IMMUNIZE AND PROTECT YOUR FAMILY

Immunization Newsletter

Pan American Health Organization

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IN THIS ISSUE:

Cholera Outbreak in Haiti

Cholera had not made an appearance on the Island of La Hispaniola for over a century prior to 2010. Ten months after the earthquake that devastated Haiti in January 2010, the Haitian Ministry of Health and Population (MSPP) was notified of an unusually high numbers of patients being treated for acute watery diarrhea and dehydration in the Artibonite and Centre Departments. Within a few days, the National Public Health Laboratory (LNSP) in Haiti had isolated *V. cholerae* serogroup O1, serotype Ogawa in specimens from hospitalized cases. As of week five after the outbreak had been registered, all ten departments in Haiti had reported cholera cases (Figure 1), and the first case had been registered in the Dominican Republic. The highest number of new cases and hospitalizations reported at the national level (in Haiti), was over epidemiological weeks (EW) 46 and 52 (Figure 2).

The cholera outbreak in Haiti sparked an international chain reaction. Members of international community immediately responded to the outbreak by assisting Haiti with outbreak control measures and encouraging countries to update their preparedness and response plans, as well as strengthen their surveillance for the timely detection of cases.

Overall, Haiti reported 179,379 cases and 3,990 deaths in 2010. At the beginning of the outbreak, the case-fatality rate (CFR) and the hospital CFR (cumulative hospital deaths divided by cumulative hospitalized cases) were reported to be >1%[1]. However, activities aimed at increasing access to rehydration treatment, including oral rehydration solution, as well as improved training of health providers for the improvement of case management, have helped decrease the CFR.

Unless there are substantial improvements in the access to drinking water and basic sanitary measures, there is a distinct possibility that cholera will become endemic in Haiti. Mid and long-term improvements in access to clean drinking water and sanitation will not only be essential elements for the control of cholera in the country, but also for the prevention and control of other diarrheic diseases and other diseases that are transmitted via fecal-oral transmission.

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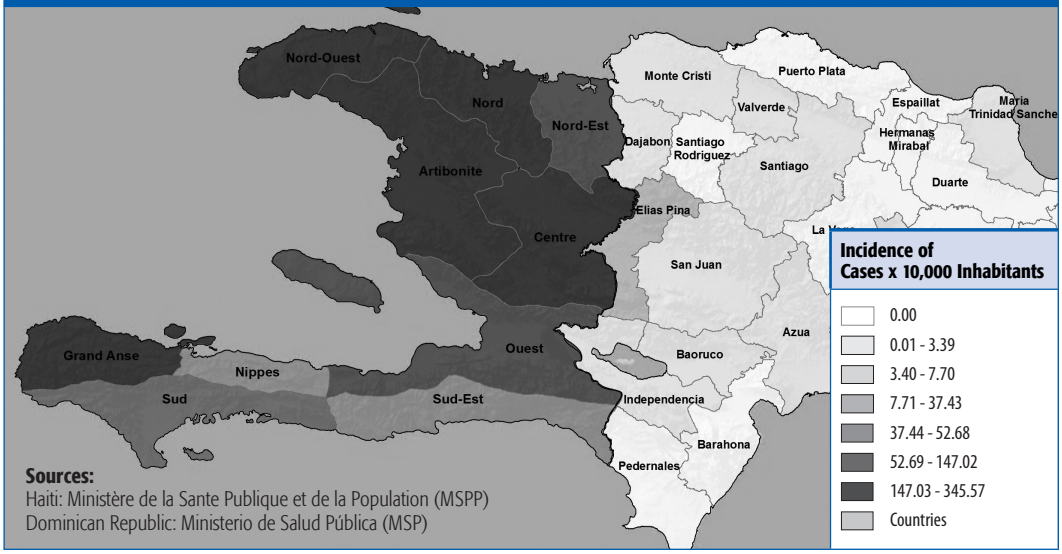
[1] Generally speaking, a CFR <1% can be achieved when appropriate care is sought early in the course of the disease

Figure 1. Cholera Cumulative Cases x 10,000 Inhabitants October–December, 2010



Ad-hoc Scientific Consultation on the Potential Role of Cholera Vaccination in the Americas in the Context of the 2010 Outbreak on the Island of La Hispaniola

On 17 December 2010, PAHO/WHO convened an *ad-hoc* emergency consultation to revisit the potential use of cholera vaccines as an additional mean to mitigate the cholera outbreak occurring in Haiti since October 2010. More than 20 international experts on cholera, immunization and disease control, along with key opinion leaders in the Region and stakeholders participated in the consultation.

An initial review of the potential use of vaccines early in the outbreak led PAHO not to recommend cholera vaccination. Among the reasons for this decision were that the initial response to the outbreak in Haiti needed to focus substantial efforts on preventing mortality through clinical treatment, as well as preventing exposure through improvements in drinking water, sanitation, and hygiene measures. Other considerations not to recommend vaccination included the vaccine characteristics, amount of vaccine available, and vaccine deployment capacity. At the time, a survey of manufacturers determined that a limited supply of cholera vaccines (approximately, 250,000 doses over the following four months) was available from only two manufacturers. Two vaccine doses are needed to confer protection against cholera.

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***AD-HOC* CONSULTATION** from page 1

The goal of the meeting was to advise PAHO on future actions that it might take to consider the use of cholera vaccines in this setting and for the potential future spread of cholera in the Region of the Americas. Specifically, the group was charged to consider three questions:

1) What is the current status of cholera vaccines – their safety, efficacy, availability and future supply?
2) How might the vaccines be most effectively used if available – in which populations, settings and with what strategy to determine who would and would not receive the vaccine?
3) How would we be able to monitor and assess the results of this intervention?

After reviewing the evidence presented and the high level issues raised by the participants (many of which will require follow-up discussions with key stakeholders), the participants' general agreement included that PAHO and partners should engage in a dialogue with manufacturers and potential funders to assess current and future production and procurement options. Given the likelihood that some vaccine (up to 250,000 doses) could be made available within several months and the willingness of some local leaders to consider introducing cholera vaccines to highly vulnerable communities, Haiti's Ministry of Public Health and Population, PAHO and the other counterparts could conjointly consider projects to assess general feasibility, best delivery practices, and other issues under the specific conditions. Gained experiences and findings could inform strategies for a broader use of vaccines if steady supplies were to become available in the second half of 2011 and beyond. A cholera vaccine stockpile was strongly recommended and further consultation will be needed to assess the future conditions for its management. Further research will also be needed to understand how to maximize benefits from available cholera vaccines that could be lifesaving in a variety of epidemic situations.

It was highlighted that the recommendations given should not deter efforts to continue programs for the treatment of cholera patients or attempts to further improve water and sanitation that are ongoing. If adequately planned, funded and implemented, and as long as it would not cause competing demands on resources of other control and prevention activities, vaccination might reduce pressure on already limited health resources. The group also indicated that they would welcome and encourage further discussion and action on these recommendations with public health leaders in both Haiti and the Dominican Republic.

PAHO is working with an advisory committee to engage a group of stakeholders and partners in discussion and consideration of these recommendations. Also, it will work toward their implementation once agreement has bee reached with the Government of Haiti, other affected countries, and partners. ■

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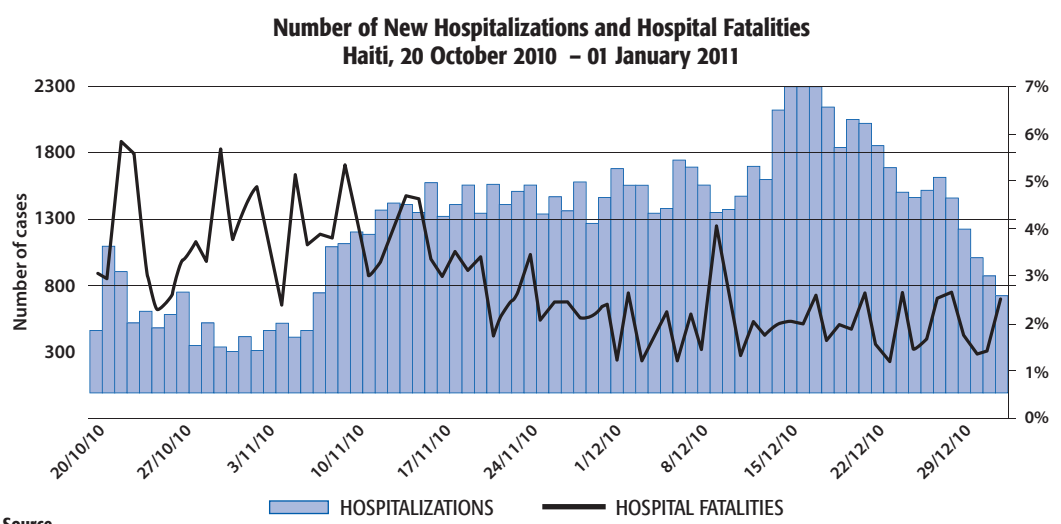
It is important to note that while repeated cholera exportations from Haiti to other countries of the Americas have occurred, none has yet resulted in sustained outbreaks, with the exception of the Dominican Republic. It is in this context that Members States in the Region should double-up their efforts to improve their surveillance systems. Cholera surveillance should be part of their integrated country surveillance programs and should include timely reporting at the local and global levels. It is recommended that counties use the case definitions provided by the World Health Organization (WHO) in order to obtain a more precise estimate of the global burden of cholera and enable the identification of more sustainable intervention strategies.

At the onset of the outbreak and after an Expert Consultation in December 2010, cholera vaccination in Haiti was not recommended (see article on page 1 of this Newsletter). The need to focus efforts on the provision of highly effective and time-tested rehydration treatment and on the implementation of emergency sanitation measures, were considered key activities in the immediate aftermath of the outbreak emergence. Additionally, the limited availability of the pre-qualified vaccine and anticipated logistical challenges to deploy a vaccine in the post-earthquake setting were additional considerations. However, as the epidemic progressed rapidly and is ongoing, this position might need reconsideration.

Figure 2. Daily Hospitalized Cholera Cases, EW 42-52 2010, Haiti.



Source
Haiti, Ministry of Public Health and Population; Rapports des cas: Journalier et cumulatif, up to 1 January 2011.
Available from: http://www.mspp.gouv.ht/site/index.php?option=com_content&view=article&id=57&Itemid=1.

Cholera Vaccines

Cholera vaccines that are currently marketed globally include 1) Dukoral® (WC-rBS): a monovalent oral vaccine based on formalin and heat-killed whole-cells (WC)

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of *V. cholerae* O1 plus recom-binant cholera toxin B subunit and 2) Shanchol®: bivalent oral vaccines based on serogroups O1 and O139. The CVD 103-HgR, an oral live attenuated single-dose vaccine, is no longer being produced. The injectable vaccine prepared from phenol-inactivated strains of *V. cholera* is still manufactured in a few countries, but its use has never been recommended by the WHO.

Dukoral® is the only WHO-prequalified cholera vaccine. Dukoral® and Shanchol® vaccines are safe for all age groups in which they are licensed (≥2 years and ≥1 year, respectively). Both types of vaccine offer significant protection against cholera during the first two years after vaccination. The ranges of protective efficacy at 4-6 months, 1 year, and 2 years after vaccination are 66%-86%, 45%-62%, and 58%-77%, respectively. The Table shows key characteristics of the two vaccines.

Characteristics	Dukoral™	Shanchol™
WHO prequalification	Yes, in October 2001	No, process ongoing
Licensed ages	≥2 years	≥1 year
Number of doses for primary immunization	Ages 2–5 years: 3 doses Ages ≥6 years: 2 doses	2 doses
Interval between doses	≥7 days (but <6 weeks)	≥14 days
Booster	Ages 2–5 yrs: after 6 months Ages ≥6 yrs: after 2 years	After 2 years
Administration	Oral with bicarbonate buffer (75 ml for children aged 2–5 yrs; 150 ml for persons aged ≥6 yrs)	Oral
Food and water restrictions	No food or water 1 hr before and after vaccine ingestion	No restriction
Packaging	3 ml single dose vial + effervescent granules in sachet	1.5 ml single dose vial
Cold chain and other storage requirements	Storage at 2–8 °C; 68cm3 packed volume per dose*	Storage at 2–8 °C; unknown packed volume

* DTP dose $3cm^3$

WHO/PAHO recommendations for the use of Cholera Vaccines:

Use of Oral Cholera Vaccines in Endemic Areas

- Cholera control should be a priority in areas where disease is endemic
  - Endemicity is defined as the occurrence of fecal culture-confirmed cholera diarrhea cases in ≥3 of the previous 5 years
- Oral cholera vaccines should be used in conjunction with other prevention and control strategies
- Vaccinating entire population not warranted, rather targeted at high-risk areas and groups
  - School-aged children
  - Pregnant women, and immunocompromised individuals
- Periodic mass vaccination probably most practical vaccination strategy

Use of Oral Cholera Vaccines in areas with or at-risk of outbreaks

- Treatment, potable water/sanitation and communication are the mainstay of control measures
- As an additional control measure, local health authorities *should* consider pre-emptive vaccination and *could* consider reactive vaccination
- Factors to consider in the local decision-making process: local infrastructure; thorough characterization of current and historical cholera situation; clear definition of areas to be targeted
- Vaccination should cover as many (eligible) people as possible and be conducted as quickly as possible ■

Vaccination should not disrupt provision of other time-tested, high-priority health interventions to control or prevent cholera outbreaks.

Sources:

1. Haiti, Ministry of Public Health and Population; Reported (cholera) Cases; Daily and cumulative, up to 1 January 2011. Available from: http://www.mspp.gouv.ht/site/index.php?option=com_content&view=article&id=57&Itemid=1.
2. Pan American Health Organization. Interactive Report of Cholera Outbreak; Atlas of Cholera Outbreak in La Hispaniola & Cholera Treatment Facilities in Haiti, 2010-2011. Available from: http://new.paho.org/hq/images/Atlas_IHR/CholeraHispaniola/atlas.html.
3. United States, Centers for Disease Control and Prevention. Haiti Cholera Outbreak Summaries: *Morb Mortal Wkly Rep.* 2010;59(43):1411, 59(45):1479, 59(48): 1586-1990, 59(50): 1637-1641. Available from: http://www.cdc.gov/haiticholera/mmwr.htm.
4. World Health Organization. Cholera in Haiti; Global Alert Response (GAR). 2010; 26 October – 26 November. Available from: http://www.who.int/csr/don/archive/country/hti/en/.
5. World Health Organization. Cholera Vaccine: Position Paper; Weekly Epi Rec (WER). 2010; 85(13): 117-128. Available from: http://www.who.int/wer/2010/wer8513/en/index.html.

National Computerized Nominal Immunization Registries: Workshop to Share 'Lessons Learned'

Bogotá, Colombia, 1-3 February 2011

From 1-3 February 2011, 20 countries of the Americas came together in Bogotá, Colombia to discuss issues related to the development and implementation of national computerized nominal immunization registries in the Region. The goal of the workshop was to share experiences and lessons learned among those countries using computerized nominal immunization registries, those advanced in their development and implementation, and those now starting to develop such registries. Participants in the workshop included immunization and information systems (IT) representatives from 20 countries as well as representatives from partner agencies such as UNICEF, PATH, the CDC, the WHO, and the Sustainable Sciences Institute (SSI). The Gates Foundation was unable to attend.

For the workshop, national computerized nominal immunization registries were defined as computerized population-based and confidential information systems/databases that include data on vaccine doses administered nationwide. Two characteristics of these registries were highlighted as highly desirable: 1) the system should provide reports and other outputs to facilitate monitoring vaccination coverage by vaccine, dose, geographical area, age (or other target group) and provider, and 2) the system provide outputs to facilitate the individualized and timely follow-up of vaccination schedules and the identification of defaulters.

Following plenary sessions, participants were assigned to seven working groups to highlight problems, identify potential issues and considerations, and propose solutions in diverse countries and situations. The topics were: 1) considerations before proposing the development of a nominal immunization registry; 2) data flow and entry of data in a computerized system; 3) inclusion of all children in the registry in different scenarios to ensure a comprehensive population-based registry; 4) implementation of nominal registries; 5) outputs, reports and maps for immunization program managers at different levels; 6) considerations for the selection of the informatics tools and standards, updates and maintenance, and type of development; and 7) potential use of mobile technologies.

Participants agreed that 1) clear objectives and scope for a computerized immunization registry must be defined, 2) a collaborative and transparent decision-making process is essential, 3) agreeing on technical and functional standards beforehand is highly important, and 4) once implemented in the field, training and supportive supervision of staff and data managers must be ongoing to ensure that accurate and reliable information is routinely captured in the system.

The openness of the participants to share experiences, products, successes and failures was commendable. A community of practice i.e., an Internet-based site for the participants of the meeting and other stakeholders to share documents, experiences, and exchange ideas and information is being set up. Also, based on the group presentations at the workshop, a report is being developed which will summarize lessons learned, best practices, and problems and proposed solutions for issues related to the development and implementation of national computerized nominal immunization registries in the Region. ■

PAHO Revolving Fund: Vaccine and Syringe Prices, 2011

Over more than 30 years, PAHO's Revolving Fund (RF) has served as a strategic mechanism facilitating the timely access to safe, effective, and affordable vaccines and syringes.

In 2010, with the aim of strengthening this mechanism and maintaining its strategic significance in the Region, a series of initiatives for the continuous improvement of the services offered by the RF to countries and territories were implemented.

In order to facilitate demand forecasting and improve accuracy, improvements were made to the demand planning tool (PAHO-173). Additionally, working sessions within countries, with the participation of representatives from the RF, ministries of health, ministries of finance, and customs, have resulted in the identification of opportunities for improving both local coordination and RF operations.

During 2010, PAHO's Revolving Fund provided support to 40 countries and territories in Latin America and the Caribbean in the acquisition of their vaccine, syringe, and cold chain supply requirements. The RF provided approximately 188 million vaccine doses, including the influenza H1N1 vaccine, for a total of US$504.7 million.

The portfolio of vaccines procured through the RF consists of 51 different presentations, including recently World Health Organization (WHO) prequalified vaccines. In 2011, it is estimated that the RF will provide approximately 187 million doses.

With regards to syringes, in 2010 there were five providers for nine different syringe types. The RF procured 78.4 million syringes equaling a total of US$5.1 million. In 2011, it is estimated that the RF will provide approximately 82.6 million syringes. ■

Table 1. Prices for Vaccines Purchased through the PAHO Revolving Fund, 2011 (prices in US$)

Vaccine		Doses per vial	Average Price per dose
BCG		10	0.1019
DT Pediatric		10	0.0850
DTP		10	0.1750
DTP-Hepatitis B-Hib	Lyophilized	1	2.9500
	Liquid	1	3.1900
DTP-Hib	Lyophilized	1	2.6500
		10	3.5000
	Liquid	10	3.4000
Hepatitis A	Adult	1	11.0000
	Pediatric	1	7.1250
Hepatitis B (Recombinant)	Adult	1	0.3700
		10	0.2167
	Pediatric	1	0.2330
Hib	Lyophilized	1	2.0000
	Liquid	1	3.6000
Human Papillomavirus (bivalent)		1	14.0000
Influenza Seasonal Northern Hemisphere USA origen	Adult 1	10	3.5000
	Adult 2	10	3.9000
	Pediatric	20	1.9500
Meningococcal A+C Polysaccharide		10	0.8500
Meningococcal C Conjugate (10-valent)		1	14.0000
Measles/Rubella		1	1.4500
		10	0.5588

Vaccine		Doses per vial	Average Price per dose
Measles/Mumps (Zagreb Strain)/Rubella		1	1.6000
		5	0.8500
		10	0.9200
Measles/Mumps (Urabe Strain)/Rubella		1	2.7000
		10	2.0000
Pneumococcal Polysaccharide Adult		1	6.5084
		5	6.4192
Pneumococcal Conjugate Pediatric		1	14.8500
Polio, Oral (Plastic)		10	0.2100
		20	0.1900
Polio, Inactivated		1	5.5000
Rabies Human Use (Vero Cells), French Origin		1	10.6000
Rabies Human Use (Purified Chick Embryo Cell Culture), Indian Origin		1	10.5000
Rotavirus, Liquid	2-dose Immunization Schedule	1	7.5000
	3-dose Immunization Schedule	1	5.2500
Td Adult		10	0.0798
Tdap Triple Acellular Adolescent/Adult		1	8.5498
DTaP Triple Acellular Pediatric		1	10.0000
Varicella		1	8.5214
Yellow Fever	Brazilian Origin	10	0.6700
	French Origin	10	1.4000

Table 2. Prices for Syringes Purchased through the PAHO Revolving Fund, 2011 (prices in US$)

Disposable Syringes, Plastic with Attached Needle

Size	Packed per case	Price per unit *
1cc 22G x 1 1/2"	3,600	0.0395
	2,000	0.0355
	800	0.054
1cc 23G x 1"	3,600	0.0395
	800	0.054
1cc 25G x 5/8"	3,600	0.0395
	2,000	0.0355
	800	0.054
1cc 26G x 3/8"	3,600	0.0395
	2,000	0.0355
1cc 27G x 3/8"	3,600	0.0395
5cc 22G x 1 1/2"	1,600	0.043
	1,000	0.033

Auto-disable Syringes, Plastic with Attached Needle

Size	Packed per case	Price per unit *
0.5cc 22G x 1 1/2"	3,000	0.054
0.5cc 23G x 1"	3,000	0.051
	1,300	0.049
0.5cc 25G x 5/8"	1,300	0.049
	3,000	0.051
0.1cc 26G x 3/8"	1,300	0.058
0.1cc 27G x 3/8"	3,300	0.065
	1,300	0.058

* Prices FCA (Free Carrier) for each syringe.

Source: For up-to-date vaccine prices, please visit: http://new.paho.org/hq/index.php?option=com_content&task=view&id=1864&Itemid=4135 (click on 'Vaccine Prices 2011' - under the 'Revolving Fund Related Documents' column).

Frequently Asked Questions (FAQs) about the Revolving Fund

The Revolving Fund of the Pan American Health Organization (PAHO) is a cooperation mechanism for the joint procurement of vaccines, syringes, and related supplies for participating Member States.

Through the Revolving Fund, for over 30 years, participating Member States have ensured a continuous supply of high-quality products at the lowest possible price for their immunization programs thanks to the economies of scale that these Member States provide.

Based on the principle of equity, and thanks to economies of scale, all participating Member States have access to the same products, offered through the Revolving Fund at the lowest price, which is a single price independent of the country's size or economic situation.

All participating Member States contribute 3.5% of the net purchase price to a common fund. Three percent of it is used entirely as working capital to offer a line of credit to Member States that may require it and 0.5% is used to cover the administration costs of purchasing activities. The line of credit enables a Member State to pay the Revolving Fund within 60 days of receipt of the products.

The Revolving Fund has been a critical factor in making the Region of the Americas a global role model for the success of immunization programs and for its successful introduction of new vaccines. For this reason, promoting its achievements and protecting its well-being is in everyone's interest.

Frequently asked questions (FAQs)

Who owns the Revolving Fund and what is the source of the funds for procuring products through this mechanism?

The Revolving Fund belongs to the PAHO Member States. PAHO serves as the secretariat that manages the negotiation and procurement processes on behalf of the participating Member States. Almost 100% of the resources that countries use to purchase what they need through the Revolving Fund come from their national budgets. For this reason, by securing the lowest prices, the Revolving Fund fosters the financial sustainability of national immunization programs.

What requirements should Member States meet to participate in the PAHO Revolving Fund?

To participate in the Revolving Fund, PAHO Member States should meet three basic requirements: the immunization program should have a 5-year plan of action; there should be a line item in the national budget for the procurement of vaccines, syringes, and supplies to support its program; and, finally, there should be an entity responsible for running the program. Moreover, participating Member States should contribute 3.5% of the net value of each purchase made and be up-to-date with their credit payments.

How is the PAHO Revolving Fund able to offer a single, lowest price to participating Member States?

Based on its annual vaccine and syringe demand forecasting, the Revolving Fund consolidates the requirements of all participating Member States into a single regional order for each product. It obtains the lowest prices thanks to the economies of scale this represents for producers and to the conditions, rules, and procedures PAHO has established for the Revolving Fund.

By agreeing to a single, lowest price for every product, countries can make the most our of their national vaccine procurement budgets.

How does the negotiation process between the Revolving Fund and the producers work?

The Revolving Fund issues a public bid solicitation annually, based on the annual consolidated demand from the participating Member States. The bid solicitation specifies not only quantities of vaccines, syringes, and related supplies, but also the quality characteristics, presentations, and conditions required by PAHO.

The tender is sent to producers, inviting them to submit a bid to meet the annual demand. Following the deadline for the close of the bidding, and in the presence of the participating producers, the bids are opened and disclosed.

Based on the lowest price, the quantity offered, and the producer's quality and service record, producers are selected to cover the annual demand that has been calculated. To guarantee the supply, PAHO assigns at least two producers, whenever possible, to cover the demand calculated for each product.

Why the 3.5% contribution on net purchases made by Member States participating in the Revolving Fund?

Of the 3.5% of the net value of products that is contributed by the Member States each time they make a purchase through the Revolving Fund, 3% goes to the common capital fund, which is used by PAHO as working capital to provide a line of credit to participating Member States, and 0.5% goes to the costs of administrative and purchasing activities.

The capital fund makes it possible to pay producers before receiving reimbursement from Member States, which have a 60-day grace period.

Frequently asked questions (FAQs) cont'd

When Member States acquire vaccines and supplies through the Pan American Health Organization (PAHO), is the Revolving Fund functioning as a supplier to the countries?

PAHO is not the vaccine supplier. As part of PAHO's technical cooperation, countries may purchase through the PAHO Revolving Fund, which assumes the functions of negotiation, administration of purchase orders, and coordination of shipments, as well as the financing functions of payment to suppliers and collection. For all Member State purchase transactions, the producer appears as the supplier and seller, and the country as the buyer. The producer is responsible for the quality, safety, and effectiveness of the products sold to the purchasing country.

How does PAHO ensure that the vaccines and syringes acquired through the Revolving Fund are of high quality, safe, and effective?

The vaccines and syringes offered through the Revolving Fund are products that have been prequalified by the World Health Organization (WHO). Prequalification verifies that the WHO principles and specifications for Good Manufacturing Practices and Good Clinical Practices are complied with, guaranteeing that the vaccines and syringes used in national immunization services are safe and effective for the recommended groups, and that they also comply with particular operational specifications for presentation and packaging.

The Revolving Fund also offers some products that are not priorities for the WHO prequalification system, and as a result are not evaluated for prequalification. For these products to be accepted, they must be approved by a reference regulatory agency: FDA (Food and Drug Administration, USA), EMEA (European Medicines Agency, European Union), Health Canada (Canadian regulatory agency), KFDA (Korea Food and Drug Administration), or TGA (Therapeutic Goods Administration, Australia).

Do other Regions of the world have a mechanism similar to the Revolving Fund for the procurement of vaccines and supplies for public health systems?

For the time being, only the Region of the Americas has this centralized procurement mechanism; nevertheless, other WHO Regions are in the process of implementing similar mechanisms with support from WHO, PAHO, and other partners, using the PAHO Revolving Fund as a model.

Are national laws important to the operation of the Revolving Fund?

Through national laws, countries ensure the allocation of national funds for the procurement of vaccines, syringes, and related supplies, thereby ensuring the financial and operational sustainability of immunization programs.

How does the Revolving Fund contribute to the introduction of new vaccines in country immunization programs?

PAHO has a technical team to support individual countries with the evaluation of cost-effectiveness and technical preparations necessary for the introduction of new vaccines. Once a country decides to introduce a new vaccine into its program, it can do it through the Revolving Fund, provided the vaccine is prequalified by the WHO. Every time a country introduces a new vaccine into its program and procures it through the Revolving Fund, it strengthens the Fund's economies of scale increasing affordability.

How much could a participating country save by purchasing through the Revolving Fund, compared to purchasing directly from manufacturers?

According to studies, a country that purchases through the Revolving Fund can save at least 11% compared to purchasing directly from the manufacturer. Compared with countries outside the Region, the price differential could be up to twice as much.

Participating in the Revolving Fund not only offers better financial conditions, but also provides access to the vaccine supply, especially for countries that would have major difficulties purchasing them on their own, given the low volumes that they need.

Moreover, by purchasing through the Revolving Fund, countries obtain vaccines and syringes that are prequalified using WHO safety and effectiveness standards.

Does the Revolving Fund promote the production of vaccines and syringes in the Region of the Americas?

Vaccines and syringes are acquired from different producers around the world, through the Revolving Fund, provided they meet the technical specifications established by the Revolving Fund and offer favorable financial conditions for Member States.

The Revolving Fund does not participate in projects or programs for vaccine production in the Region. However, it does offer new producers in any region of the world the opportunity to participate in the bidding process, provided that they meet the established requirements. ■

Source: PAHO's Revolving Fund, FAQs. Available from: http://new.paho.org/hq/dmdocuments/2010/RevolvingFund_FAQs_ENG.pdf.

Join the STOP Program and Help Prevent Measles Importations, Eradicate Polio, and Strengthen Immunization Systems!

The Stop the Transmission of Polio (STOP) program was created in 1999, as part of the US Centers for Disease Control and Prevention's (CDC) efforts to assist The Global Polio Eradication Initiative (GPEI). This program is a partnership with The World Health Organization (WHO), The United Nations Children's Fund (UNICEF), the Canadian Public Health Association (CPHA) and Rotary International. Since its creation, STOP has trained and deployed more than 1,300 participants – to over 60 countries.

STOP participants provide a wide range of technical support to effected countries. This includes: field surveillance for polio and other vaccine-preventable diseases, training local health care providers in surveillance, and planning and monitoring polio and measles vaccination campaigns. In addition, participants have assisted with establishing and enhancing data management systems and supported Ministries of Health (MOHs) with communications and social mobilization activities. The STOP program recruits qualified public health staff and other professionals who have at least 5 years experience in public health and a degree. CDC and WHO cover all travel, *per diem* and training expenses but ask that public health officials obtain release from their current organization and can commit to a 3 ½ month assignment, which includes 2 weeks of training and 3 months of field deployment.

STOP teams receive 2 weeks of intensive trainings from the immunization experts at CDC, to reinforce their understanding of polio eradication and other vaccine preventable diseases. During the 3-month field assignment, STOP participants have the opportunity to work closely with counterparts from MOH, WHO, UNICEF, and local communities at the district level, as well as to help build international bridges and global connections among public health professionals and organizations. We need:

- **Public Health Professionals**
- **Health Communications Specialists**
- **Public Health Data Managers**

For information, application and curriculum vitae (CV) format please go to the STOP website: www.cdc.gov/vaccines/programs/stop

Please direct inquiries about the program to STOPinquires@cdc.gov ■

The *Immunization Newsletter* is published every two months, in English, Spanish, and French by the Comprehensive Family Immunization Project of the Pan American Health Organization (PAHO), Regional Office for the Americas of the World Health Organization (WHO). The purpose of the *Immunization Newsletter* is to facilitate the exchange of ideas and information concerning immunization programs in the Region, in order to promote greater knowledge of the problems faced and possible solutions to those problems.

An electronic compilation of the *Newsletter*, "Thirty years of *Immunization Newsletter:* the History of the EPI in the Americas", is now available at: www.paho.org/inb.

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