), Atlanta, Georgia, USA, the Laboratory Center for Disease Control (LCDC), Ottawa, Canada, the Department of Health, London, England and the Los Angeles County Health Department, Los Angeles, California, USA, the Caribbean Epidemiology Center (CAREC), Port of Spain, Trinidad and Tobago, the Caribbean Program Coordinator (CPC) Office, Bridgetown, Barbados and its Headquarters, Washington, D.C., USA. Dr. Beryl Irons, EPI manager, Jamaica, chaired the Meeting and Mr. Henry Smith and Dr. Ciro de Quadros served as Secretaries.

2. Objectives of the Meeting

As in previous meetings, the main objectives of this 10th meeting was to review the implementation of the 1993 Plans of Action and identify the major constraints encountered in the process. With this analysis, participants prepared their national 1994 Plans of Action. Special emphasis was given to the discussion of the poliomyelitis eradication certification process and to the improvements in measles surveillance.

Recommendations pertaining to Hepatitis B and Heamophilus Influenza B made at the 9th Caribbean EPI Managers Meeting remain valid and need to be acted upon.

3. Conclusions and Recommendations

3.1 Immunization Coverage

Table 1
Levels of Immunization Coverage
18 Caribbean Countries and Suriname
1991, 1992 and 1993*

Level of Coverage	Number of Countries								
	DPT-3			Polio-3			Measles		
	'91	'92	'93	'91	'92	'93	'91	'92	'93
90% plus	11	12	13	11	11	14	12	10	13
80-89%	7	3	6	7	4	5	4	2	6
Under 80%	1	4	-	1	4	-	3	7	-

* Projected

Table 2
Immunization Coverage by Country
1991, 1992 and 1993*

Country	DPT-3			POLIO-3			MEASLES		
	'91	'92	'93	'91	'92	'93	'91	'92	'93
Anguilla	100	100	100	100	100	100	100	100	100
Antigua	94	100	100	97	100	100	87	100	88
Bahamas	92	92	88	91	92	88	93	94	77
Barbados	82	90	88	84	89	92	92	90	95
Belize	82	89	90	82	89	90	76	83	85
Bermuda	82	76	85	82	77	85	84	71	80
BVI	98	100	100	95	100	100	84	76	95
Cayman Isl.	97	100	100	96	97	100	90	99	100
Dominica	98	99	99	94	99	99	98	99	99
Grenada	85	90	95	81	87	95	96	73	100
Guyana	81	79	95	81	87	95	76	73	91
Jamaica	85	84	92	86	74	95	77	73	89
Montserrat	100	100	100	100	100	100	100	100	100
St.Kitts/Nevis	100	100	100	100	100	100	100	99	80
St. Vincent	99	100	100	99	100	100	100	100	100
St. Lucia	96	96	100	95	96	100	97	75	90
Suriname	75	63	81	72	63	81	84	90	80
Turks/Caicos	100	76	100	100	77	100	100	59	96
TRT	82	87	87	81	87	87	93	83	90

*Projected

The English-speaking Caribbean and Suriname, in general, present one of the highest immunization coverage in the world. However, there are indications that coverage, particularly for measles, may be slipping in some countries, as happened in 1992 (See **Tables 1 and 2** above). This is of particular concern as a resulting rapid accumulation of susceptibles could fuel a major measles outbreak, should an introduction occur in any country. Although projections for 1993 indicate that this trend may be reversed, with no country presenting coverage for DPT, Polio and Measles vaccines below 80%, an extra effort will be necessary to ensure that this is accomplished. If not accomplished, particularly for measles vaccine, catch-up campaigns in the 1-4 age group will be necessary to eliminate this critical mass of suceptibles and prevent potential outbreaks of the disease in the future.

It is recommended that all countries take the necessary steps to prevent any children from forming a pool of susceptibles every year and to identify and immunize any pockets of children eventually left unvaccinated from one year to another. These steps may include: a) use of enhanced reminder/recall system; b) special catch-up vaccination at certain periods of the year to pick up the eventual defaulters; and c) use of birth lists for infant tracking.

3.2 Poliomyelitis Eradication

The last cases of poliomyelitis reported from the English speaking Caribbean were in 1982. A Caribbean Certification Commission is now being formed to evaluate the quality of surveillance for acute flaccid paralysis (AFP) and the other surveillance indicators which will be required by the International Certification Commission before the Region can be certified polio free. It is of great concern that most countries do not present indicators at the level required by the Certification Commission. These are: a) At least 80% of the reporting units should report in a timely fashion; b) at least 80% of cases of AFP should be investigated within 48 hours of being reported. At present, only 48% of these cases are being investigated in a timely fashion; c) at least 80% of the AFP cases should have two stools samples properly collected within 15 days of onset of paralysis and properly transported to the CAREC laboratory. Only 9% of the AFP cases reported from the English- speaking Caribbean have two stool samples collected within 15 days of onset; d) at least 80% of the cases of AFP should have stools collected from 5 contacts. Only 23% of the cases have contact stools collected in the Caribbean; and e) the rate of AFP cases for children under 15 years of age should be at least 1 per 100,000, annually.

All countries are urged to improve these surveillance indicators as soon as possible to allow the Region of the Americas to be certified polio free. It will be necessary to involve all

hospitals and specially pediatricians and neurologists to report promptly all cases of AFP, including those diagnosed as Guillain-Barre Syndrome (GBS).

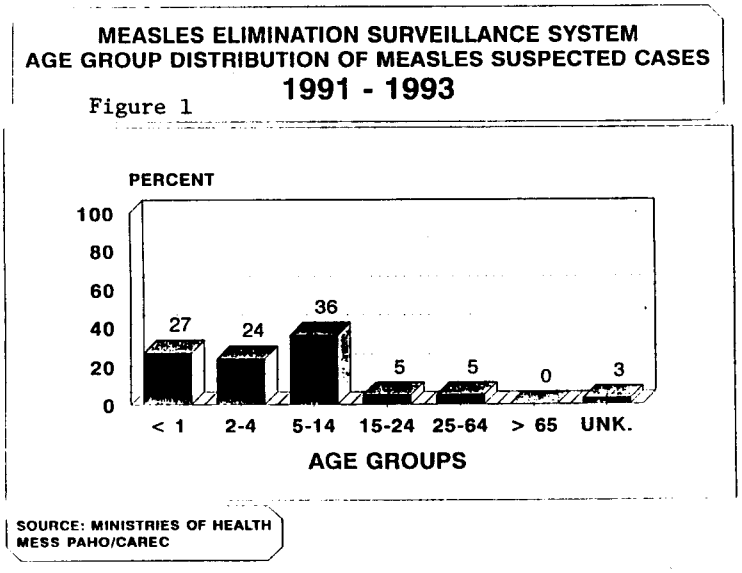
The recent importation of wild poliovirus from the Netherlands into Canada is a good reminder of the permanent vigilance that this Region needs to maintain in order to ensure freedom from polio.

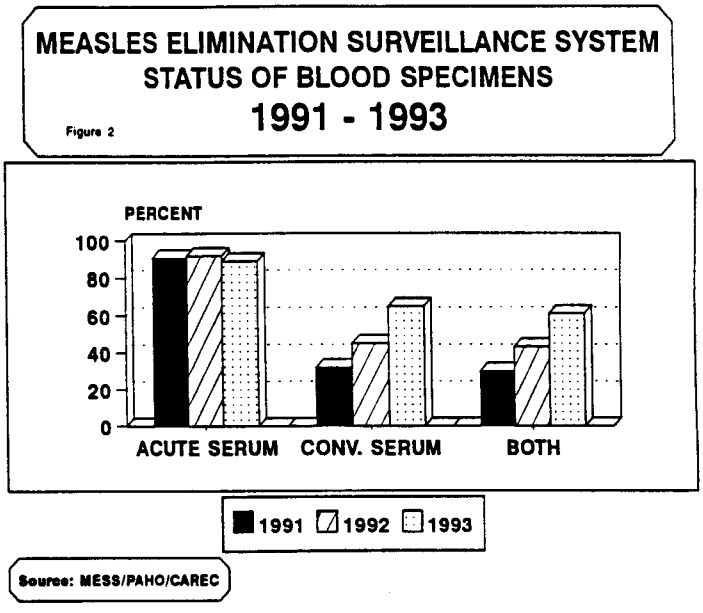
3.3 Measles Elimination

Surveillance for rash and fever illnesses has improved considerably during the past year. This is demonstrated by the fact that:

* Over 80% of the 639 suspected cases reported between week 1, 1992 and week 44 of 1993 were investigated. The majority (87%) of the suspected measles cases which met the case definition were in the 0-14 age group (**Figure 1**). Fifty five percent of the cases had documented evidence or history of at least one dose of measles vaccine.

* The number of convalescent sera being collected has increased by over 10% in 1993, compared to 1992 (**Figure 2**).

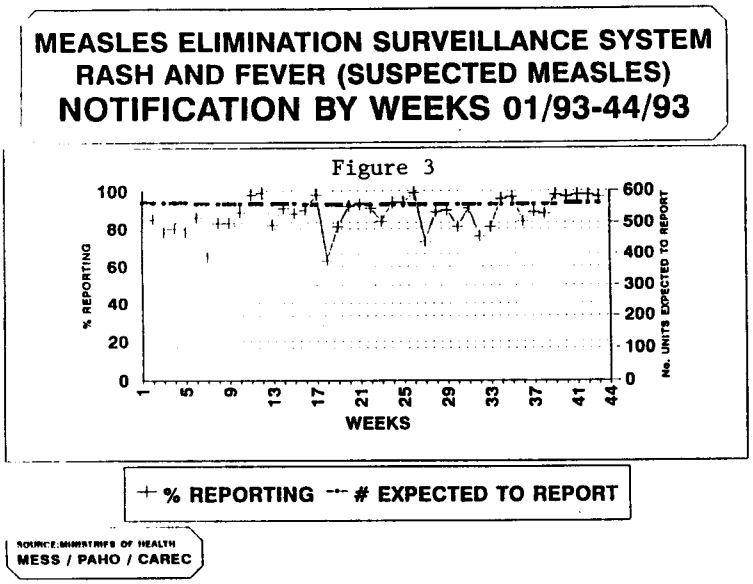


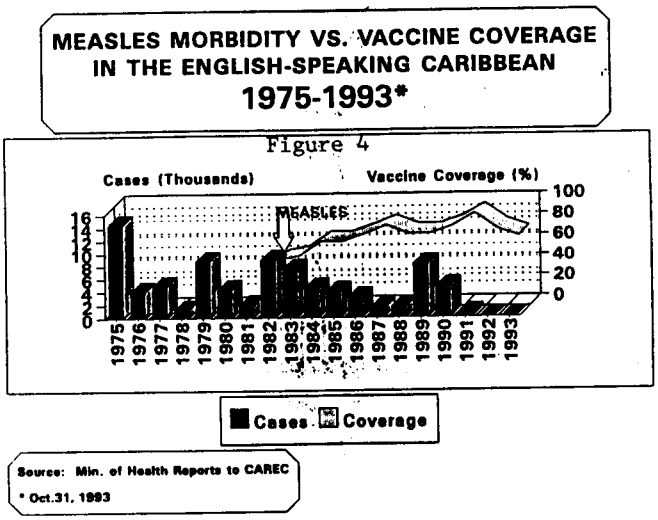


* The proportion of cases being classified as compatible has declined to 4% in 1993, down from 61% in 1991 and 25% in 1992.

* The proportion of cases meeting the case definition has increased from 51% in 1991 to 61% in 1993.

In spite of increased surveillance (which in 1993 included nearly 600 weekly reporting sites from public and private sectors - (**Figure 3**), since the launching of the elimination drive in May 1991 there have been only two laboratory- confirmed cases of measles in the English-speaking Caribbean (both in Barbados during week 51, 1991, and both imported from the USA) and one in Suriname, during week 35, 1993 (**Figure 4**).



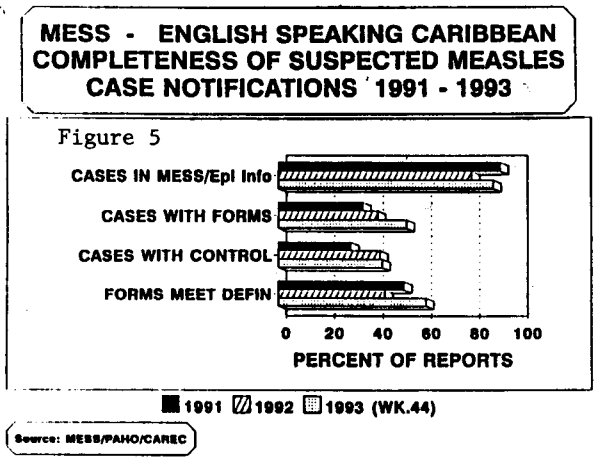


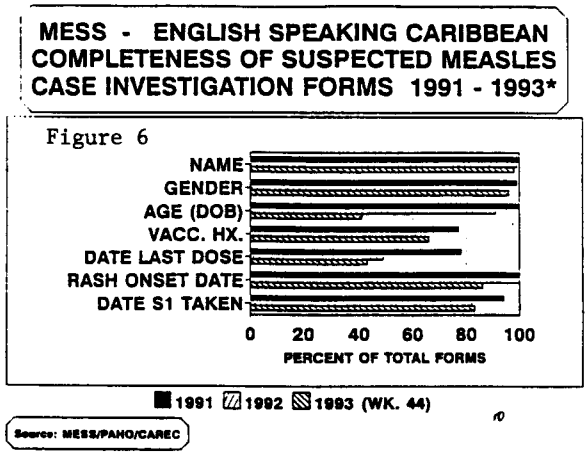
Despite such progress, major problems still remain and need to be resolved to ensure success of the initiative. Among the problems it could be cited that:

* Some countries are not sending serum specimens to the CAREC laboratory and in some instances in-country laboratories are still stockpiling serum specimens, leading to unnecessary delay in the classification and response to reported cases. Jamaica reported transportation problems which if unchecked could jeopardize the elimination effort.

* Although some improvement was observed, the response (proper investigation and control) to suspected cases or potential

outbreaks is limited and poorly documented and guidelines described in the Measles Elimination Field Guide are not being followed (See **Figures 5 and 6**).





There are several actions that should be taken in each country to address these problems. Among these, it is suggested that:

* Surveillance be expanded to include hospitals and private sector health providers.

* A line-listing for rash and fever cases reported should be kept and a summary of data (e.g. age, onset of rash, vaccination history and final diagnosis) should be tabulated for analysis, which will serve to check the sensitivity of the surveillance system. These data should be presented at the next meeting.

* All investigation forms be reviewed at the national level to ensure completeness of data. Specimens sent to the laboratory should be accompanied by the minimum information required by the lab to process the specimens. This should include the case number, location, age and vaccination status, with date of last vaccination.

* A final diagnosis should be provided for all discarded cases.

* Sustained use of the mass-media be pursued, aiming at the education of parents, teenagers and the private sector for increasing the prompt notification of suspected measles cases.

3.4 Rubella Surveillance

At previous meetings, the need to ensure that no women enter their child bearing years susceptible to rubbella has been stressed. A detailed study on rubella susceptibility in antenatal women in Trinidad and Tobago revealed troubling results: 46% of these women were susceptible to rubella. Should rubella be introduced in these populations, an epidemic of congenital rubella syndrome could follow. In Trinidad and Tobago, despite recommendations on school girl rubella immunization and postnatal immunization, those have not been properly implemented. Similar difficulties may be occurring in other countries as well. As recommended in the previous meetings, every effort should be made to ensure that there are **no** pregnant women susceptible to rubella.

3.5. Tuberculosis control

In recent years there has been concern about the resurgence of TB both in developing and developed countries. Factors contributing to increasing rates include the AIDS epidemic and deteriorating socio-economic conditions which have been prevalent for over a decade. An additional concern about TB is the emergence of multi-drug resistant strains.

A ten year review from 1983 to 1992 of TB rates in CAREC member countries reveals that rates steadily declined until 1988 reaching a low of 8.3 cases per 100,000 population. Since then rates have slowly increased; in 1992, the rate was 9.9 per 100,000 population. This rate is comparable to that in U.S.A. and many Western European countries. In contrast, African and South-East Asian countries experience rates of 75 to 150 cases and 50 to 100 cases per 100,000 population respectively.

In CAREC member countries, the rate of AIDS cases during this same time frame has steadily increased and will likely continue to do so. In 1992, the rate was 14 per 100,000 population. HIV-infected individuals may increasingly contribute to the burden of TB in the Caribbean. It is estimated that an HIV-infected individual has a 50% risk of developing active TB. From 1982 to 1993, 7% of the reported AIDS cases were ages 0 to 14 years. This has policy implications for those countries in the Caribbean routinely administering BCG vaccine. BCG vaccine should not be given to symptomatic HIV-infected individuals and should only be given to asymptomatic HIV-infected children residing in highly endemic TB areas where the risk of TB may outweigh potential complications of BCG immunization.

To evaluate TB control and surveillance in CAREC member countries, a survey was recently undertaken by CAREC. Preliminary results indicate that Ministries of Health are not positioned to deal with TB. In general, there is a lack of training, diagnostic capacity, case management protocols, and reliable stocks of

therapeutic drugs. Deficiencies in tuberculosis control and surveillance within many Caribbean countries will need to be resolved in order that they be prepared to face this new epidemiological challenge.

3.6 Social Mobilization

Remarkable progress have been by most countries in the development of a strong social mobilization component to their program. Countries are using data from survey results and program information and evaluation to prepare target messages for the general public and other specific groups as well as the health staff. Different forms of media, such as T-shirts, cups, calendars, balloons, radio and TV attest to the degree of sophistication and diversity of the strategies being used to increase public awareness for increasing vaccination coverage. Belize, for example, has made special efforts to document the impact of their social mobilization efforts on the immunization coverage and Grenada has made inroads in the mobilization of the community for participation in the surveillance of fever and rash illnesses.

While funding was not available to bring local NGO representatives to this meeting (with exception of the delegation from Rotary International which was self-financed), it was reaffirmed by all participants that these organizations carry on significant valuable activities and facilitate the achievement of national EPI objectives. Through this increased partnership with government initiatives, developing organizational capacity and fostering new relationships, NGOs will continue to provide support and increased access to the grassroots level. With the idea that additional resources are needed to the achievement of the goals of the program in particular and all other health objectives in general, the NGO/government relationship must not only continue to evolve, but should also be nurtured.

The development of this strong social mobilization component and the NGO involvement are good indicators of the level of sustainability being achieved by the program in the countries of this region.

3.7 1994 Plans of Action

All countries completed the 1994 Plans of Action, which included all objectives and targets to be achieved during the year and the activities to be implemented. These plans included the costs of each activity and the sources of funding that are already identified, both from the national governments and from the collaborating agencies. Funding for some activities is not yet identified and program managers will have to stress this fact to the national authorities to ensure that funding sources are secured.

The total estimated needs to implement the national Plans of Action amount to **US$10,357,200**, with the following sources:

National Funds	**US$9,091,500**
External Sources	**US$1,265,700**
PAHO (Incl. AID and CPHA Grants)	US$369,100
UNICEF	570,800
Rotary International	105,500
Source not yet Identified	220,300

Funds from the external agencies or those for which the source is not yet identified are being requested to cover activities related to the following areas of action:

Area of Action	Amount	(Source not identified)
Biologicals	US$149,000	US$20,000
Cold Chain	201,300	99,300
Training	221,900	43,000
Social Commun.	206,800	30,500
Operating Costs	298,400	22,000
Supervision	50,300	-
Surveillance	61,500	2,500
Research	30,000	-
Evaluation	46,500	3,000
TOTAL	**1,265,700**	**220,300**

4. Future Meeting Plans

The 11th Meeting of the Caribbean EPI Managers is proposed to be held in the Bahamas in November 1994.