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BELLAGIO II (Volume I) (TASK FORCE FOR CHILD SURVIVAL)
Front Office

TRANSLATED BY DR. STEVE JONES, EDC. RECEIVED 1/11/85.

MINISTRY OF HEALTH

MINISTRY OF EDUCATION

Belcayo

YOUTH TASK FORCE FOR CHILD SURVIVAL

The strategy of extended channeling applied to high priority infant health programs by means of health sentinels

TABLE OF CONTENTS

INTRODUCTION

The Plan for Child Survival which is presented in this document may well be the most important advance in the health of the nation in many years, because of the results expected from it and because the social principles upon which it is based are considered the most progressive and promising in the area of public health in the entire world.

The document begins with a summary which explains the essence of the proposed strategy, pointing out that what is new and important comes from the implementation and application of extended channeling to high priority health programs. Next are presented the goals related to the program in itself as well as the specific goals of each program such as immunization, control of diarrhea etc., which are included in the attachments relating to each program.

In order to focus on the strategy and for it to be clear, criteria and the minimum elements needed for its execution are explained, followed by a chart which synthesizes needed action. The steps and activities which must be accomplished in the health and education sectors as well as the community, are described for the purpose of establishing this important mechanism in the nation, which will greatly increase the effectiveness of health activities.

Consistent with the idea that new effects will arise from the proposed strategy, special attention has been paid to the financing of those aspects which give it life and force. A preliminary schedule organizes activities in time, subject to adjustments which development at the regional level may impose

Finally, reference documents for the carrying out of immunization, diarrhea, acute respiratory infection, malnutrition, perinatal mortality and psychoaffective deprivation programs based on extended channeling are included as attachments.

DEFINITION OF TERMS

CHILD SURVIVAL: This expression summarizes the intent to substantially reduce infant mortality in children under five years - as part of the overall goal of achieving health for all in the year 2000.

EXTENDED CHANNELING: Consists of the major strategy for accomplishing the purpose of Child Survival. Similar in certain ways to the channeling used in the Vaccination Program (P.A.I.), but having greater depth, coverage and permanence; it also includes health education activities directed towards families for the prevention and management of specific health problems, detection of cases and channeling these to points of the National Health System, where they can be properly treated.

HEALTH SENTINELS: Are community workers who will carry out the work of extended channeling. Mainly young persons, basically high school students, but also health promoters, volunteers from the Red Cross and other entities.

YOUTH TASK FORCE: Is the totality made up of all of the health sentinels, whose action will be the principle factor for reducing infant mortality.

1. YOUTH TASK FORCE FOR CHILD SURVIVAL - SUMMARY OF STRATEGY

Many countries have turned to their young people in crucial moments of their history, but, sadly, in the majority of cases it has been to deal with military conflicts. Today, the government of Colombia has also decided to call upon Colombian youth, but, happily, not to go to war, but rather the contrary, to give them the noble mission of saving the lives of thousands of Colombian children by means of the PLAN FOR CHILD SURVIVAL. This shall be a valuable contribution, which youth, the Educational sector and the Health sector shall offer the nation in the quest for social justice and peace.

In Colombia, given the limitations which define its social and economic state of development, it is not feasible to try to meet all the health needs of its citizens; but it is possible to confront the major health problems causing death of its people.

Thanks to information from the National Health System, the principle causes of death of children are known with reasonable exactitude. Likewise, the means of avoiding and preventing the great majority of these deaths are known. The fact that the efforts expended to place such means at the disposal of the population have not yet borne the expected fruit makes a "special effort" imperative, which will put an end to so many deaths which, without doubt, can be avoided.

The "special effort" which needs to be undertaken is similar to that which took place recently in the Vaccination Expeditions, which the technicians called "CHANNELING". The channeling performed by thousands of volunteers consisted of searching for children who needed innoculation and taking them to places where they could be vaccinated. This simple effort, of grasping a need and leading it to a place where it could be satisfied produced the greatest increase of vaccinated children in the entire history of public health in this country.

Something similar to channeling children to vaccination places is what needs to be done to confront diarrhea, acute respiratory infection, perinatal mortality, certain aspects of malnutrition and of the growth and development of the child. Also, this channeling will have certain different characteristics since it cannot be of a temporary nature like that which took place on the vaccination expeditions, rather it needs to be permanent; it will include orientation and education for the family regarding what needs to be done to prevent such problems and about what the family may do when they arise; it will also establish a permanent vigilance for the early detection of cases of this group of diseases for the purpose of directing them to an appropriate facility for treatment when primary care in the family is not sufficient.

This simple but vitally important task cannot be directly undertaken by doctors and other health workers. For its execution, the cooperation of thousands of people who have received training and orientation in the subject, who understand the social and human significance of the mission which is entrusted to them and who develop the most elevated attitude of social responsibility.

The mission of channeling, in the PLAN OF CHILD SURVIVAL will be entrusted, preferentially, as an obligation, to Colombian youth, who are receiving the benefits of secondary education, as required practical activity in their training in behavior and health, in a similar way to what they do for literacy. Additionally, other youth groups who desire to participate will be welcomed, as well as various kinds of volunteers and community workers, such as health promoters.

By means of the above mentioned human resources, a large social force for health will be created, which will make community participation in the solution of its health problems a reality. This invaluable resource will place itself at the disposal of the Regional Health Services, who will be responsible for its utilization following the standards which the Minister of the District may formulate for the execution of health programs.

2. GOALS

1. The strategy of "extended channeling" has the overall goal of substantially reducing infant mortality in children under five years of age, by means of activities which increase the effectiveness of control programs for diarrhea, acute respiratory infection, vaccine preventible diseases, malnutrition, perinatal mortality and psychoaffective deprivation.

2. When the plan reaches its complete development, it should have created a youth task force of health sentinels made up of 180,000 people, principally high school students, health promoters, other health workers and volunteers from different institutions.

3. Each sentinel will cover a minimum of 20 families, who have children under five years old or pregnant women, which implies a coverage of 3,600,000 families and in them approximately 20,000,000 Colombians. In this way, nearly every child in Colombia will be covered.

3. CRITERIA FOR THE APPLICATION OF THE STRATEGY

The Plan for Child Survival will apply the strategy of extended channeling to each of the following problems in the way explained below:

- Vaccine Preventible Diseases
- Acute Diarrheal Disease
- Acute Respiratory Infection
- Perinatal Mortality
- Undernourishment
- Psychoaffective deprivation.

The application of extended channeling will be based on the following elements:

- PROBLEM: This is how diseases and health situations are defined which have received priority in the Plan for Child Survival

- RISKS: These are the aspects of each one of the problems which must be identified by the channeling workers.

. ROLE OF THE CHANNELING WORKER: (HEALTH SENTINEL)

His job consists of detecting risks, evaluating them according to a series of criteria supplied in his working manual and then acting against the risk using educational methods for prevention, primary care and where necessary, channeling patients to where they can be treated properly.

. TECHNOLOGY FOR CONFRONTING RISKS

The technology which has been demonstrated the most appropriate given the current state of knowledge has been selected for dealing with each risk.

. RESPONSIBILITY FOR APPLYING THE TECHNOLOGY:

In some circumstances the technology for preventing or treating the risk may be applied by the family, in others, by the channeling agent (health sentinel), when he acts as Primary Health worker, and in others, by health personnel.

. RESOURCES: The Plan for Child Survival will basically utilize existing resources in programs currently underway for confronting problems incorporated in the Plan. Nevertheless, an additional effort will be made to guarantee the supply of resources which are essential for the successful outcome of the activities.

. STANDARDS Standards and technical procedures for each program appear as attachments to this document.

CHILD SURVIVAL
(EXTENDED CHANNELING APPLIED TO HIGH PRIORITY CHILDHOOD HEALTH PROBLEMS AND RISKS)

PROBLEM	RISK	ROLE OF THE CHANNELING WORKER		TECHNOLOGY AGAINST RISK	RESPONSIBLE FOR APPLYING T.A.	RESOURCES
		Evaluation of Risk	Action to deal With Risk			
Vaccine Preventible diseases	Child not vaccinated against: Diphtheria TBC Tetanus Polio Whooping cough Measles	. Age of child. (after 1 yr. child should have all immunizations).	. Education . Channeling	. Vaccination	. Vaccination Posts	Resources of the P.A.I
	Pregnant women not vaccinated against tetanus	Pregnant susceptible to tetanus				
Acute diarrheal disease.	Flaws in hygiene of: Kitchen Foods Water Person	(Criteria attached)	. Education			Resources of the EDA
	Dehydration	(Criteria attached)	. Education and information . Channeling	Appropriate rehydration with ORS	. Family . Oral Rehydration Post.	
	Invasive bacterial infection	Fever and bloody stool	. Channeling	Antibiotics	. Doctor	

CHILD SURVIVAL
(EXTENDED CHANNELING APPLIED TO HIGH PRIORITY CHILDHOOD HEALTH PROBLEMS AND RISKS)

PROBLEM	RISK	ROLE OF THE CHANNELING WORKER		TECHNOLOGY AGAINST RISK	RESPONSIBLE FOR APPLYING T.A.	RESOURCES
		Evaluation of Risk	Action to deal With Risk			
Acute respiratory Infection	Severity of the disease.					Of the family and health institutions
	- Low	Document attached	. Education	. Document attached	. Family	
	- Moderate	Document attached	. Education . Channeling	. Document attached	. Ambulatory care	
	- High	Document attached	. Channeling	. Document attached	. Hospital care	
Perinatal mortality	- Lack of Registration. - Not going to checkups.	Each pregnant woman should be evaluated institutionally at least once	. Education . Channeling	Prenatal visit Card	Health institutions	Of the Mother-Child program and health
	- Inadequate care at childbirth	High-risk pregnancy criteria	. Channeling	Institutional care for high-risk births	Health institutions	
	- Infections related to perinatal period	Fever and (Others in document attached)	. Channeling	Institutional care on evidence of perinatal infection.	Health institutions	

CHILD SURVIVAL

(EXTENDED CHANNELING APPLIED TO HIGH PRIORITY CHILDHOOD HEALTH PROBLEMS AND RISKS)

PROBLEM	RISK	ROLE OF THE CHANNELING WORKER		TECHNOLOGY AGAINST RISK	RESPONSIBLE FOR APPLYING T.A.	RESOURCES
		Evaluation of Risk	Action to deal With Risk			
Nutrition	Malnutrition	Measure the circumcumference of the arm (attachment)	. Education . Channeling	Breast-feeding	. Mother	Of the family
		Weight of newborn and under 5 years		Mixture of foods	. Family	
	Parasitosis		. Education	.Semi-annual deparasitization	. Family	Of the health institutions
				.Supplemental feeding		
Psychoaffective deprivation	- Retardation Physical Intelectual Social	Document attached	. Education . Channeling	. Adequate stimulation	. Family	Of the family
	- Learning difficulties	Document Attached	. Channeling	. Psychopedagogical support	. Health and educational institutions	

5. IMPLEMENTATION OF THE STRATEGY

The implementation of the YOUTH TASK FORCE FOR CHILD SURVIVAL basically requires appropriate information and adequate motivation which will produce a receptive attitude in the civil servants in the Education and Health sectors, in the persons who will act as "Health Sentinels" and the community to achieve the common goal and reduce infant deaths, especially those under five years of age.

We hope to achieve this favorable attitude first by means of a large commitment from the government, headed by the president of the republic with the solid support of the Health, Education, Communications, Agricultural, etc. sectors. Additionally, this favorable attitude will be driven and supported by wide popularization, a massive mobilization and an educational process by means of workshops, seminars and joint meetings between the various sectors which will participate as well as those responsible for any activity within the Plan for Child Survival.

In order to achieve the above, it is necessary to develop a series of activities for which the Health and Educational sectors will have the responsibility, which are as follows:

I. IN THE HEALTH SECTOR.

- The Ministry of Health should:

a) Encourage the political decision, the commitment of the government and the strong support of the community.

b) Inform and stimulate the personnel of the Educational sector and the channeling workers.

c) Establish standards which govern the activities intended to develop the Child Survival Plan

d) Prepare the instruments needed for carrying out the plan in coordination with the Ministry of Education, such as Manuals, Guides, learning aids, etc.

e) Prepare those responsible for training, both from the Educational Sector as well as from the Health Sector, at the respective Sectional levels

f) Discuss and popularize the Plan in every way that is available to it.

- The Sectional Health Services should:

a) Plan the progressive application of the strategy of extended channeling to the six programs of the Child Survival Plan, following the standards of the Ministry of Health for these programs and in accordance with actual conditions.

b) Inform and motivate officials of the Regional Secretariats of Education, the channeling workers and the Regional community.

c) Direct coordination with the Secretariat of Education and with other sectors to accomplish specific actions which develop the plan.

d) Train health personnel at the local level so that they may carry out the program

e) Inform, motivate and mobilize the community so that it accepts, supports and participates in the Plan.

- Local Health Units will have the responsibility of seeing that the doctors and nurses who serve in Mandatory Social Service:

  - Carry out the execution of the program in the high schools

    Train the channeling workers or "Health Sentinels".

    Plan and coordinate the activities of extended channeling.

  In addition, Local Health Units should also:

  a) Inform and motivate channeling workers

  b) Provide emblems to channeling workers

  c) Inform, mobilize and educate the community regarding the various aspects of the Plan.

II. IN THE EDUCATIONAL SECTOR.

- The Ministry of Education should:

  a) Prepare standards and indespensible directives in the educational sector for the execution of the program.

  b) Prepare, in cooperation with the Ministry of Health, the manuals, guides and learning aids needed to modify the contents and practices of the Behavior and Health Course.

- The Departmental Secretariats of Education should:

  a) Actively participate in the Training Workshops

  b) Plan the progressive implementation of the Plan in coordination with the respective Sectional Health Service.

  c) Inform Supervisors, Educators and Students about the Child Survival Plan.

- Local Level should:

  a) Participate in Training Workshops

  b) Develop the Behavior and Health Program in coordination with the respective Local Health Unit.

  c) See that each channeling workers wears his badge.

III. THE COMMUNITY.

In the communities, families should receive complete information by means of the mass media about the Child Survival Plan and the role of students and other workers who will serve as health sentinels in extended channeling, in order to establish a positive and receptive attitude toward the program.

In order to accomplish this goal it is necessary to prepare and obtain the solid support of the communications media: press, radio, television and others, supplying them with documents and favoring them with interviews and other activities which allow them to clearly know the goals of the Plan and its great social importance.

The students and other volunteers who may participate in the extended channeling program should have sufficient knowledge and motivation to create in them a positive and enthusiastic attitude toward carrying out the program.

CHILD SURVIVAL PLAN

COSTS - 1985 - 1989

PROGRAMS AND ACTIVITIES		1985	1986	1987	1988	1989	TOTAL
I.R.A	Personnel	14.5	32.5	33.0	16.0	-	96.0
	Training	5.0	10.0	10.0	5.0	5.0	35.0
E.D.A.	Training	10.0	10.0				20.0
P.A.I.	Serums and Syringes	202.4	129.6	155.4	185.6	255.2	928.2
	Cold Chain	15.0	17.4	20.1	23.4	27.1	103.0
PERINATAL DISEASES	Personnel	48.0	112.0	112.0	64.0	64.0	400.0
	Training	5.0	5.0	10.0	10.0	5.0	35.0
MALNUTRITION	Training	15.0	9.5				24.5
PSYCHOAFFECTIVE DEPRIVATION		15.0	10.0	5.0	5.0		35.0
CHANNELING	Production of Medications		10.0	20.0	20.0		50.0
	Training	89.3	72.9				162.2
	Publicity and Motivation	10.0	10.2				20.2
	Leaflets	10.0	32.5	32.5	20.0	12.4	107.4
	Personnel	3.7	12.5	12.5	7.6	4.7	41.0
WORKSHOPS MANUALS			20.0	30.0	40.0	60.0	150.0
TOTAL INVESTMENT.....		442.9	494.4	440.5	396.6	433.4	2,207.5
TOTAL OPERATION.....		6,605.3	7,662.3	8,888.2	10,310.3	11,959.9	45,426.0
GRAND TOTAL.....		7,048.2	8,156.4	9,328.7	10,706.9	12,393.3	47,633.5

CHILD SURVIVAL PLAN
FINANCING PLAN 1985-1989

SOURCE	1985	1986	1987	1988	1989	TOTAL
NATIONAL HEALTH SYSTEM- OPERATION	6,605.3	7,662.3	8,888.2	10,310.3	11,959.9	45,426.0
NATIONAL BUDGET - MOTHER- CHILD INVESTMENT	60.0	69.6	80.7	93.6	108.6	412.5
P.A.I.	100.0	129.6	155.4	185.6	255.2	825.8
E.D.A.	50.0	58.0	67.3	78.0	90.5	343.8
SUBTOTAL GOVERNMENT CONTRIBUTIONS	6,815.3	7,919.5	9,191.6	10,667.5	12,414.2	47,008.1
FINANCING COST	442.9	494.1	440.5	396.6	433.4	2,207.5
TOTAL.....	7,258.2	8,403.6	9,632.1	11,064.1	12,847.6	49,215.6

SEQUENCE OF ACTIVITIES FOR CARRYING OUT THE FIRST PHASE OF THE CHILD SURVIVAL PLAN

First Row:

MINISTRY OF EDUCATION

Makes the political decision
Establishes standards
Communicates them to the Secretariats of Education

THE SECRETARIATS OF EDUCATION

Coordinate with regional health services
Plan implementation of plan
Advise supervisors and principals

THE HIGH SCHOOLS

Coordinate with local health units
Prepare their work plan for developing extended channeling

Second Row

THE MINISTRY OF HEALTH SHOULD:

Negotiate political decisions
Publish and publicize plan
Establish standards
Prepare workshops

Holding of the first information workshop for the first group of health services and secretariats of education

HEALTH SERVICES

Coordinate with the Secretariats of Education
Prepare the execution of the six programs
rrepare for the implementation of channeling
Inform regional and local levels
Inform the community
Prepare local workshops

TRAINING OF HEALTH SENTINELS

ADJUSTMENT OF PROCEDURES

Third Row

LOCAL HEALTH UNITS

Holding of workshops for health personnel and teachers at local level

. Manage execution of plan in high schools
. Prepare for the execution of the six programs at the local level
. Plan and coordinate the activities of extended channeling at the local level
. Inform the community

First phase of execution for evaluation of procedures and materials

Fourth Row	DEFINITION OF CONTENT OF: Health record books Teacher's record books Local health manuals Brochures Posters Folders Calendars Insignias Family files Perinatal cards	CONTRACT FOR PRODUCTION	DESIGN	VALIDATION AND APPROVAL OF MINISTRIES	PRODUCTION OF EXAMPLES	DISTRIBUTION FOR FIELD TESTING	CORRECTION OF MATERIALS
Fifth Row	DEFINITION OF OBJECTIVES AND CONTENT OF PUBLICITY AIMED AT THE COMMUNITY RADIO T.V. VIDEO CASSETTE SIGHT AND SOUND	CONTRACT FOR PRODUCTION	DESIGN	VALIDATION AND APPROVAL OF MINISTRIES	EXECUTION OF PUBLICITY CAMPAIGNS		
Sixth Row	Study of tools, instruments and manuals for child workshops	Purchase of Items	Distribution to workshops workshops				

TELEPHONE PLAZA 4-1234

CABLE ADDRESS UNICEF

UNICEF

UNITED NATIONS CHILDREN'S FUND · FONDS DES NATIONS UNIES POUR L'ENFANCE

UNITED NATIONS, NEW YORK

MEMO TO: ALL BELLAGIO PARTICIPANTS

FROM: WILLIAM H. FOEGE, M.D.

DATE: OCTOBER 17, 1984

SUBJECT: UPDATE ON IMMUNIZATION ACTIVITIES

You have received the report developed by Colombia on their immunization activities. An evaluation of the program is currently being planned with the help of PAHO. They will share this evaluation with the Bellagio participants. In addition, of tremendous importance is that Colombia is now looking at how best it can learn from the immunization experience to expand primary health services in general. This is a most exciting exercise that will take place over the next months.

Senegal has requested the services of a technical operations officer and this person is currently in Dakar assisting in the detailed development of their national plan. Dr. Phillip Stoeckel arranged for a consultant from Management Services for Health to assess, with a Sengalese counterpart, the status of health projects involving the government of Senegal and outside groups. This investigation has provided a very useful background for the development of a detailed country plan.

India has a large amount of immunization activities taking place and the national commitment is obvious. The Secretary of Health, Mr. C.R. Vaidyanathan, has outlined their plans to have a national immunization program immunizing 20 million children under the age of 14 months by 1988. Various studies are underway in the country on vaccine delivery schemes and on different cold chain approaches. India is particularly interested in assistance to develop their own vaccine production capabilities and assistance in improving the cold chain. Short term assistance with vaccines will obviously be required until internal production meets the demand.

During the recent meetings in Calgary, a number of people (including Drs. Assaad, Lucas, Henderson, Halstad and Nossal) summarized the current immunization research initiatives in the world. Our interest was to

identify the gaps which require special attention from our Task Force. It was felt that the selection of vaccine development priorities and the coordination of vaccine development research is now well addressed by the combination of The Expanded Programme of Immunization, The Tropical Disease Research Programme, The Diarrheal Disease Control Programme and The SAGE Group organized by Dr. Assaad. The true gaps appear to be:

(1) Coordination and promotion of application research.

(2) Adequate funding of the vaccine research priorities which have been identified.

(3) Difficulties between vaccine development and commercial availability (manufacture, field testing, etc.).

Proposals to address these gaps are being developed.

The Task Force is now functional with the arrival of Mr. Bill Watson who has retired as Deputy Director of the Centers for Disease Control to devote full time to the objectives outlined in March 1984 at Bellagio. We are now in a position to more actively respond to needs and requests in the three countries and the research areas mentioned. We welcome your ideas at:

1989 North Williamsburg Drive
Suite I
Decatur, Georgia 30033
Telephone: (404) 325-2452/2453

Finally, noting the results in Colombia, the Inter-American Development Bank has been discussing possible roles in Primary Health Care development with PAHO. This is a most exciting prospect.

Bill

William H. Foege, M.D.

R1

TELEPHONE PLAZA 4-1234

CABLE ADDRESS UNICEF

1201

UNICEF

UNITED NATIONS CHILDREN'S FUND · FONDS DES NATIONS UNIES POUR L'ENFANCE

UNITED NATIONS, NEW YORK

10-25-84
TO: JOHN NORTH

MEMO TO: ALL BELLAGIO PARTICIPANTS

FROM: WILLIAM H. FOEGE, M.D.

DATE: OCTOBER 17, 1984

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Bill

William H. Foege, M.D.

THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

Bellagio

DATE February 14, 1985

TO Mesdames N. Birdsall and I. Husain; Messrs. S. Denning and E. Schebeck

FROM Anthony R. Measham Tony.

EXTENSION 61573

SUBJECT Bellagio Task Force

1. Attached are the minutes of the January 11, 1985 meeting of the Task Force, and a recent update on developments from Dr. William Foege, the Executive Director. I would appreciate your bringing these reports to the attention of staff, as appropriate.

Attachment

(5)

The Task Force for Child Survival
1989 North Williamsburg Drive • Suite I • Decatur, Georgia 30033
(404) 325-2452 • Telex 8107518512
Administratively Affiliated with Emory University

January 23, 1985

Ackn. 2/12/85

Anthony R. Measham, M.D.
Health Adviser
Health, Population and Nutrition
The World Bank
1818 H Street, N.W.
Washington, D.C. 20433

Dear Tony:

Please find enclosed a draft of the minutes of The Task Force meeting held in our offices on January 11, 1985. Please advise me of any suggestions or comments you may have regarding the minutes.

Sincerely yours,

Bill

William C. Watson, Jr.
Project Manager

Enclosure

MINUTES OF THE MEETING OF THE TASK FORCE
FOR CHILD SURVIVAL

JANUARY 11, 1985

A fourth meeting of The Task Force was held at The Task Force offices, 1989 North Williamsburg Drive, Decatur, Georgia, on January 11, 1985. In attendance were: Dr. Ralph Henderson, WHO; Dr. Ken Warren, Rockefeller Foundation; Dr. Steve Joseph and Mr. Newton Bowles, UNICEF; Dr. Tony Measham, World Bank; Dr. William Foege, Mr. Bill Watson, and Ms. Carol Walters of The Task Force staff.

SENEGAL

Mark LaPointe gave a report on Senegal, having returned to CDC in mid-December from a 3-month UNICEF assignment to Senegal. He distributed a report on the status of immunization activities in Senegal, and reported on a proposed plan of action which has been tentatively agreed upon by the Ministry of Health and the Dakar UNICEF office. The basic points of this plan are:

1. To begin an expanded, accelerated program in 10 geographic sites in Senegal. These sites were selected while Mark was there.

2. To conduct training courses for national, regional and departmental officials who will be involved in the program prior to the initiation of immunization activities. These courses will utilize the training modules developed by WHO and CDC, and will be patterned after similar training efforts conducted by WHO.

3. The Ministry of Health of Senegal has requested that Mark LaPointe return for a long-term (2-year) assignment to assist with their immunization activities. This assignment, as with Mark's short-term assignment, will be under the sponsorship of UNICEF.

4. The proposed plan calls for the development of computer software and programming, which will enable the program to collect and analyze data which is necessary to the conduct of the program and its evaluation.

5. In keeping with the discussions with the Ministry of Health and the UNICEF Dakar office before Mark returned in December, he has developed a budget proposal of $385,400 for the first year of activities.

Mark will develop a narrative program proposal to go with the budget projection, and will take this plan and budget to Dakar the latter part of January. He will be going to Chad on CDC business, and will stop in Dakar on the way. After approximately 4 weeks in Chad, he will come back by Dakar where Bill Foege and/or Bill Watson will join him to, hopefully, consummate agreement on the

plan. It will then go from the Ministry to the Dakar/UNICEF office and then to the UNICEF New York office. Task Force discussion focused on UNICEF support for the first year of this program, with long-term funding possibly coming from an existing World Bank loan.

INDIA

Mr. Watson and Dr. Foege reported that several organizations, other than the five Task Force agencies, either have ongoing or proposed activities in India. Rotary International has indicated to Dr. Foege that it would entertain a proposal from India to provide polio vaccine for the entire country for a 5-year period if the proposal is tied to an effective, overall plan for an immunization program. USAID and the Centers for Disease Control have projects which could directly or indirectly effect immunization activities in India. Several countries have evidenced interest in helping the Indians develop their vaccine production capabilities, for example, France, Canada and the United States. (Dr. Henderson warned that the vaccine production area is fraught with problems because some of the involved parties see this as an area for potential profit making.)

Several different ideas on how to proceed with respect to India were discussed:

1. The four Task Force agencies with representatives in India (WHO, UNICEF, The World Bank, and UNDP) could convene a meeting.

2. Dr. Mahler and Mr. Grant could approach the new Prime Minister and pursue the idea of an immunization campaign as a living memorial to Mrs. Gandhi.

3. The Task Force could employ a 60-90 day consultant to work in India --someone, perhaps, like Dr. Diesh.

4. The 10th anniversary of the eradication of smallpox in India, 1985, could be used as a springboard for an immunization campaign.

5. The Task Force could convene a meeting in India with both local and international representatives from the sponsoring agencies.

No agreement was reached on which of these various approaches should be taken. Everyone agreed that getting the input and advice of Mr. Haxton, the UNICEF representative in India, would be useful and important. Mr. Haxton will be in New York during the week of January 14. Dr. Joseph will consult with him and Mr. Grant and contact Dr. Foege. After that consultation, Dr. Foege and The Task Force staff will be in a better position to decide how to proceed.

VACCINE DEVELOPMENT

At lunch, discussion focused on how to assay progress in vaccine research and development, how to predict the availability of various vaccines for field use, and how to determine what needs to be supported. Dr. Warren reported that the Rockefeller Foundation is sponsoring a study and will be issuing a report in February or March. It was agreed that Dr. Foege will use this report as a tool in determining next steps. There was some sentiment in favor of The Task Force employing a temporary technical consultant to work in this area.

NIGERIA

After lunch, Dr. Stan Foster, of CDC, reported on immunization activities in Nigeria. In the next few months, Nigeria will launch what sounds like a very well-planned campaign. He gave Mr. Richard Reid, the UNICEF representative in Nigeria, a great deal of credit for the development of this program. It calls for launching a campaign in one department in each of Nigeria's 19 States. Senior and mid-level personnel have been trained in immunization program management. Appropriate equipment (vehicles, needles, vaccine) have apparently been procured, and the equipment for a functioning central cold chain in each of the departments is in place. There is also a well developed plan to integrate these campaigns into the ongoing primary health care programs.

COLOMBIA

Dr. Steve Jones, of CDC, reported on the status of the evaluation of the Colombia program. The Commission charged with conducting this evaluation is scheduled to meet in Colombia February 11-15. Dr. de Quadros, of PAHO, and Dr. Jones are scheduled to participate. Dr. Jones said that the Colombians have a record of good health work, and he expects that this evaluation will be competently and effectively done.

"BELLAGIO II"

The discussion then moved to the "Bellagio II" meeting to be held in Cartagena, October 14-17, 1985. Dr. Warren reported on his recent trip to Colombia, during which it was agreed that the President's villa in Cartagena would be available for the meeting. Dr. Joseph also reported on his recent visit to Colombia. Dr. Duque has been named coordinator of the meeting for the Colombian government. The Colombians have suggested that President Betancur send a letter of invitation following the initial one from the heads of the five sponsoring Task Force agencies.

There was then a discussion of the agenda for the meeting. It was agreed that the following topics should be included:

1. Colombia Experience
2. Requirements to Achieve the 1990 WHO Objectives for Immunization
3. Summary of Activities Since "Bellagio I"
4 Contribution of Immunization to Primary Health Care and Appropriate Next Steps
5. Status of Vaccine Development

Within this basic agreement, The Task Force staff will work out details which will be discussed at the April meeting. Dr. Joseph suggested that Dr. Duque be invited to attend that meeting. In addition to the original "Bellagio I" participants, it was decided the following will be invited to Cartagena: Dr. David A. Hamburg, President of Carnegie Corporation of New York; Mr. Franklin A. Thomas, President of The Ford Foundation; Mr. Paul Doolen, Chairman, The MacArthur Foundation; Dr. Carlyle Guerra de Macedo, Director, PAHO; Mr. Robert Smith, President of the Pew Memorial Trust; Mr. Herbert A. Pigman, General Secretary of Rotary International and the Ministers of Health of Bangladesh, Brazil, Burkina Faso, Egypt, France, India, Indonesia, Japan, Nigeria, Pakistan and Russia.

How was this developed? Why Ministers of Health & ? France, Japan. Why not Laird himself? 2/14 BEING CORRECTED. Ann.

The two letters of invitation to the Cartagena meeting were reviewed and changes made. These letters will be written on the new Task Force stationery and sent to the Task Force representatives. After each agency head's signature is secured, the letters will be returned to the Atlanta Task Force office. The Atlanta office will then consolidate the signatures onto one page and mail the letters.

A mock-up of the proposed Task Force letterhead was reviewed. One change was proposed, and then the group approved its printing. Dr. Joseph requested that each Task Force representative be provided a large copy of the Task Force logo.

OTHER ITEMS

Dr. Foege reported that during the week before Christmas, a request for 50,000 doses of measles vaccine and jet injectors for Ethiopia was received from a relief agency. With the cooperation of CDC and WHO, the Task Force was able to respond to this request within 48 hours. He also mentioned that a meeting to discuss research and development of improved jet injectors will be held with Colonel Franklin Top of Walter Reed within the next few weeks.

Mr. Watson distributed a skeletal research and development matrix, which the Task Force staff will be completing in consultation with technical experts from CDC and perhaps other places. Suggestions and comments from the Task Force members were requested.

Dr. Joseph suggested that the April Task Force meeting be a "think tank" to discuss the organization of The Task Force office and long-range planning. Dr. Henderson suggested that the Cartagena working papers be decided upon and assigned in April. There was a request that the meeting with Pritech be changed from April 5 to the morning of April 4, and that The Task Force meet the afternoon of April 4 and April 5.* It was tentatively agreed that the Task Force will meet July 23-24 in New York.

*This change has been made with Pritech.

The Task Force for Child Survival
1989 North Williamsburg Drive • Suite I • Decatur, Georgia 30033
(404) 325-2452 • Telex 8107518512
Administratively Affiliated with Emory University

~~JDN~~
ARM

February 8, 1985

Mr. John North
Director
Health, Population and Nutrition
The World Bank
1818 H Street, N.W.
Washington, D.C. 20433

Dear Mr. North:

This is the third in our series of reports to keep you updated on activities since we met in Bellagio, Italy last March.

As you know from our previous reports, Colombia completed the third of its three planned Jornadoes, or National Immunization Days in which the Colombians estimate that a total of five million doses of vaccine were given. The program in Colombia continues to receive strong political support from President Betancur and others, and the level of enthusiasm for the program continues. Evaluation of the program is now going on, and is expected to be completed in February 1985. Technical consultants from the Pan American Health Organization and CDC visited Colombia in November 1984 to assist and advise in the development of the evaluation activities. The Colombians continue to take enormous pride in what they have accomplished, and are now taking the next step, namely, developing their Primary Health Care program on a long-term basis.

Colombia has invited us to hold "Bellagio II" in Cartagena, and the Task Force has accepted their gracious offer. The meeting will be held October 14-17, and you will be receiving an invitation to attend in the very near future.

Dr. D.B. Bisht, Director-General of Health Services in India, visited with us in Atlanta October 15-17, 1984. From this visit, subsequent correspondence, and from my visit to India, it appears that collaboration with India will fall into three general areas: (1) collaboration in developing their vaccine production, particularly for polio and measles vaccine; (2) working with them to procure additional vaccines until production is geared up; and (3) improvement of their cold chain system. Mr. Rajiv Ghandi, the newly elected Prime Minister of India, has committed his government to an expanded national immunization program which is included in their new 5-year plan.

Mark LaPointe has completed a 90-day detail to Senegal under the aegis of UNICEF to assist in the development of a plan for their immunization program. We expect that this plan will be completed within the next few weeks and forwarded to UNICEF for action. Part of this plan calls for Mark to return to Senegal for a 2-year assignment as a consultant under the sponsorship of UNICEF. The plan, as conceived, calls for initiation of accelerated programs in 10 selected sites in Senegal, and a training program for personnel engaged in the program.

Burkina Faso completed a 10-day immunization campaign in December 1984. The enclosed information indicates that they, too, met the goals they set for themselves. Dr. Stoeckel's APMP was instrumental in this undertaking, and Russ Charter was there on short-term assignment under the sponsorship of UNICEF. They are now in the process of developing a follow-on long-term program, and plans are being developed for Russ to return on a long-term, 2-year assignment, again under the sponsorship of UNICEF.

Richard Reid, the UNICEF representative in Nigeria, visited Atlanta in December 1984. Nigeria has launched a very well planned campaign. Initially, the campaign will include one department in each of Nigeria's 19 States. Senior and mid-level personnel have already been trained in immunization program management. Appropriate equipment (vehicles, refrigerators, needles, and vaccine) has been procured. Early data indicates that immunization levels of over 80 percent are being achieved. There is also a well developed plan to integrate these campaigns into the ongoing primary health care programs. Nigeria has the largest population of any country in sub-Sahara Africa, and the development of a model program there could be important to the entire continent. The UNICEF representative in Lagos has been instrumental in assisting in the development of the program. As in Senegal and Burkina Faso, part of the future UNICEF contribution will be the assignment of an additional full-time consultant for a 2-year period. He will arrive in Nigeria on February 10, 1985.

Enclosed is mortality data which we have just received from a survey in Liberia. These data confirm once again the enormously high death rate among young children, so much of it from the vaccine preventable diseases.

Drs. Donald Francis and Roger Bernier of CDC, utilizing a paper developed by Dr. Rafe Henderson of WHO, are taking the lead in developing a priority list of the top 10 or 12 research and development projects which would contribute most to the improvement of immunization programs and which, hopefully, can be completed in a short time frame. A meeting on how to improve and expedite the process from vaccine discovery to actual vaccine use will be held at the Salk Institute on March 18-20, 1985.

Sincerely yours,

William C. Watson, Jr.

for William H. Foege, M.D.
Executive Director

Enclosures

EXCERPTS FROM CABLES
(DATED DECEMBER 12th AND DECEMBER 14th, 1984)
FROM UNICEF, OUAGADOUGOU, BURKINA FASO

Final data for 23 out of 30 completed provinces is:

VACCINE	NUMBER VACCINATED	PERCENT TARGET POPULATION
Measles	942,283	72
Yellow Fever	1,571,651	60
Meningitis	2,086,097	80

Total data for seven partial provinces and 23 completed provinces is as follows:

VACCINE	NUMBER VACCINATED	PERCENT TARGET POPULATION
Measles	1,035,515	79
Yellow Fever	1,804,519	69
Meningitis	2,307,163	89

A random sample evaluation (will be) conducted in early 1985 to determine the vaccination coverage. (The UNICEF consultant) recommends that a stratified random sample be used in order to obtain valid coverage data for each province as well as the nation. Without good statistical base line data on each province, it will be very difficult to measure any improvements made my EPI. UNICEF and WHO should make every effort to assist the government in conducting an evaluation which will provide valid data by province.

"Vaccination commando" (with all its problems and shortcomings) can be termed a success for many reasons:

1. The population was mobilized beyond all expectation.

2. The population was informed about vaccinations and what they do for each person.

3. Large quantities of vaccine were administered across the country in a relatively short period of time - 15 days.

4. The government has focused the population's attention on preventative health measures, and thus has provided a foothold from which to launch EPI.

5. The government and the people have proved to themselves that when they determine to accomplish something, given the resources, they can achieve their goal.

The real proof of success will be provided during the months of January through May when measles, yellow fever, and meningitis diseases normally occur in epidemic proportions in Burkina Faso. If only small outbreaks or scattered cases of these diseases are seen among the target populations then the campaign can be termed a real success. After all the real goal of "vaccination commando" was to reduce the incidence of these diseases among the target population and thereby reduce infant mortality caused by the diseases.

LIBERIA
CAUSE OF DEATH IN CHILDREN UNDER 5 YEARS

CAUSE	NUMBER	PERCENT
All	1,380	100
Tetanus	96	7
Measles	311	23
Diarrhea	274	20
Malaria	167	12
Unknown	155	11
Uncoded	213	15
Other	164	12

THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

Date: November 1, 1984

To: Mr. John North, Director, PHND

From: Anthony R. Measham for A R Measham SK

Extension: 61573

Subject: Bellagio Task Force Meeting - October 31, 1984

1. This brief note describes the highlights of this third meeting of the Task Force, the second hosted by the Bank. In attendance were Dr. William Foege and Mr. William Watson (Task Force secretariat), Dr. Rafe Henderson (WHO), Dr. Stephen Joseph and Mr. Newton Bowles (UNICEF), Dr. Ken Warren (Rockefeller) and myself. The agenda is attached as Annex I.

Progress

2. Dr. Foege believes the Task Force now has real direction and momentum. He, Rafe Henderson, Steve Joseph and Ken Warren all consider Colombia to have been a great success. The three campaign days helped raise immunization coverage to about 60%, from 43% in 1983 and 27% in 1982. The Colombians are extremely enthusiastic. They have requested the Task Force to send six technical experts to help them develop a broader PHC strategy. They would also like to host Bellagio II. The Task Force will try to meet the request for technical assistance, and the group agreed that the invitation to hold Bellagio II in Colombia should be accepted.

3. Rafe Henderson reports a growing enthusiasm for campaigns as an important tactic in a longer term strategy. Bill Foege says he is much more positive about campaigns that he ever thought he would be. We recalled the important role of "oral polio Sundays" in the U.S., and agreed that campaigns have a place when the infrastructure is reasonably well developed.

4. Dr. Foege expects that Senegal will have a plan for a nationwide campaign to present to the donors before the end of the year. In India, there were many recent positive developments but Mrs. Gandhi's assassination

makes it unclear what contribution the Task Force can make there. India has been moving rapidly toward a plan to achieve full national coverage by 1988. They were seeking assistance principally in the areas of vaccine production and the cold chain.

5. Other countries - Burkina, Nigeria, El Salvador - were reported to be interested in Task Force assistance. The group agreed that requests from other countries would receive a positive response to the extent that this was feasible without short-changing Colombia, India and Senegal.

Budget

6. The Task Force budget through 1985 is attached as Annex II. So far, UNICEF and WHO have each contributed $50,000, and Rockefeller, $35,000. The group would like a total of $75,000 from the Bank, and asked that we process the $25,000 for this fiscal year as soon as possible. It should be channelled through UNICEF.

Bank Role

7. I reiterated our desire to help with economic analysis and project evaluation. The offer was well received but no specific requests emerged. I also stressed our concerns about developing a solid proposal for Bellagio II that would show what had been accomplished and learned, and chart a clear course for the future. The group favors developing a concrete proposal although the strategy is not yet clear. (Attached as Annex III is a note from Dr. Foege entitled "Plans before Bellagio II meeting".) What seems likely to emerge is a proposal for a larger Task Force effort along current lines, i.e. no call for major resources and no new institutional mechanisms, but rather an expanded catalytic and facilitating role. Bellagio II might then be oriented more towards fomenting donor and country commitment to expanded immunization and PHC efforts, rather than a funding exercise.

Research

8. The group agreed to ask three individuals to review Rafe Henderson's paper on priorities in immunization, to see if the Task Force should play a role in stimulating more research, especially applied research. The three reviewers would report to the next Task Force meeting.

Meeting with Mr. Husain

9. Dr. Foege and I had a useful meeting with Mr. Husain, who asked how the Bank might help. Dr. Foege asked if we could provide someone for the technical assistance mission to Colombia, and small amounts of funds in Senegal and Colombia. Mr. Husain said he thought we would be able to send someone to Colombia for the 1-2 week mission, (perhaps in December) and said it was possible that our projects in Senegal and Colombia might provide an avenue for support to immunization. He asked me to follow-up, which I have done with Aubrey Williams, Steve Denning and Willy De Geyndt. There are savings in the Senegal project that could be used for this purpose. There is provision for immunization support in the Colombia project, but perhaps more could be done if requested by the government.

Conclusion

10. The Task Force appears to be on track and doing good work. This meeting was productive and congenial, and the foundations were laid for developing a strategy and well-defined proposal for Bellagio II. The next Task Force meeting will be held in Atlanta on Friday, January 11, 1985.

cc: Mr. S. Denning
Ms. K. Hall
Mr. E. Schebeck
Dr. B. Liese
Ms. N. Birdsall
Mr. A. Williams
Mr. W. De Geyndt

ARMeasham:sr

Annex I

TASK FORCE FOR CHILD SURVIVAL MEETING

October 31, 1984
10:00 a.m. - 5:00 p.m.

The World Bank
801 19th Street, NW
Washington, D.C.

PROPOSED AGENDA

I. Status Reports - Dr. Foege

- A. - Colombia
- B. - India
- C. - Senegal
- D. - Calgary Meeting
- E. - Upper Volta

II. Collaboration

III. Status of Administrative Arrangements - Mr. Watson

IV. Other Items:

- A. - Colombian invitation to host meeting.
- B. - Group to advise Colombia in December.
- C. - Proposals for research involvement.

BUDGET PROJECTIONS

	10/1/84-6/30/85 (9 months)	10/1/84-10/1/85 (12 months)	10/1/84-12/31/85 (15 months)
Personnel (Project Director, Office Manager, two Secretaries)	$101,631	$137,153	$172,719
Rent, Utilities (electricity only) and Insurance	7,430	9,243	12,718
Purchase of Furniture	7,300	7,300	7,300
Installation of Phones	775	775	775
Communications (monthly telephone/postage)	3,717	4,956	6,195
Office Supplies	3,735	4,980	6,225
Equipment (dictation, copier, postage meter)	1,900	2,500	2,947
Word Processing (purchase and maintenance)	9,800	10,174	10,450
Printing	3,753	5,000	6,255
Travel	56.250	75,000	93,750
TOTAL	$196,291	$257,081	$319,334
8% Overhead (Emory Univ.)	15,703	20,556	25,547
GRAND TOTAL	$211,994	$277,637	$344,881

ONE TIME EXPENDITURES

Purchase of Furniture	$ 7,300
Installation of Telephone	775
Purchase of Transcribing Equipment	475
Purchase of Word Processing Equipment	9,070
Purchase of Copier	1,500
TOTAL	$19,120

PLANS BEFORE BELLAGIO II MEETING

I. INTRODUCTION AND OBJECTIVES

In March 1984, thirty-four world leaders participated in a conference in Bellagio to consider the subject of better protecting the health of the world's children. At that meeting, the formation of an Ad Hoc Task Force for Child Survival was proposed and endorsed by all participants. Dr. William Foege of The Centers for Disease Control was asked to serve as Executive Director of the Task Force, which would be responsible to a group consisting of five agencies: WHO, UNICEF, UNDP, The World Bank and The Rockefeller Foundation. Dr. Foege has been approved by the Director of CDC to work up to half time for the Task Force, and the five agencies to whom he reports have agreed to furnish him with a small staff and logistics support. The objective of this Task Force as spelled out in the Bellagio Conference Report and agreed to in subsequent meetings of the five sponsoring agencies are:

1. To develop nationwide immunization plans for Senegal, Colombia and India.

2. Begin program activities in each of these countries within the first year with a view toward developing an operational program throughout each country within four years.

3. To promote the integration of other procedures such as oral rehydration, family planning and other primary health care activities in pilot areas in each country.

4. To examine the experience of these first three countries in terms of implications for other countries and develop a strategy for accelerating the immunization activities in developing countries.

5. Accelerate the identification of basic and applied knowledge gaps to effective and efficient immunization programs and promote research to close those gaps.

6. Develop an agenda for a second meeting in Bellagio in October 1985.

II. PROPOSED PLAN OF ACTION TO MEET OBJECTIVES

The following proposed plan of action to meet the objectives was developed by Dr. William H. Foege, Executive Director of The Task Force for Child Survival in Atlanta, Georgia:

A. General

1. Develop an operating arrangement with the five sponsoring agencies to coordinate activities so as to enhance work already being accomplished in immunization, oral rehydration therapy and primary health care.

2. Develop a familiarity with and understanding of the global interests, resources, and activities involved in immunization and primary health care.

3. Develop a familiarity with and understanding of the people and activities in the target countries of Colombia, India and Senegal.

4. Identify and develop an inventory of donors who might contribute or increase contributions for the program. Work with the five sponsoring agencies to contract and/or visit with possible donors before Bellagio II.

5. Develop a projection of funding needs for use in the above visits and discussions.

6. Develop periodic memos or other forms of communication with Bellagio participants to keep them informed of progress.

7. Identify world leaders in government and the private sphere to serve as Board(s) of Consultants to provide publicity, assistance, recommendations, etc.

8. Develop an agenda for Bellagio II.

9. Develop proposals for activities to be undertaken after Bellagio II.

II. PROPOSED PLAN OF ACTION TO MEET OBJECTIVES (continued)

B. Research

1. Determine research gaps in both biotechnology and operations and determine where the Task Force should put its emphasis.

2. Develop a plan to obtain support for key research activities.

3. Provide mechanisms for coordinating the exchange of information for:

   - research needs from the field

   - research findings for the field

4. Investigate the possibilities for solving or improving problems with the cold chain through both engineering and biological approaches.

5. Initiate a systems approach review of vaccine delivery to identify areas that could improve efficiency and effectiveness.

6. Identify key needs from vaccine discovery to vaccine delivery which might facilitate global immunization program.

C. Country Specific Plans

1. Senegal

   Develop a long-term national plan for immunization and primary health care, including the following:

   i. A statement of the problem.

   ii. A projection of resource needs.

   iii. Plans for staging immunization, evaluating the program and adding other components to the program.

   iv. A plan for outside assistance (including implementation).

   - commodities

   - personnel

   - other

II. PROPOSED PLAN OF ACTION TO MEET OBJECTIVES (continued)

C. Country Specific Plans (continued)

2. Colombia

Develop a long-term national plan for immunization and primary health care, including the following:

i. A statement of the problem.

ii. A projection of resource needs.

iii. Plans for staging immunization, evaluating the program and adding other components to the program.

iv. A plan for outside assistance (including implementation):

- commodities

- personnel

- other

v. Develop a response to Colombia's request for a technical team to assist them in improving their primary health care system.

3. India

Determine where the Task Force can best assist India in:

i. Planning their country-wide effort.

ii. Providing vaccines to other commodities.

iii. Evaluating their activities.

iv. Providing assistance and consultation in their vaccine production effort.

v. Assist in implementation of those plans.

THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

J.S Nath
Bellagio

Date: October 30, 1984

To: Mr. S. Shahid Husain, Vice President, Operations Policy

From: Anthony R. Measham, Acting Director, PHN

Extension: 61573

Subject: Briefing Note for Meeting with Dr. William Foege

1. This is a background note for the meeting you requested with Dr. William Foege, which is scheduled for 4.30 pm, Wednesday, October 31, 1984. I plan to accompany Dr. Foege.

2. Dr. Foege is a distinguished physician epidemiologist with extensive experience overseas, mainly in India and Nigeria. He was a leading figure in the global smallpox eradication program and served as director of the Centers for Disease Control in Atlanta from 1977 to 1983. After playing a leading role in the Bellagio Conference in March 1984, Dr. Foege was chosen to lead the Bellagio Task Force composed of WHO, UNICEF, UNDP, the Rockefeller Foundation and the Bank. Dr. Foege is devoting half of his time to this effort, with his salary paid by the Centers for Disease Control (CDC), where he is a special adviser to the director. He is assisted by two epidemiologists paid by the CDC, plus 2 managers and two secretaries.

3. As you will recall, the Bellagio Task Force is devoting most of its attention to catalyzing nationwide immunization efforts in Colombia, Senegal and India. Dr. Foege has spent much of his time since March in these efforts, plus, more recently, on similar activities in Burkina. Three national immunization days in Colombia are reported to have been highly successful, with over 800,000 children immunized on each occasion. An evaluation of this effort by the Pan American Health Organization is currently under way. The efforts of the Task Force in Senegal are also reported to be successful, although details are not available. (Dr. Foege will provide a progress report to the Task Force members on October 31, 1984). In India, progress to date has been slower.

4. The meeting this week will be the third for the Task Force and the second one hosted by the Bank. The key item on the agenda will be the work plan proposed by Dr. Foege and his colleagues for the period between now and October 1985, when a second Bellagio meeting is scheduled.

5. The Bank has not been heavily involved so far in the work of the Task Force. We have offered to assist both in economic analysis and in program evaluation, but these offers have not yet been taken up. WHO and UNICEF have worked closely with Dr. Foege, but other Task Force members have been less active. We intend to offer our services again at this week's meeting.

6. Each of the Task Force members has been requested to provide $50,000 to support the work program. WHO and UNICEF have already contributed. We expect to follow suit soon, as indicated in our recent memo (Schebeck to van der Tak, October 19, 1984).

cc: Mr. J.D. North o/r
Mr. S.M. Denning
Mr. E. Schebeck
Dr. B. Liese
Ms. K. Hall

ARMeasham:sr

THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

(1) AM. Thanks. Would you please draft a note which I could send to AWC to bring him up to date? See my queries above

(2) Return to JDN

Date: January 14, 1985

To: Mr. John North

From: Anthony R. Measham Tony.

Extension: 61573

Subject: Bellagio Task Force Meeting, Atlanta, January 11, 1985
Back-to-Office Report

1. The Bellagio Task Force secretariat - Dr. Foege and his colleagues - hosted this fourth meeting of the group. It was a productive meeting with a great deal to report and discuss (please see attached agenda), and a shared conviction that the Task Force is rapidly becoming an important actor in immunization efforts, and in fostering effective collaboration between its members (WHO, UNICEF, UNDP, Rockefeller Foundation and the Bank).

Status Reports

2. Senegal. Mark Lapointe reported on his short-term assignment which has resulted in a revised proposal to cover 1.5 million (out of 6 million) individuals in all ten administrative areas of the country, with a one-year budget of $385,000. Lapointe will return to Dakar to assist the Senegalese authorities in presenting the proposal to UNICEF, which is expected to fund it and a two-year assignment for him. This represents a pilot project using the "plan as you go" technique that worked well in the smallpox eradication campaign. We discussed the possibility that years 2 and 3 might be funded from the savings in the Bank-financed project. Lapointe will follow up on this and plans to contact Aubrey Williams. All agreed that the revised approach in Senegal is much more likely to be feasible than the original large and costly proposal.

What's the ?

3. Colombia Drs. Steve Joseph and Steve Jones (CDC) gave first-hand accounts of activities in Colombia, which appear to have been very successful. The PAHO-led international evaluation commission returns to Bogota February 11 to review the final report. I have reviewed the preliminary report (given to me in Spanish by Dr. Ciro de Cuadros of PAHO). If the evaluation

meets its objectives, it will provide just the kind of evaluation of impact, cost-effectiveness, and lessons learned that we have been seeking. Dr. de Cuadros urged me to join the February commission but the Zimbabwe mission rules that out. However, Steve Denning has agreed that Willy de Geyndt should try to join the group.

What will February do?

4. India. Task Force efforts to catalyze a meeting to discuss India's national program have not yet borne fruit. However, there is significant Indian interest and Dr. Bish, Director General of Health, recently visited Atlanta. In addition, Jim Grant has suggested to Prime Minister Rajiv Gandhi that the expanded immunization effort be made a "living memorial" to Mrs. Gandhi. Dr. Foege will coordinate efforts to arrange a meeting in India as soon as possible. One possibility discussed was for the Task Force to see if the Indian authorities would welcome discussions with donors interested in providing assistance (SIDA, Denmark, AID, CIDA and Rotary International have expressed interest). Another option discussed was to hold a future Task Force meeting in Delhi.

5. Burkina Faso. Early returns show that Project "Commando" achieved the following:

Vaccine	No. Vaccinated	% of Target
Measles	1,035,515	79
Yellow Fever	1,804,519	69
Meningitis	2,307,163	89

6. Nigeria. Dr. Stan Foster reported on a successful effort in Oyo State that raised coverage from 8% to 80% with UNICEF assistance. Dr. Foster believes a campaign approach is required in Lagos to deal with measles.

7. Ethiopia. The Task Force succeeded in coordinating a response to a request that resulted in jet injectors and vaccine arriving in Addis within 48 hours!

8. Bellagio II. We agreed that the main agenda would be:

a) How to reach the 1990 goal of universal access to EPI vaccines.
b) Lessons learned in Colombia, Senegal, India, etc.
c) The state of the technology.
d) How best to integrate immunization into PHC.
e) Proposed future activities of the Task Force.

Assignment of background papers and other tasks would take place in a 1-1/2-day meeting to be hosted by the Bank on April 4-5, 1985. It was proposed to add diarrheal disease control (CDD/ORT) to the agenda of Bellagio, and to invite Mike Merson. I suggested that family planning be considered in addition to, or instead of, diarrheal disease control. It turns out that Dr. Foege is writing a paper with D.A. Henderson that recommends immunization, CDD and family planning as the three key PHC interventions. How this will be handled on the agenda will be the subject of further discussion.

9. Preparations for Bellagio II are moving along nicely. We commented on draft invitation letters which will be finalized and sent for agency head signature. President Betancur will also write to each invitee. We also discussed at length increased developing country participation in Bellagio II. Likely additions are: Nigeria, Burkina Faso, Egypt, Pakistan, Bangladesh, Brazil, Bolivia, and El Salvador.

10. Campaigns. Although most, if not all, Task Force members began as skeptics about campaigns, a significant shift appears to be occurring. The evidence from Brazil (I will circulate this) and Colombia appears to attest to cost-effectiveness of campaigns. Moreover, seasoned hands like Stan Foster see a role for campaigns even in Africa, for example, in urban settings, or when carefully linked to an overall strategy. We should keep an open mind on this issue, in my view.

11. There is an emerging consensus in the Task Force that it can play a major role in promoting greater efforts in EPI, PHC more generally, and in improving donor coordination. This clearly needs to be articulated with care and precision in time for Bellagio II.

cc: Mesdames N. Birdsall
I. Husain
K. Hall
N. Maraviglia
Messrs. S. Denning
A. Berg
Dr. F. Sai
Messrs. D. Hodgkinson
W. De Geyndt (with Colombia Report)
D. Radel (with Nigeria paper)
H. Jones
A. Williams (with Senegal Report and Burkina Faso telex)
Dr. M. Porter
Dr. A. Prost

ARMeasham:sr

THE TASK FORCE FOR CHILD SURVIVAL
January 11, 1985
10:00 a.m. - 4:30 p.m.

Proposed Agenda

I. Status Reports

A. Senegal
- Report by Mr. Mark LaPointe

B. India

C. Colombia

D. Burkina Faso

E. Vaccine for Ethiopia

II. Bellagio II Meeting

A. Report by Drs. Joseph and Warren Re: Arrangements of Meeting in Cartagena

B. Agenda

C. Invitations

D. Additional Invitees

III. Status Reports (continued)

A. Nigeria
- Report by Dr. Stan Foster

B. Colombia
- Report by Dr. Steve Jones

IV. Other Items

A. List of Donors

B. Salk Institute Meeting in March

C. Meeting with Military (Franklin Top)

D. Research and Development Matrix

E. Bellagio Status Report

F. Information Repository

V. Administrative Matters

A. Status Report

B. Letterhead

C. April Meeting

Bellagio

MINUTES OF MEETING OF
THE TASK FORCE FOR CHILD SURVIVAL

31 October, 1984

A third formal meeting of The Task Force was held at The World Bank in Washington, D.C. on October 31, 1984. In attendance were Drs. Ralph Henderson, WHO; Steve Joseph, UNICEF; Ken Warren, The Rockefeller Foundation; Tony Measham, The World Bank; William Foege, CDC; Messrs. Newton Bowles, UNICEF; and William Watson, Task Force, Atlanta.

At the beginning of the meeting Dr. Joseph suggested that the group focus first on programmatic matters and take up administrative matters at the end of the day. This course of action was agreed to by the group.

Mr. Measham stated that he had received a letter from Dr. George Curlin of USAID indicating that they were making $6 million available to the U.S. Public Health Service for vaccine development. Mr. Measham stated that any suggestions from The Task Force as to appropriate activities for the Public Health Service to undertake in this connection would be welcome.

Dr. Warren reported on a meeting of Grantmakers in Health on October 22-23, 1984 at Rockefeller University dealing with international health. This was the first meeting of this group in which they focused on international health activities, and Dr. Warren stated that there was a lot of enthusiasm.

Colombia

Dr. Foege then reported on the status of the program in Colombia. Colombia has completed the third of its three planned Jornados, or National Immunization Days. The last of these Jornados on August 24, 1984 was observed by Dr. Macedo, the Director of the Pan American Health Organization, Dr. Foege, Mr. Watson, and representatives from several other countries. The campaign in Colombia continued to receive strong political support from President Betancur and others, and the level of enthusiasm for the program was maintained throughout all three days. Data from the program is preliminary but indicates that the goals that the Colombians set for themselves were met. Evaluation of the program is now going on and is expected to be completed by December of 1984. Technical consultants from the Pan American Health Organization and CDC recently went to Colombia to assist and advise in the development of the evaluation activities. The Colombians continue to take enormous pride in what they have accomplished and are now asking for technical experts to advise them as to where they go from here in developing their Primary Health Care programs. Dr. Foege asked whether The Task Force could arrange for a person to serve on the team to provide this advice. It was agreed that The Task Force could and should do this, but that the team should work through the PAHO and UNICEF representatives in Colombia who have been asked to take the lead in this effort.

The discussion then moved to the next Bellagio meeting. Dr. Warren stated that the Bellagio conference center had been reserved for the period October 14-17, 1985. Dr. Foege informed the group that when he was in Colombia, the Colombians told him that they would like to host the next "Bellagio" meeting, perhaps in Cartagena. After considerable discussion, the group agreed that there would be advantages to holding "Bellagio II" in Colombia, and that Dr. Foege would check with appropriate Colombian officials to verify their invitation. It was the concensus of the group that the meeting would be sponsored by The Task Force, but hosted by Colombia. After confirmation from Colombia, Dr. Foege is to draft a letter to the original attendees at "Bellagio I" for review by the sponsors.

Inter-American Development Bank

Dr. Foege then reported on a luncheon meeting he had attended sponsored by the Inter-American Development Bank. Representatives of the Bank evidenced an interest in and support for The Task Force program. Specifically, they indicated an interest in supporting a program for developing regional plans for supporting immunization, such as regional evaluation teams. It was decided that Dr. Foege would continue to work with PAHO to develop a plan of this sort.

World Bank Assistance with Program Evaluation

Dr. Measham offered the help of The World Bank in evaluating programs. The Bank can be particularly helpful with economic analyses.

India

Dr. Foege then reported on his trip to India this summer from June 22 to August 5, 1984. While the purpose of his trip was not primarily to discuss immunizations, he had considerable discussion on this subject with several Indian officials while he was there. Many immunization activities are underway in India, but they are not well coordinated. The Secretary of Health indicated to Dr. Foege that they are developing a national immunization plan, which includes measles vaccine, aimed at reaching 20 million children per year under one year of age. The Indians estimate that they are now immunizing 12 million children a year; however, they are not all in the right age group. From Dr. Foege's visit to India and from Dr. Bisht's subsequent visit to Atlanta, it appeared that India would need assistance in three areas: (1) assistance in developing their vaccine production, particularly for polio and measles vaccine; (2) assistance in purchasing additional vaccines until production is geared up; and (3) assistance with cold chain problems. Concern was expressed by the group about the impact on the program of Mrs. Ghandi's assassination, which had occurred the day before.

Polio Vaccine

Following a discussion concerning the relative merits of oral and inactivated poliomyelitis vaccines, The Task Force reaffirmed that both vaccines are highly effective and that the major problem in countries where polio remains uncontrolled today is not with the choice of one instead of another vaccine, but with the failure to apply either vaccine to a high proportion of susceptible children.

Oral polio vaccine has been endorsed for routine use in developing countries by WHO/EPI because of its widespread availability and lower cost per dose, but WHO has also encouraged research concerning the use of inactivated vaccines in developing countries, recognizing the high efficacy of the newer vaccines in schedules involving a two-dose schedule, and the logistic advantages such schedules bring. The Task Force strongly encouraged that studies on IPV be supported including, in particular: studies shedding light on the efficacy of a single dose; the earliest age at which immunization can be initiated; and the minimum interval between doses in multiple dose schedules.

Senegal

Mark LaPointe is currently on a 90-day detail to Senegal under the aegis of UNICEF to assist in the development of a plan for their immunization program. This plan is scheduled to be completed in November or December. It is conceivable that the short-term LaPointe assignment will evolve into a long-term one or two-year assignment of a consultant.

Calgary Meeting - Research Needs

Dr. Foege then reported on the meeting held on September 17-19, 1984, in Calgary, Canada to discuss research and development needs. At that meeting, there was a concensus that R&D efforts need to focus on three areas: (1) application or operational problems; (2) fund raising for vaccine research; and (3) how to improve and expedite the process from vaccine discovery to actual vaccine use. Dr. Warren expressed strong concern about the lack of effort going into the development of vaccines for many diseases, but specifically for the diarrheal and parasitic diseases. After considerable discussion of this problem, it was agreed that Dr. Warren will encourage SAGE to take the lead in this effort. The Rockefeller Foundation has had a consultant looking at the problem.

It was also agreed that Dr. de Quadros of WHO/PAHO and Dr. Alan Hinman of CDC would be asked to review Dr. Ralph Henderson's paper on applied research needs, and advise The Task Force on which areas it should concentrate. Dr. Warren will ask Dr. Scott Halsted to take the lead in advising The Task Force about basic research needs. It was also agreed that Dr. Salk would be asked to take the lead on defining the barriers from vaccine discovery to vaccine use.

Jet Injectors

Over lunch, there was considerable discussion about the need for and possibility of developing an improved jet injector for immunization programs.

Name for The Task Force

Dr. Jonas Salk continues to have objections to the name "The Task Force for Child Survival." In a discussion with him on this subject, Dr. Foege proposed the name "The Task Force for Healthy Children," which Dr. Salk liked. Dr. Joseph stated that UNICEF has a strong stake in the title "Child Survival" and would have great reluctance to change the name of The Task Force at this

point. Other members of The Task Force were not willing to vote to change the name over the objection of UNICEF. It was decided that Dr. Joseph would discuss this matter with Mr. Grant.

Donor List

The Task Force staff in Atlanta was asked to develop a complete list of possible donors for expanded immunization programs. This list will be circulated to the sponsoring agencies for additions and deletions, as well as suggestions on how the list might be used.

Burkina Faso (Upper Volta)

Dr. Joseph reported on the program to be conducted in Burkina Faso in December. Burkina Faso is now asking for a long-term replacement for Russ Charter, and Dr. Joseph feels that this assignment is critically important to the program. He requested the assistance of The Task Force in identifying someone for a one-year assignment.

Collaboration

Possible Task Force collaboration with other organizations was discussed, but no conclusion was reached.

Plan of Action

Dr. Foege distributed a four-page document (copy attached) proposing a plan of action for the Atlanta staff before "Bellagio II." He asked for review, comments and suggestions from the five donor agencies.

Organizational and Administrative Matters

Mr. Watson reported on the status of The Task Force office in Atlanta. The office has now been established at 1989 North Williamsburg Drive, Suite I, Decatur, Georgia, 30033 (telephone number (404) 325-2452). In addition to Mr. Watson, the following staff have been employed: Carol C. Walters, Office Manager; and Vicki A. Ledet, Secretary. A very effective and satisfactory administrative relationship has been established with Emory University. Mr. Watson distributed a proposed budget for the next Nine, Twelve and Fifteen months, a copy of which is attached. The Task Force approved the proposed budget for the twelve-month period October 1984-September 1985, and made commitments as follows: WHO has contributed $50,000, and expects to contribute another $50,000 during the year, for a total of $100,000; UNICEF has contributed $50,000, and expects to contribute another $50,000, for a total of $100,000; The World Bank has allocated $25,000 out of this fiscal year's budget (the Bank's fiscal year ends June 30, 1985), and expects to contribute another $50,000 next fiscal year. The Rockefeller Foundation has received a grant application from The Task Force for $35,000, which has now been approved.

Each of the sponsoring agencies agreed to provide a copy of its logo to be placed on the walls of the Atlanta office.

It was proposed and agreed upon that the next meeting of The Task Force would be held in Atlanta, Georgia on January 11, 1985.

Attachment: Plan of Action
Proposed Budget

BUDGET PROJECTIONS

	10/1/84-6/30/85 (9 months)	10/1/84-10/1/85 (12 months)	10/1/84-12/31/85 (15 months)
Personnel (Project Director, Office Manager, two Secretaries)	$101,631	$137,153	$172,719
Rent, Utilities (electricity only) and Insurance	7,430	9,243	12,718
Purchase of Furniture	7,300	7,300	7,300
Installation of Phones	775	775	775
Communications (monthly telephone/postage)	3,717	4,956	6,195
Office Supplies	3,735	4,980	6,225
Equipment (dictation, copier, postage meter)	1,900	2,500	2,947
Word Processing (purchase and maintenance)	9,800	10,174	10,450
Printing	3,753	5,000	6,255
Travel	56,250	75,000	93,750
TOTAL	$196,291	$257,081	$319,334
8% Overhead (Emory Univ.)	15,703	20,556	25,547
GRAND TOTAL	$211,994	$277,637	$344,881

ONE TIME EXPENDITURES

Purchase of Furniture	$ 7,300
Installation of Telephone	775
Purchase of Transcribing Equipment	475
Purchase of Word Processing Equipment	9,070
Purchase of Copier	1,500
TOTAL	$19,120

WORK PLAN

SENEGAL

PAST ACTIVITIES

1. Dr. Foege visited Dakar, Senegal 4/23-4/26, 1984.

2. Bellagio conference was held 3/12-3/16, 1984.

3. Management Sciences for Health Report.

FUTURE ACTIVITIES

1. TDY in Dakar for Dr. Marc LaPointe for 2-3 months.

2. Assign Dr. Marc LaPointe to Dakar for two years--supervision by The Task Force for Child Survival.

   a) Salary - paid by CDC.

   b) Travel and per diem--paid by UNICEF.

   c) $31,000 needed to equip office (two vehicles, office furniture, utilities, personnel, etc.)

3. Develop country plan--France, U.S., Belgium, plus agencies.

COLOMBIA

PAST ACTIVITIES

1. Dr. Steve Jones visited Colombia 9/30-10/13, 1984.

2. Dr. William Foege visited Colombia 5/27-5/29, 1984.

3. Dr. William Foege and Mr. William Watson visited Colombia 8/24-8/26, 1984.

   They participated in a special "Immunization Day." 900,000 children were immunized.

FUTURE ACTIVITIES

1. Track evaluation.

2. Send Technical team to Colombia in December to look at Primary Health Care for Children. UNICEF, WHO, World Bank and CDC (and maybe UNDP) each sponsor one person.

3. Raise money - Inter-American Development Bank.

4. Possible meeting - Foege and Macedo (first week in November).

INDIA

PAST ACTIVITIES

1. Dr. Foege visited India 7/20-8/8, 1984.

FUTURE ACTIVITIES

1. Investigation "cold chain" problem. Ice-making machines in lieu of refrigerators (cold chain modules).
2. Measles and polio vaccines (phasing up/phasing down).
3. Investigate what AID is doing in vaccine production (through Hopkins, Griggs or Linda Vogel). Dr. Hilleman - possible consultant.
4. AID experiment (Diesh).
5. Share informal plan with Bisht.

RESEARCH

PAST ACTIVITIES

1. Dr. Foege attended Calgary meeting 9/17-9/19, 1984.

FUTURE ACTIVITIES

1. Investigate gap in application research.
2. Investigate fund raising methods.
3. How to go from "discovery" to "delivery" (appoint small group to look at this).
4. Have input in vaccine meeting scheduled for March 1985 at Salk Institute.
5. How to capitalize on publicity.
6. Share Calgary results with Salk.
7. Phil Russell--military systems approach.

GENERAL OBJECTIVES

1. Involve international people in TFCS.
2. Appoint Board of Advisors.
3. Involve Mrs. Coretta Scott King.
4. Include Upper Volta.

FILE
Bilateral

COPY

The World Bank / 1818 H Street, N.W., Washington, D.C. 20433, U.S.A. • Telephone: (202) 393-6360 • Cables: INTBAFRAD

February 28, 1985

Ms. Adriana Vink
UNICEF
A-6-M
866 United Nations Plaza
New York, New York 10017

Dear Ms. Vink:

I am pleased to advise you that the World Bank will make a contribution of $25,000 towards the Task Force for Child Survival.

Ms. Fullerton has contacted our Accounting Department to initiate the paperwork. If you have any questions, please contact Ms. Fullerton on 676-1566.

Sincerely,

John D. North
Director
Population, Health and Nutrition Department

Attachment

cc: (without attachment)
Mr. Husain, OPSVP
Dr. Measham
Mr. Hodgkinson
Ms. Fullerton

ATF:ck

Bellagio

MINUTES OF THE MEETING OF THE TASK FORCE
FOR CHILD SURVIVAL

JANUARY 11, 1985

A fourth meeting of The Task Force was held at The Task Force offices, 1989 North Williamsburg Drive, Decatur, Georgia, on January 11, 1985. In attendance were: Dr. Ralph Henderson, WHO; Dr. Ken Warren, Rockefeller Foundation; Dr. Steve Joseph and Mr. Newton Bowles, UNICEF; Dr. Tony Measham, World Bank; Dr. William Foege, Mr. Bill Watson, and Ms. Carol Walters of The Task Force staff.

SENEGAL

Mark LaPointe gave a report on Senegal, having returned to CDC in mid-December from a 3-month UNICEF assignment to Senegal. He distributed a report on the status of immunization activities in Senegal, and reported on a proposed plan of action which has been tentatively agreed upon by the Ministry of Health and the Dakar UNICEF office. The basic points of this plan are:

1. To begin an expanded, accelerated program in 10 geographic sites in Senegal. These sites were selected while Mark was there.

2. To conduct training courses for national, regional and departmental officials who will be involved in the program prior to the initiation of immunization activities. These courses will utilize the training modules developed by WHO and CDC, and will be patterned after similar training efforts conducted by WHO.

3. The Ministry of Health of Senegal has requested that Mark LaPointe return for a long-term (2-year) assignment to assist with their immunization activities. This assignment, as with Mark's short-term assignment, will be under the sponsorship of UNICEF.

4. The proposed plan calls for the development of computer software and programming, which will enable the program to collect and analyze data which is necessary to the conduct of the program and its evaluation.

5. In keeping with the discussions with the Ministry of Health and the UNICEF Dakar office before Mark returned in December, he has developed a budget proposal of $385,400 for the first year of activities.

Mark will develop a narrative program proposal to go with the budget projection, and will take this plan and budget to Dakar the latter part of January. He will be going to Chad on CDC business, and will stop in Dakar on the way. After approximately 4 weeks in Chad, he will come back by Dakar where Bill Foege and/or Bill Watson will join him to, hopefully, consummate agreement on the

plan. It will then go from the Ministry to the Dakar/UNICEF office and then to the UNICEF New York office. Task Force discussion focused on UNICEF support for the first year of this program, with long-term funding possibly coming from an existing World Bank loan.

INDIA

Mr. Watson and Dr. Foege reported that several organizations, other than the five Task Force agencies, either have ongoing or proposed activities in India. Rotary International has indicated to Dr. Foege that it would entertain a proposal from India to provide polio vaccine for the entire country for a 5-year period if the proposal is tied to an effective, overall plan for an immunization program. USAID and the Centers for Disease Control have projects which could directly or indirectly effect immunization activities in India. Several countries have evidenced interest in helping the Indians develop their vaccine production capabilities, for example, France, Canada and the United States. (Dr. Henderson warned that the vaccine production area is fraught with problems because some of the involved parties see this as an area for potential profit making.)

Several different ideas on how to proceed with respect to India were discussed:

1. The Task Force representatives in India (WHO, UNICEF, The World Bank, and UNDP) could convene a meeting.

2. The Task Force itself could convene a meeting in India with both local and international representatives from the sponsoring agencies.

3. Dr. Mahler and Mr. Grant could approach the new Prime Minister and pursue the idea of an immunization campaign as a living memorial to Mrs. Gandhi.

4. The Task Force could employ a 60-90 day consultant to work in India --someone, perhaps, like Dr. Diesh.

5. The 10th anniversary of the eradication of smallpox in India, 1985, could be used as a springboard for an immunization campaign.

No agreement was reached on which of these various approaches should be taken. Everyone agreed that getting the input and advice of Mr. Haxton, the UNICEF representative in India, would be useful and important. Mr. Haxton will be in New York during the week of January 14. Dr. Joseph will consult with him and Mr. Grant and contact Dr. Foege. After that consultation, Dr. Foege and The Task Force staff will be in a better position to decide how to proceed.

VACCINE DEVELOPMENT

At lunch, discussion focused on how to assay progress in vaccine research and development, how to predict the availability of various vaccines for field use, and how to determine what needs to be supported. Dr. Warren reported that the Rockefeller Foundation is sponsoring a study and will be issuing a report in February or March. It was agreed that Dr. Foege will use this report as a tool in determining next steps. There was some sentiment in favor of The Task Force employing a temporary technical consultant to work in this area.

NIGERIA

After lunch, Dr. Stan Foster, of CDC, reported on immunization activities in Nigeria. In the next few months, Nigeria will launch what sounds like a very well-planned campaign. He gave Mr. Richard Reid, the UNICEF representative in Nigeria, a great deal of credit for the development of this program. It calls for launching a campaign in one department in each of Nigeria's 19 States. Senior and mid-level personnel have been trained in immunization program management. Appropriate equipment (vehicles, needles, vaccine) have apparently been procured, and the equipment for a functioning central cold chain in each of the departments is in place. There is also a well developed plan to integrate these campaigns into the ongoing primary health care programs.

COLOMBIA

Dr. Steve Jones, of CDC, reported on the status of the evaluation of the Colombia program. The Commission charged with conducting this evaluation is scheduled to meet in Colombia February 11-15. Dr. de Quadros, of PAHO, and Dr. Jones are scheduled to participate. Dr. Jones said that the Colombians have a record of good health work, and he expects that this evaluation will be competently and effectively done.

"BELLAGIO II"

The discussion then moved to the "Bellagio II" meeting to be held in Cartagena, October 14-17, 1985. Dr. Warren reported on his recent trip to Colombia, during which it was agreed that the President's villa in Cartagena would be available for the meeting. Dr. Joseph also reported on his recent visit to Colombia. Dr. Duque has been named coordinator of the meeting for the Colombian government. The Colombians have suggested that President Betancur send a letter of invitation following the initial one from the heads of the five sponsoring Task Force agencies.

There was then a discussion of the agenda for the meeting. It was agreed that the following topics should be included:

1. Colombia Experience
2. Requirements to Achieve the 1990 WHO Objectives for Immunization
3. Summary of Activities Since "Bellagio I"
4. Immunization within Primary Health Care
5. Status of Research and Development
6. Future Directions

Within this basic agreement, The Task Force staff will work out details which will be discussed at the April meeting. Dr. Joseph suggested that Dr. Duque be invited to attend that meeting. In addition to the original "Bellagio I" participants, it was decided the following will be invited to Cartagena: Dr. David A. Hamburg, President of Carnegie Corporation of New York; Mr. Franklin A. Thomas, President of The Ford Foundation; Mr. William T. Kirby, Vice-Chairman, The MacArthur Foundation; Dr. Carlyle Guerra de Macedo, Director, PAHO; Mr. Robert Smith, President of the Pew Memorial Trust; Mr. Herbert A. Pigman, General Secretary of Rotary International and Representatives from Bangladesh, Brazil, Burkina Faso, Egypt, France, India, Indonesia, Japan, Nigeria, Pakistan and USSR.

The two letters of invitation to the Cartagena meeting were reviewed and changes made. These letters will be written on the new Task Force stationery and sent to the Task Force representatives. After each agency head's signature is secured, the letters will be returned to the Atlanta Task Force office. The Atlanta office will then consolidate the signatures onto one page and mail the letters.

A mock-up of the proposed Task Force letterhead was reviewed. One change was proposed, and then the group approved its printing. Dr. Joseph requested that each Task Force representative be provided a large copy of the Task Force logo.

OTHER ITEMS

Dr. Foege reported that during the week before Christmas, a request for 50,000 doses of measles vaccine and jet injectors for Ethiopia was received from a relief agency. With the cooperation of CDC and WHO, the Task Force was able to respond to this request within 48 hours. He also mentioned that a meeting to discuss research and development of improved jet injectors will be held with Colonel Franklin Top of Walter Reed within the next few weeks.

Mr. Watson distributed a skeletal research and development matrix, which the Task Force staff will be completing in consultation with technical experts from CDC and perhaps other places. Suggestions and comments from the Task Force members were requested.

Dr. Joseph suggested that the April Task Force meeting be a "think tank" to discuss the organization of The Task Force office and long-range planning. Dr. Henderson suggested that the Cartagena working papers be decided upon and assigned in April. There was a request that the meeting with Pritech be changed from April 5 to the morning of April 4, and that The Task Force meet the afternoon of April 4 and April 5.* It was tentatively agreed that the Task Force will meet July 23-24 in New York.

*This change has been made with Pritech.

Bellagio

The Task Force for Child Survival
1989 North Williamsburg Drive • Suite I • Decatur, Georgia 30033 (404) 325-2452 • Telex 8107518512
Administratively Affiliated with Emory University

April 19, 1985

NOTE TO TASK FORCE MEMBERS

The Science and Technology Subcommission met in New Delhi last week. I co-chaired the Health Work Group with Dr. Ramalingaswami. The Work Group selected immunization as the #1 priority for Indo-U.S. collaboration in the immediate future, and it is possible that Prime Minister Ghandi will bring this as a specific item to the attention of President Reagan in June when he visits Washington, D.C.

Although the last 9 months have seen a change in the Minister of Health, the Secretary of Health, the Director of MCH and the Director of the EPI, India now has a National Immunization Plan, which they intend to distribute in April. The Secretary of Health is very interested in pursuing the Immunization Initiative, and Dr. Bisht, the Director-General, continues his strong support.

A Pritech team will be going to India next week to provide ideas in three states. A variety of groups are providing assistance in different ways, and to sort this out, we are making arrangements to get a short-term Indian consultant to summarize what is now being done and what needs India has for outside support in order to carry out their National Plan. This consultant will also get a copy of the India National Plan, which we will share with you as soon as it is available.

Sincerely,

Bill

William H. Foege, M.D.
Executive Director

Bellagio

UNITED NATIONS CHILDREN'S FUND FONDS DES NATIONS UNIES POUR L'ENFANCE

UNITED NATIONS, NEW YORK, N.Y. 10017
CABLE ADDRESS: UNICEF - TELEPHONE: (212) 754-1234

9535L

17 April 1985

To: Jim Himes, Akram Piracha, Hans Narula, Fuad Kronfol

From: Stephen Joseph
"dictated but not read"

Subject: Bellagio Conference: "Immunization Lessons Learned"

At the "Bellagio II" Conference on immunization, to be held in Cartagena, Oct. 14-17, 1985, I will be presenting a paper on "Lessons Learned in the Past 12 Months".

As part of my paper, I would like to review our recent country experience.

My own list includes activities of unusual interest in:

Colombia	Burkina Faso	Turkey	India
Bolivia	Senegal	Oman	Pakistan
El Salvador	Addis Ababa	(Egypt?)	China
Haiti	Sudan		
Nicaragua			
Brazil			

I would appreciate it very much if each of you could:
1. Suggest any additions or alterations to this list.
2. Send me whatever brief summary of <u>each</u> program that you think <u>best</u> describes it.

In addition, by copy of this memo, I am requesting colleagues in Evaluation, PFO, Communications, Supply, and JNSP to contribute any ideas or material that they think are relevant.

Thank you for your speedy response.

cc: T. Johnson	J. Williams	J.P. Grant	R. Henderson/
A. Jensen/	M. Vianello	R. Jolly	WHO
J. Gilmartin	P. Greaves	P. Adamson	T. Meesham/WB
N. Bowles			

Bellagio

UNITED NATIONS
CHILDREN'S FUND

from Stephen C. Joseph, M.D.
Special Coordinator
Child Health and Survival

With the compliments
of
UNICEF

UNICEF

UNITED NATIONS CHILDREN'S FUND
FONDS DES NATIONS UNIES POUR L'ENFANCE

INTEROFFICE MEMORANDUM

TO: Mr. T. Johnson, Planning and Evaluation
DPDP

DATE: 11th March 1985

FILE NO.: NY-YUA-5/85

FROM: Y.J. Pellé

SUBJECT: El Salvador - Rapid Appraisal Case Study

Following my visit to Central America - 1 to 8 March 1985 - I am sharing with you some preliminary comments on the immunization campaign in El Salvador.

The principle of a Rapid Appraisal Case Study has been discussed and agreed upon with both the government and our Guatemala office colleagues. Agop Kayayan will send you a memorandum detailing our discussions on the subject.

I am off for Africa tomorrow, coming back on 13 April and will go to El Salvador again in 19 April for two to three weeks as planned.

Regards.

Send cc of this, + attachment to Bellagio bp

cc: R. Jolly
J. Himes
A. Kayayan, Guatemala Office
Mr. Assadi
Dr. Nyi Nyi

Immunization Campaign in El Salvador
An impressionistic overview

1. General: The immunization campaign in El Salvador is an unquestionable success. Bearing witness to this is:

- the increasing number of children immunized (1st day 227,000 - 2nd day 258,000).
- the extensive promotion work done by the press and the media.
- the active support and participation from the highest authorities.
- the mobilisation of national resources from both the public and private sectors.
- the extension of the campaign to zones under guerilla control.

2. The political will: Undoubtedly, the personal interest and the active role played by the President have being determining factors in the success. They stem from the following consideration.

- the social content of the campaign met with the President's own social orientations.
- the opportunity to carry out concrete activities showing quantified, immediate results serves the interest of a government which is being criticised for its ineffectiveness.
- the campagin brings about some sort of national concensus, even though short-lived. A remarkable achievement in a country torn by civil war.

There are also concealed motivations as will be seen later in this document. It is however important to observe that coincidence of interest between national authorities and UNICEF has been a key factor in success. How to exploit it when it does exist- to create it when it is not there- are decisive questions to be addressed.

3. Organisation of the campaign. Even though there have been problems, short comings, mistakes...mostly in relation to transport, supply delivery, manning of health posts...it can be said that the campaign was well organised, well monitored through the National Coordinator and the National and Regional Executive Committees. The only drawback is the prominent role played by the Ministry of Health, so prominent that it was detrimental to the multisectorial approach required to ensure full success. Some queries come however to one's mind:

- Given the fact that the campaign is being run with existing resources and structures, why is it that it did not take place earlier? How is it that their regular EPI programme has been so ineffective in the past? What additional inputs, qualitative as well as quantitiative, have been necessary to turn the heavy health machinery into an efficient tool of promotion and implementation?

4. Promotion and motivation. A remarkable effort has been made to saturate the country and the various groups concerned with educative messages. Their content, nature, presentation, impact, deserve to be investigated thoroughly. An interesting achievement is the establishment of an Information and Communication Production Cell integrated by representatives from various sectors. In addition to the work carried out through the press and media, several other techniques have been tested with success:-

- First is the process of Canalisation of potential beneficiaries, through house to house visits by health or social workers in order to detect, inform, motivate. The process gained momentum between the 1st and 2nd day and accounts for larger turn over of children.

- Other imaginative techniques have been used, such as: air dropping of leaflets in remote areas, popular parades in the major cities, musical shows.

As said earlier, this most important aspect of the campaign deserves to be thoroughly documented and investigated. Questions which can be raised in this connection are as follows:

- Will the Information and Communication cell be disbanded or will it remain as a permanent system?

- As such massive and intensive use of the press and media cannot be repeated ad infinitum, what are the communication techniques (low cost, effectivenes) which can be mobilised at short notice and whenever necessary.

5. Participation It has been ample and enthusiastic.

5.1 Public sectors Very good as far as the health sector is concerned, yet not matched by a similar effort from other sectors (Education). Also, health workers complain that their full time involvement in the campaign prevented them from attending to other needs and activities.

5.2 NGOs. Active support has been provided by a number of organisations: Rotary, Green Cross, Scouts, Red Cross...The Red Cross was entrusted with the task of covering the zones under guerilla control. During the 1st day, their work was accomplished with success and good co-operation from the guerilla. On the 2nd day, four zones could not be covered as the army was bombing them.

5.3 The Church.. In several ways, the Catholic church is playing an important and crucial role. First, it used its influence over public opinion, also its extensive network to propagate and disseminate messages. In rural areas, priests and nuns were often active elements of the immunization teams. Second, it acted as a mediator between the fighting groups so as to get their agreement on days of peace. Thirdly, it is through them that messages and even supplies can be routed swiftly in the direction of the guerrilla zones.

Of course, in such a sensitive context as that of El Salvador, this role meets with difficulties. Their connections with the guerilla generate adverse reactions from the more radical groups (army, extreme right). In order to remain credible, the church adopts a neutral position, hence, their refusal to participate or to be associated with official demonstrations. Even though it knows, and certainly approves of the church's contacts with the guerilla, President Duarte and his entourage, have to distantiate themselves from the church in order not to be accused of complicity or leniency towards the left.

6. The political aspects. The President, the Ministries, the Church, and others, claim repeatedly that the campaign is a national event, with no political content or implications. The truth is that it is loaded with political connotations and that everyone is trying hard to exploit it for its own political purposes and goals.

There is little doubt that the timing has been selected by the Government so as to coincide with the election campagin (elections are due to take place on 31 March). The government hopes to capitalise on the massive participation of the population and on the opportunity it provides to mobilise them around messages and goals which have little to do with mothers and children. Parties from the right accuse President Duarte of enlisting mothers and children in his election campaigns. On the other hand, Durate's supporters complain that the stickers distributed by the thousands bear the colours of of Arena (extreme right), blue and red. In a country where the majority of voters are illiterate, colours have a heavy significance as it is through them that parties are identified and recognised. The guerrilla gave enthusiastic support to the campaign and, more than anyone else, associates UNICEF's name and role to it. For them, it is a way of being associated and recognised by the U.N. system, thus gaining legitimacy for their politicial objectives.

In brief, the immunization campaign is very much part of the political game. Is this good or bad? We would say neither as long as the ultimate objective, saving childrens' lives is fulfilled and also, as long as UNICEF as an institution is not involved in political manipulations. We are pleased to say that thanks to the skill and firmness of our collegues for the Guatemala office, our neutral and humanitarian stand and status remain intact.

Anyhow, these particularities and peculiarities, their implications, the way this has been handled, deserve to be recorded and analysed, for, in one way or another, they can repeat themselves in other countries.

7. The role of UNICEF. Ever since the idea of a campaign has been "sold" to President Duarte, UNICEF's role has been crucial and predominant. Be in terms of organisation and management, of promotion and diffusion of messages, of technical advice, of mediation between the differents parties involved, it is obvious that not much would have moved ahead but for UNICEF's active, persistent and efficient involvement (much credit for this goes to H. Jaramillo, Programme Officer). The credibility and trust it enjoys from every corner is too evident to need further elaboration. Also, the idea of having UNICEF's staff numbers in each of the 7 Regional headquarters as observers is excellent as it allows first hand observation and the collection of precious information that no other system can provide. High praise and credit should thus go to our colleagues and most particularly to Agop Kayayan, H. Jaramillo and Paco SANDOUAL, whose respective skills and input have largely contributed to the success of the campaign.

However, even though our collegues have been very careful to leave the front stage to national authorities, the importance of their participation raises a number of queries.

- when and how responsibility assumed by UNICEF should be transferred to nationals.

- In the future, will it be possible to organise similar events with less involvement from UNICEF?

- Which UNICEF inputs are inescapable in order to make a qualitative difference?

- In such a highly politicised context, are all UNICEF staff equipped, prepared, properly instructed to handle essential issues? How far can UNICEF influence, correct the course of events? For example what stands, what action/position should it take when the army breaks the truce as it did on the 2nd day?

8. <u>What next</u>? With the experience acquired, results achieved so far, there is little doubt that the 3rd day will be another success in terms of mobilisation, maanagement and numbers of children immunized. Will this last round be a day of peace? Much depends indeed on the results of the election process. Victory for Duarte would consolidate his power, silence his opponents from the right. Should the contrary happen, there would be justification for worry, even fear that not only truce but the campaign itself could be in jeopardy.

Setting aside the political aspects and looking ahead, it is time to think about what will or should remain when the campaign is over. To our mind, the following deserve action and thought.

- First, is the extention of immunization to those children who joined the second or third days, also to those children who, for one reason or another have not been covered. This raises the question of the relationship between campaign and regular programmes, between formal systems and innovative approaches. How far can such a campaign modify structures, behaviour, methods of work.

- Secondly, in a country which has no system of evaluation or monitoring, the process of canalisation should be pursued and to the extent feasible institutionalised. It is, at present, the best and only way to get accurate information, to retain control over the beneficiaries.

- Thirdly, the social communication system must be kept alive. At least, capacity and capability of production should be there, ready for use whenever necessary. Campaigns cannot be repeated immediately, yet localised specific activities bearing relation to the GOBI package are logical next steps. Capitalising on the success of the immunization campaign a mid-term programme of activities for children could be thought of.

Bellagio

UNITED NATIONS CHILDREN'S FUND FONDS DES NATIONS UNIES POUR L'ENFANCE

UNITED NATIONS, NEW YORK, N.Y. 10017
CABLE ADDRESS UNICEF - TELEPHONE: (212) 754-1234

9535L

17 April 1985

To: Jim Himes, Akram Piracha, Hans Narula, Fuad Kronfol

From: Stephen Joseph
"dictated but not read"

Subject: Bellagio Conference: "Immunization Lessons Learned"

At the "Bellagio II" Conference on immunization, to be held in Cartagena, Oct. 14-17, 1985, I will be presenting a paper on "Lessons Learned in the Past 12 Months".

As part of my paper, I would like to review our recent country experience.

My own list includes activities of unusual interest in:

Colombia	Burkina Faso	Turkey	India
Bolivia	Senegal	Oman	Pakistan
El Salvador	Addis Ababa	(Egypt?)	China
Haiti	Sudan		
Nicaragua			
Brazil			

I would appreciate it very much if each of you could:
1. Suggest any additions or alterations to this list.
2. Send me whatever brief summary of <u>each</u> program that you think <u>best</u> describes it.

In addition, by copy of this memo, I am requesting colleagues in Evaluation, PFO, Communications, Supply, and JNSP to contribute any ideas or material that they think are relevant.

Thank you for your speedy response.

cc: T. Johnson	J. Williams	J.P. Grant	R. Henderson/
A. Jensen/	M. Vianello	R. Jolly	WHO
J. Gilmartin	P. Greaves	P. Adamson	T. Meesham/WB
N. Bowles			

Bellagio

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Director & Professor

17th May, 1985

Dr. C. de Cuadros,
Director,
Expanded Programme on Immunization,
Pan American Health Organisation,
525 23rd Street NW,
Washington DC 20037,
U.S.A.

Dear Dr. de Cuadros,

I refer to Dr. Anthony Measham's letter of 3rd May to me, copied to you, in conjunction with a review of the cost effectiveness of immunization campaign and routine services in Colombia. I note that in this letter Dr. Measham asks you to make the necessary arrangements for this assignment in Colombia.

I have since spoken to Dr. Measham and we have agreed that the assignment should begin in the second half of August. In telephone conversation with Dr. Measham yesterday (16th May), I raised the possibility of collaborative assistance on this assignment from Maria Alicia Dominguez Uga. You will recall that Mrs. Uga was the economist employed by FSESP in Rio de Janeiro to conduct data collection and analysis for the cost effectiveness appraisal of the Brazilian immunization programme. Mrs. Uga thus has a good acquaintance with the types of information required for cost appraisal in EPI and working experience of collecting such data in the context of the Brazilian programme. She also speaks Spanish, Portuguese and English.

I have no idea about Mrs. Uga's possible availability for this assignment, which I anticipate will certainly need the two weeks from 18th August in Colombia, but I think her experience in the work in Brazil makes her a potentially valuable collaborator in the Colombian work.

If PAHO/the World Bank would agree to approach Mrs. Uga in relation to this assignment, her address is:

Rua Senador Vergiero 80,
Apt. 1201,
Rio de Janeiro, JR
BRAZIL

Although I can read the background documentation on Colombia's EPI in Spanish without difficulty, I should appreciate some assistance with day-to-day working discussions in Spanish for this assignment. I should be grateful if you would bear this in mind in identifying a potential counterpart for this work.

I shall be writing within the next few days to set out the types of information which are necessary for me to fulfil the terms of reference for this assignment: I appreciate that much of this may be unavailable at present but it will considerably assist me if you could point out where existing programme review materials have documented any of these points.

With best wishes.

Yours sincerely,

Andrew Creese

6/14 ~~ONIARH~~ file

The Task Force for Child Survival
1989 North Williamsburg Drive • Suite I • Decatur, Georgia 30033
(404) 325-2452 • Telex 8107518512
Administratively Affiliated with Emory University

June 17, 1985

Note to Task Force Members

For your information...please note page 3 of the attached Report Of The Health Working Group, Seventh Session of the Indo-US Science and Technology Subcommission, New Delhi, April 8-10, 1985.

Please note the importance given to immunization.

Regards,

Bill

William H. Foege, M.D.

UNITED STATES GOVERNMENT

memorandum

DATE: May 14, 1985

REPLY TO ATTN OF: SCIATT - Philip E. Schambra

SUBJECT: Report of the Health Working Group, Seventh Session of the Indo-US Science and Technology Subcommission, New Delhi, April 8-10, 1985

TO:

U.S. Health Working Group Participants

Enclosed for your information is a copy of the report of the Health, Medical and Life Sciences Working Group of the Seventh Session of the Indo-US Science and Technology Subcommission which met in New Delhi from April 8-10, 1985. Your contributions to this report, as well as in the meeting, are much appreciated by all participants on both sides.

Also enclosed is a copy of the "Approach Paper" prepared by Dr. Curlin and Dr. S. Ramachandran at the direction of the Health Working Group to provide further details on the proposed Indo-US Cooperative Vaccine Development Action Program.

Speaking for Billa Saxena and myself, as well as other members of the Science Office and Embassy Staff, we very much enjoyed having you with us in New Delhi for this meeting and appreciate all of the hard work and commitment displayed by each member of the U.S. delegation.

Please feel free to call on us whenever we may be of further assistance.

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REPORT

OF THE

HEALTH, MEDICAL AND LIFE SCIENCES WORKING GROUP

SEVENTH SESSION

INDO-US SCIENCE AND TECHNOLOGY SUBCOMMISSION

NEW DELHI, APRIL 8-10, 1985

INDO-US SCIENCE AND TECHNOLOGY SUBCOMMISSION
HEALTH, MEDICAL AND LIFE SCIENCES WORKING GROUP
APRIL 8 - 10, 1985

A. INTRODUCTION:

The deliberations of the Health, Medical and Life Sciences Working Group encompassed: (1) broad discussions of ongoing collaboration and progress since the 1981 meeting, including recommendations for continuation, expansion or shifts of emphasis in those areas; and (2) discussion of potential new activities/initiatives, with special emphasis devoted to immunization and vaccine development, epidemiology and rapid diagnostic techniques, acute respiratory disease, reproductive biology, and occupational and environmental health, cancer, and rehabilitation of the disabled.

B. PROGRESS:

The Working Group noted the significant progress since the last Subcommission meeting in a number of priority areas. In 1981, the Subcommission made recommendations for expanded collaboration on malaria, filariasis, leprosy, tuberculosis, prevention of blindness and reproductive physiology. These recommendations have come to fruition in the form of twenty-two projects under the Indo-US Science and Technology Initiative (STI), which was agreed upon when the late Prime Minister, Indira Gandhi, met in Washington, D.C. in July 1982 with President Ronald Reagan. Progress in these six areas, both under the STI and under the Subcommission itself, is described briefly in Annex A to this summary record of discussions.

There has been important progress in other areas as well, including:

1) Research on the epidemiology of viral hepatitis and related problems.

2) A study on iron deficiency in rural populations was initiated with transfer of technology for ferritin assay.

3) Collaboration proposed on the epidemiology of precancerous oral lessions, and development of anticancer agents from indigenous plants, was continued and two new studies were also initated. The first one is a study on "pelvic versus extended radiotherapy in cancer of the cervix, stage III", and the second is a study using liposomes in a "pharmacological capsule" for the successful delivery of newly developed drugs to the target site in order to increase their potential as chemotherapeutic agents.

4) In the life sciences, the collaborative relationship in basic molecular biology with the U.S. National Institutes of Health was strengthened. The overarching theme for this collaboration is NMR spectroscopy, which has contributed to the elucidation of biological structure and activity of such large biological molecules as nucleic acid enzymes and proteins as well as biological process. A collaborative project on the use of photoacoustic spectroscopy (PAS) has been initiated. The two part study will involve PAS studies of oxygenation of hemoglobin, followed by a study of metal-induced and aging-induced changes in nucleic acid structure in cells. Other projects are under development.

5) In the field of mental health and related problems, in November 1983, a memorandum of understanding for cooperation was signed between the U.S. Alcohol, Drug Abuse and Mental Health Administration and the National Institute of Mental Health and Neurosciences in Bangalore. The agreement contemplates a broad range of cooperation, including mental health services research, neurological studies, studies of alcoholism and drug abuse, and cross-cultural aspects of mental illness and other issues. One workshop has been held and a research project on mental illness and tropical diseases is now under way.

6) On the important problem of diarrheal diseases, a project is now under way on biochemical and immunochemically fractionated antigens of E. histolytica, circulating immune complex and iron status in intestinal and hepatic amebiasis.

7) The "MAC-ELISA" technique for diagnosis of Japanese B encephalitis was perfected as a result of a collaborative project, and this technique has now been put into use for diagnosis of acute Japanese encephalitis in India.

8) In the field of neurology, a collaborative study on head injury and survival was initiated. Preliminary analysis indicates that, despite dramatic differences in the technology available in the two countries to treat severe head injuries, the mortality rates for both U.S. and Indian study groups were the same.

9) In the field of rehabilitation, a Memorandum of Understanding for a program of cooperation was signed in 1983 by the Ministry of Social Welfare on the Indian side and the National Institute of Handicapped Research on the U.S. side. Under this agreement programs to meet the needs of the disabled population are being advanced.

C. DISCUSSIONS AND RECOMMENDATIONS OF THE WORKING GROUP:

1. Immunization and Vaccine Development :

The importance of advancing all aspects of immunization was given high priority by both sides. This involves a collage of activities, across the full spectrum of activities from basic to applied, including not only the local production of existing vaccines but also new ones at a later date, as well as improved delivery of services and technologies. Included also are the needs to strengthen epidemiological capabilities in order to improve disease surveillance and strengthening of laboratory capabilities, including quality control. On the U.S. side, the Agency for International Development and the Centers for Disease Control have a special interest in collaborating with India on these immunization-related issues. The interest of Rotary International in providing to all countries all the polio vaccine which they may need for the next twenty years was noted.

In regard to vaccine development, the Working Group felt that it is critical that the two countries "capture" the energy which now prevails in the area and launch a new joint effort, which would follow three strategic paths:

(a) Introduction of better technologies for manufacture and quality control of existing vaccines. This will involve technology transfer.

(b) Further development of vaccines for which basic research has been completed, but for which additional animal studies, human volunteer trials, and field trials may be needed. An illustrative list of such vaccines might include oral cholera vaccine, pertussis vaccine, some aspects of malaria, salmonella, rotavirus and oral canine rabies vaccine.

(c) Basic research on a longer-term span on vaccines for malaria, sexually transmitted diseases, herpes simplex, human papilloma virus or others which might be identified through a joint effort to identify priorities for vaccine development

It was agreed that, to avoid dilution of efforts, attention should be focused on a few selected high priority vaccines, which show considerable promise. It was noted that training of staff would be an important need early in the collaboration.

Because of the very high priority of vaccine development a separate statement for a "Vaccine Research and Development Program" was prepared and endorsed by the Working Group. This statement is provided as Annex B to this report.

It was agreed that there are many components to a vaccine development effort, including institutional components (quality control facilities) and field laboratories for testing vaccine efficacy and epidemiological issues. A careful planning effort will have to be initiated, which will assure appropriate integration, monitoring and evaluation of all activities.

2. Leprosy

It was agreed that all ongoing collaborative projects address important needs and should be continued. The following projects/activities were recommended for future development and implementation:

(a) Production and development of diagnostic kits for mass field application:
It is recognized that a method for diagnosis of subclinical leprosy in the field is essential. Work on this problem is now under way in laboratories in both countries, including projects under the STI. There is a need for exchange and cross-checking of antigens between U.S. and Indian laboratories, as well as other exchanges. Additionally, prototype laboratory/ production methods must be developed with a view toward testing and validating diagnostic kits through large-scale field trials. Consultancy on production development would be required to bring the optimum laboratory method to a pre-industrial readiness stage.

(b) Workshop on immunology and leprosy:
It was recommended that a small workshop on the immunological and molecular biological aspects of leprosy be held in January 1986.

(c) Rehabilitation of leprosy victims:
The suggestion for cooperation between the U.S. and India on rehabilitation and treatment of leprosy patients, with emphasis on problems of the foot, tendons, thumb and hands, was endorsed.

(d) Training:
The Working Group endorsed collaboration on the application of communications and teaching technology to training needs in leprosy control programs. It was recommended that a program be developed which could be implemented in all 44 centers in India.

3. Tuberculosis:

The ongoing work on tuberculosis under the STI was recommended for continuation. A new proposal for possible correlation of bacterial load concentrations to the RIA levels of pulmonary tuberculosis antigens was recommended for development.

4. Sexually Transmitted Disease

Sexually transmitted diseases are being recognized as increasingly important public health problems in both countries. While the United States has considerable experience with organized national surveillance, treatment and control programs, STD programs in India are largely in the formative stages. The U.S. has also developed basic and clinical research capability, which has been accelerated in the past three years by recognition of the Acquired Immunodeficiency Syndrome (AIDS). India has certain STS's (Donovaniasis) which are uncommon in the United States. The Working Group encouraged scientific exchange and collaboration in STD, noting that some diseases already in the science and technology program (e.g. hepatitis B and herpes virus) may be sexually transmitted. It was suggested that a proposal be developed by Indian and U.S. scientists to include exchange of diagnostic reagents and clinical specimens.

5. Malaria

The existing complement of malaria research under the STI and under the Subcommission was viewed as appropriate in terms of level, content and productivity at this time. The Working Group

felt that the quality of the cooperation is high and holds promise for important results. It was agreed that collaborative work on data management would be useful in evaluating various vaccines. It is believed that a decentralized, microcomputer-based information system is the most feasible alternative for malaria control data management. Software packages which will provide the design flexibility critical to the evaluation of the information system will be needed. Once a pilot state system is established it will provide an ideal data base and data management capability for testing alternative interventions, including vaccine trials, when they become available. It will be possible to explore the potential for expanding the system horizontally to cover other health information needs.

The Indian side strongly affirmed its interest in participating in malaria vaccine field trials, at such time as a vaccine has been approved by the U.S. FDA for use in human subjects. In this regard, it was recognized by both sides that such trials require carefully defined study populations. Establishment of such study populations often requires several years (3-4) of advance planning, including appropriate epidemiological studies.

A workshop on malaria is planned in January 1986.

6. Filariasis

The Working Group cited the area of filariasis as a striking example of a program developed on the basis of scientist-to-scientist collaboration. It was agreed that all ongoing work, including the single project under the Subcommission and the four under the STI, addressed important research needs and should be continued. Two additional proposals were recommended for development: (1) a study of lymphatic filariasis, comparing the disease in animal models and human patients; and (2) a study of the molecular biology of filariasis. It is contemplated that both studies will involve university-based scientists in the United States. It was agreed that a visit by the proposed U.S. collaborator for the study of lymphatic filariasis should occur later this year. Additionally, the Working Group endorsed the concept of a small workshop on immunological aspects of filariasis to be held in late 1985 or early 1986. It is contemplated that this activity might be undertaken in collaboration with the Tropical Disease Research Program of the World Health Organization.

7. Guinea Worm

The importance of Guinea Worm as a public health problem and its potential for being eradicated was recognized. While recognizing the desirability of developing a test for detection at sub-clinical levels, it was felt that a higher immediate priority should be placed on searching out and eliminating the disease through an approach similar to that used for the smallpox eradication program. The U.S. side expressed willingness to participate in this effort. The National Institute of Communicable Diseases will prepare a proposal for cooperation in this area.

The Indian side indicated that immunodiagnosis of inapparent infection is of continuing interest.

8. Diarrheal Diseases

The importance of diarrheal diseases as a cause of childhood morbidity and mortality was discussed. As many as 50% of childhood deaths in India are from diarrheal disease. It is important that epidemiological studies be undertaken to assess the extent of the problem. An area of considerable epidemiologic interest is seasonal variation.

It was noted that there is one ongoing research project on biochemically fractionated antigens of E. histolytica, circulating immune complexes and iron status in intestinal and hepatic amebiasis. Additionally, other studies are under development, including the use of standardized international research protocols to prospectively study childhood diarrheal disease. An integral part of these studies will be research and development on rapid diagnostic techniques for field use. Another important area is the strengthening of oral rehydration therapy.

9. Acute Respiratory Diseases

Acute respiratory infections, coupled with diarrhea and malnutrition, are among the chief causes of morbidity and mortality among the world's children. It was noted that, despite the importance of respiratory infections, there is no overarching approach to research collaboration in this area between the U.S. and India. Areas of importance would include diagnostic tests, epidemiological studies, and vaccine development.

At the present time, there are no active collaborative projects on acute respiratory infections. Pending proposals, which were endorsed by the Group, include studies of the etiology and epidemiology of acute respiratory infections in South Indian rural children, including validation of methods which would be appropriate for field use in etiologic diagnosis of respiratory infections. Additionally, the concept of collaboration between the U.S. and India on asthmatic disease, in cooperation with the U.S. National Institute of Allergy and Infectious Diseases (NIAID) and the thirteen Asthma and Allergic Disease Centers currently supported by the NIAID was firmly endorsed by the Working Group. Interest was also expressed in the potential for development of a vaccine for streptococcal infection.

In view of the worldwide importance of respiratory diseases, the Working Group strongly recommended that further collaborative efforts be developed.

10. Leishmaniasis:

In recent years, the magnitude of the Leishmaniasis problem in India has been recognized, particularly in West Bengal and Bihar. Currently, there are no collaborative activities on this problem, yet the potential for mutually productive cooperation is excellent.

As a first step toward implementing collaboration between the two countries on this heretofore neglected problem, the Working Group recommended the further development and initiation of a collaborative project on patients with visceral Leishmaniasis and post-Kala Azar dermal Leishmaniasis. This project will involve the development of rapid diagnostic tests as well as exchange visits by the scientific participants for collaboration.

11. Rabies:

The importance of rabies in the developing world as a public health problem cannot be underestimated. In this regard, the Working Group strongly recommended that one of the newer generation vaccines for canine rabies be developed further. It was noted that two candidate vaccines are available. One has been developed by the U.S. Centers for Disease Control and has undergone some field testing. A second vaccine, using recombinant DNA technques with the vaccinia virus, is at an earlier stage.

The Working Group noted the renewed and very strong interest, that had developed in India since the last Subcommission Meeting, in a rabies vaccine. It was recommended that priority be given to the development of an oral canine vaccine. The technology is now available to address this problem. The two sides must now come up with a mechanism to apply the technology to the resolution of the problem.

It was proposed that a workshop on rabies be held in 1986 to review the state-of-the-art. The Fogarty International Center of the National Institutes of Health is prepared to host the workshop. It was also noted that, on the U.S. side, the National Institutes of Health, Centers for Disease Control, Department of Agriculture, and Agency for International Development, among others, have an interest in this issue.

12. Hepatitis:

Hepatitis is an important health problem in both the United States and India. In India, epidemic hepatitis (water-borne) strikes young adults and pregnant women.

The one active collaborative project, under the auspices of the Subcommission, is studying the epidemiology of viral hepatitis and related problems. Rapid diagnostic techniques are in various stages of development. DNA probes are being used as approaches toward the development of better vaccines.

It was noted that much of the hepatitis in India is due to non-A non-B hepatitis. Important issues are to identify the agent or agents of transmission and epidemiology. The Indian side is particularly interested in a study of the relationship of hepatitis A, which is water-borne, to the non-A and non-B hepatitis which is also water-borne.

The Working Group noted that identification of non-A non-B hepatitis as a major water-borne problem owes much to the ongoing collaborative work.

India has a strong interest in a hepatitis B vaccine. If opportunities open up to work with U.S. scientists in this area, India would like to do so.

13. Arthropod-Borne Diseases:

Important arthropod-borne diseases include Japanese B encephalitis, Dengue, and others. Studies in this area include both the human element and animal reservoirs, including domestic animal involvement.

There is interest in Ganjam/Nairobi Sheep Disease, which was recognized in India a number of years ago. This disease can be transmitted from animals to man. It was agreed that an appropriate institute in India would generate a proposal for submission to the U.S. Department of Agriculture.

14. Zoonotic Diseases:

In addition to rabies and zoonotic arbovirus diseases, which have been identified elsewhere in this report, there is interest in brucellosis, particularly Brucella Millitensis. Emphasis would be given to the methods for differentiation of antibodies for B. aborous in vaccinated and infected animals. The U.S. Department of Agriculture indicated that it would be pleased to receive proposals for cooperation.

Several other areas were identified (e.g. development of an improved foot and mouth disease vaccine), but it was determined that these proposals should be submitted to the Indo-U.S. Agriculture Subcommission, when it meets later in 1985.

15. Reproductive Biology:

The excellent program of cooperation in reproductive biology was reviewed (further details are provided in Annex A). It was agreed that all ongoing projects, both under the auspices of the Subcommission and under the STI, address important research questions and should be continued. The hope was expressed that the STI would be extended over a longer period of time, in view of the potential for good results from projects included under that mechanism. Under the Subcommission, there have been particularly good results in the area of joint drug testing. This is a truly collaborative effort, with each side using facilities of the other to fulfill testing needs. The progress on the use of Capranor, which bestows protection for up to one year and with which infertility is reversible, was noted. Additionally, there has been promising work with gonodal peptides. Preliminary data from a study using an LHRH analog as a male antifertility agent suggest that this substance causes sperm dysfunction without reducing testicular function. If found to be successful, this approach to fertility control will have worldwide benefits.

The reproductive biology area has involved a number of important workshops. Two proposed workshops concern product development and animal models that can be used to evaluate new antifertility agents.

The Working Group expressed its broad and continuing support for collaboration in the field of reproductive physiology and encouraged continued development of cooperative activities, which would include new promising areas.

18. Epidemiology and Vital Statistics:

Epidemiology, the science of the distribution and etiology of disease, is critical to the planning, effective implementation and evaluation of health and family welfare programs. Operational research in health is dependent on epidemiological skill. Discussions have been under way, including earlier meetings of the Subcommission, regarding the strengthening of epidemiological capability. Both field and clinical epidemiology are seen as important.

The Working Group broadly endorsed cooperation between the U.S. and India on epidemiology training. The specific details will be worked out with the Ministry of Health and Family Welfare, including the National Institute of Communicable Diseases and the National Institute of Health and Family Welfare as well as the Indian Council for Medical Research.

It was noted that the model health registration areas project beteen the Registrar General's Office and the U.S. National Center for Health Statistics, and which was recommended at the 1981 meeting, is now being initiated.

17. Blindness:

The Subcommission expressed satisfaction with the ongoing collaboration on blindness research and recommended its continuation and strengthening wherever required to achieve tangible results. Ongoing studies under the STI include:

a. Cataract Research--Case control study of senile cataract.

b. Nutritional research--Vitamin A deficiency in keratomalacia

c. Eales's Disease--Immunological and clinical studies

Cataract prevention by identifying risk factors was considered as the most appropriate approach. It was noted that the ICMR has already launched an epidemiological study in this regard.

It was suggested that there is a need to start a major initiative to study the basic metabolism of the lens and the effect of the identified nutritional, personal and environmental risk factors on the basic metabolic functions. It was proposed that a workshop be held to plan and formulate the new scheme, identify the collaborating centers and the training needs.

Another future area of collaboration would be the relationship of vitamin A deficiency with morbidity and mortality in pre-school children. This proposal would be based on an earlier U.S.-Indonesian study on the same subject.

18. Nutrition and Child Development:

Despite its overall importance, the field of nutrition has received only modest attention under the Subcommission in the past. The Indian Council for Medical Research has developed a collaborative project with the Agency for International Development (AID) for a multi-center study of the interaction of maternal nutrition, infectious disease status of women, and infant survival. This study has a global as well as national significance in view of high infant mortality associated with low birth weight. The Working Group recommended that this proposal be speedily approved and implemented.

A new initiative on the role of vitamin A deficiency in childhood morbidity and mortality was proposed. This work would be conducted along the same lines of a study conducted in Indonesia. The Working Group endorsed the concept of this proposal as well.

Other aspects of nutrition of interest to both sides are the role of nutrition in cancer and the role of predisposing

conditions of health, nutrition and environment on drug safety and efficacy. It was proposed that the latter subject be dealt with in a symposium in 1986, to be organized jointly by the U.S. Food and Drug Administration and the Industrial Toxicology Research Centre in Lucknow.

The Working Group recommended that greater attention be paid to nutrition issues and encouraged both sides to foster the development of additional cooperative projects on a scientist-to-scientist and institute-to-institute basis.

19. Cancer:

Cooperation in the field of cancer was characterized as one of the more "vibrant" areas under the Subcommission. Inportant ongoing studies include efforts to develop new therapeutic agents against cancer from indigenous plants. Since the beginning of this project, extracts from some 3,000 plants have been screened and approximately 200 have been found to have anticancer activity. There has also been a long-standing study of oral cancer and precancerous lesions in rural Indian populations. This project has played a role in shaping the primary prevention of oral cancer program in several states.

The members of the Working Group recognized cancer as an important area for study. A comprehensive approach employing epidemiological studies; early detection using modern technologies; preventive oncology, with special reference to tobacco usage and diet; clinical trials with new anticancer drugs; chemo-prevention, especially in cancer with recognized precancerous states (e.g. cervix, oral and possibly esophagus); viral oncology, with special reference to nasopharyngeal cancer and cervical cancer; nutrition and cancer; cancer chemoprevention and rehabilitation, were recommended. A workshop on chemoprevention was agreed upon.

Realizing the state-of-the-art in the U.S., transfer of technology for cancer control efforts and implementation of the National Cancer Control Programme in India were considered as areas for exchange of information.

20. Occupational and Environmental Health:

The Working Group briefly reviewed progress in recent years. Three projects dealing, respectively, with water supplies and sources for virus and bacteria, impact of stack emissions on air quality, and biochemical effects of particulate air pollution, have been completed.

There are a variety of new suggestions and proposals for cooperation including cooperation on occupational health standards, studies of occupationally-linked asthmatic and allergic disorders, comparative epidemiologic and pathologic studies of cotton, jute and other dust-exposed workers, as well as neurotoxicity of selected industrial and environmental chemicals.

An agreement has been reached to convene a workshop on the recognition and technology for assessing health risks of chemicals, dust and other hazards.

The recent visit to India by experts of the U.S. Environmental Protection Agency was noted. Illustrative areas of interest include health aspects of toxic substances management and safety, differential response to toxic substances, dermal absorbtion of toxics and pesticides under temperature and humidity differences, and environmental epidemiology.

The Indian side expressed interest in cooperation in the use of radiation to disinfect sewage as a means of preventing the spread of infection. This will be explored further.

The Working Group expressed general support for a broad program of cooperation in environmental and occupational health issues. It was noted that the "new triad" of the 20th century is environmental hazards, occupational hazards and self-induced risks. The participating agencies on both sides will exchange proposals on activities which are ready for development.

21. Rehabilitation of the Disabled:

The ongoing work between the Ministry of Social and Women's Welfare (MOSWW) and the National Institute of Handicapped Research, U.S. Department of Education, was noted. At its December 1981 meeting, the Subcommission agreed that greater efforts should be made to develop collaborative programs in the area of rehabilitation of the disabled. The specific areas identified for collaboration were: (1) development of the national institutes for the deaf, blind, mentally retarded and orthopaedically handicapped; and (2) development of appropriate orthotic and prosthetic devices for the disabled. The Subcommission endorsed the continuation of the collaborative efforts between the U.S. Department of Education/National Institute of Handicapped Research and the Indian Ministry of Social and Women's Welfare. A list of the core provisions of this agreement is provided in Annex C to this report.

The Ministry proposed the establishment of service programs for paraplegics, spastics and mentally retarded in the national institutes capable of taking up such services. Potentials for collaboration in these areas will be discussed further between officials of the MOSWW and the NIHR. A stronger role by the NIHR in technical aspects and facilitation of training of Indian rehabilitation personnel both in India and the United States was encouraged. It was agreed that the MOSWW will prepare a proposal, which will prioritize training needs, for submission to the NIHR for consideration.

A proposal for assessment of high frequency hearing disabilities and its relevance to clinical audiology and medical services was discussed. The objectives include development of an audiometer that can be used in field conditions in developing countries, field testing and evaluating the prototype. There was consensus that this is an interesting new proposal, and it was agreed that both Governments will consider it within their normal process for scientific merit review.

22. Alcohol, Drug Abuse and Mental Health:

At the 1981 Subcommission meeting, a recommendation was made to include mental health and related subjects in the program of cooperation. Following up on this, a memorandum of understanding was signed by the National Institute of Mental Health and Neuro-Sciences in Bangalore and the U.S. Alcohol, Drug Abuse and Mental Health Administration. Since then, a number of actions have taken place to promote the development of proposals for cooperation and other scientific interactions. A joint Conference on Affective Disorders, Mania and Depression will be held in November 1985. Additionally, a number of projects on alcoholism, schizophrenia and other areas of mental health are under development. It was also recognized that there are important oppotunities for collaboration on basic research on the central nervous system in primates and in neuroepidemiology. Training in neuroepidemiology at the National Institutes of Health in Betheda is possible.

23. Emergency Medical Services:

Over the past three years, there have been discussions between U.S. and Indian officials regarding possibilities for

collaboration in the area of emergency medical services. Both sides remain interested in this area, with particular interest in India in EMS related to large-scale emergencies as well as in connection with the new trauma center being established at the All India Institute of Medical Sciences. It was agreed that the Ministry of Health and Family Welfare would provide the U.S. with a brief proposal for this cooperation.

24. Communications/Information Exchanges:

The importance of biomedical communications and health education was emphasized. The visit by representatives of the National Library of Medicine in 1984 was recalled. The representative from the U.S. National Institutes of Health indicated that they would be pleased to receive a proposal for cooperation from the Indian side.

A recommendation was made that educational information and materials in the area of pathology be exchanged. The U.S. representatives indicated that they would explore this possibility.

25. Basic Research and Biotechnology:

Basic research and biotechnology first became a part of the agenda of the Subcommission in 1981. As a consequence of that decision, and based upon earlier scientist-to-scientist collaboration, an effort was made in the years 1981 - 1985 to broaden the base of cooperation. Indeed, it is noteworthy that there has been a long tradition of productive research association between the intramural scientific staff of the U.S. National Institutes of Health and with physical biochemists and experimental and theoretical spectroscopists in India. The common bond of this collaboration has been nuclear magnetic resonance (NMR) spectroscopy. The NMR studies have evolved from esoteric investigations of the phenomena itself in the 1950s to techniques for determining structure and conformation of macromolecules to the recent burgeoning of NMR applications as a diagnostic tool using imagining techniques which can give pictorial presentations of active biological processes.

At this Subcommission meeting, a decision was made to provide greater impetus to collaboration through the development of a framework for cooperation in the basic sciences. This framework, which was heartily endorsed by the Working Group, is provided below:

A. Life Science:

The Working Group emphasized the importance of encouraging collaborative interaction between Indian and American scientists in basic research in life sciences, which must form the cornerstone of further understanding and applications of biology to human needs. The following were identified as substantive areas of mutual interest:

1) Molecular and cellular immunology.

2) Developmental biology.

3) Drugs and cell surface interactions.

4) Structure and interactions of biological molecules.

5) Plant molecular biology.

6) Neurobiology and behaviour.

7) Molecular, cellular and microbial genetics.

9) Synthesis of biologically active molecules.

B. Biochemical Engineering:

Biological and enzyme initiated processes require highly sophisticated engineering and process control inputs to be able to ensure process stability and economic viability. The Group felt that active interaction between specific groups in both countries which have expertise should take place in the approved manner in areas of interest such as (a) microbial membrane structure and functions, (b) software and algorithm for biological processes, (c) growth of recombinant-DNA cells, (b) anaerobic acidogenesis, and (c) immobilization of enzyme sensors.

C. Advanced Scientific Interactions:

The Group felt that education and training in modern areas of biology is very important. There is a vast scope for collaboration in the area of educational technology, especially computer-aided instruction for effective teaching.

Further, the Group proposed that joint activity in these areas be supported by such means as:

1) Formulation of collaborative projects;

2) Workshops, seminars and symposia;

3) Providing means for exchanges of scientists and post-doctoral students from various institutions in both countries; and

4) Exchange of research materials.

The Group stressed the desirability of promoting individual contact between scientists and stressed that such interaction was one of the best ways to ensure formulation of joint projects in areas of mutual interest. There was consensus among the Group that basic research is essential to progress in the life, medical, agricultural, and bioengineering sciences and that all existing mechanisms should be used to further collaboration and development of high priority programs.

In regard to education, it was suggested that there be some emphasis on using new methods of scientific communication.

It is understood that proposals will be developed within the framework of the broad areas identified above, and that they will be submitted to appropriate authorities in the respective governments for review and processing in accordance with program procedures. Each government has the responsibility for making opportunities for cooperation known within its respective scientific community.

26. Other Research Opportunities:

It was recognized that from time-to-time an important research opportunity might arise which does not fall within any of the priority areas identified in this report. In general, these proposals are ones which are based on the availability of a special study population. Such is the case of a currently pending project on urolithiasis. It was agreed that these proposals must be judged upon their individual scientific merit by the respective governments.

27. Materials for Research Support:

The need in India for polymer plastics for the use in ELISA tests and other laboratory requirements was identified. It was agreed that efforts would be made by both sides to address this problem.

28. Administrative and Working Procedures:

The idea of considering areas of cooperation, both current and proposed (particularly on infectious diseases) within the context of a matrix which would show the full spectrum of activity from basic research through application, was discussed. It was agreed that this idea has merit. Rubrics which could be included in such a matrix include: basic research, research reagents, rapid diagnosis, epidemiology research, clinical intervention, health services research, vaccine development and rehabilitation.

The desirability of streamlining the process of scientific merit review and other clearances in order to facilitate the timely implementation of projects was discussed by the Working Group. It was generally agreed that a number of lessons could be learned from the STI. A set of guidelines to help achieve this end will be developed by the Subcommission as a whole.

ANNEX A

STATUS AND PROGRESS ON SELECTED INDO-US COLLABORATIVE STUDIES IN THE FIELD OF HEALTH, MEDICAL AND LIFE SCIENCES

COMMUNICABLE DISEASES

MALARIA

There are four ongoing collaborative projects in the field of Malaria under the Science and Technology Initiative (STI). The first is on the detection of infected mosquitoes using the two-site immunoradiometric assay (IRMA). The Indian scientists have received training on vector incrimination using the IRMA technique. Necessary reagents for A. culicifacies including chemicals and monoclonal antibodies would be utilized for field-collected samples with an IRMA assay. An attempt would be made to develop ELISA techniques for vector incrimination and also to develop monoclonal antibodies against P. vivax, P. falciparum and P. malariae at the Malaria Research Center, New Delhi.

The second study is on the transmission blocking immunity in Plasmodium cynomolgi and P. knowlesi. The myeloma cell lines brought from NIH will be used with the partially purified gametes of P. knowlesi to obtain hybrids producing monoclonals.

The studies propose to identify surface antigens on gametes and zygotes of P. knowlesi and P. cynomolgi, production of monoclonals for identification of target antigens, and immunization of monkeys with gametes using various routes and antigens.

The third study is on the antigenic variation during relapses of P. cynomolgi infections. The cloning of P. cynomolgi B has been achieved by the limit dilution method and transmission of clonal P. cynomolgi B infection through A. stephensi is in progress. The work will continue on the collection of relapse stabilates from two clones and their cryopreservation, chemotherapeutic response, both in vitro and in vivo systems of different isolates, to study the relapsing pattern in order to identify varient antigens specific to each relapse and compare in genomic composition by DNA hybridization technique.

The last study is on immunization of simians with purified malaria antigens. Virulence and immune response tests showed that falciparum malaria parasites in the majority of monkeys

acquired virulence. Mosquitoes fed in the night on monkeys with 1-4% parasitaemia produced oocysts but not sporozoites in the gut. The other strains of A. stephensi are being screened at the Malaria Research Center for their suitability in transmission. CDRI/Lucknow scientists would work on M 40,000 and 80,000 antigens to apical organell/rhoptries substance. Sporozoite antigens will be supplied by New York University and tested for immunization of simians at CDRI, Lucknow.

LEPROSY

Under the STI collaboration, five of the seven approved projects in leprosy have been initiated. The first project is on the study of the role of dendritic cells in the antigen induced in vitro lymphoproliferative responses in leprosy. The initial attempts to purify dendritic cells from mice as well as from human were unsuccessful. Currently attempts are underway to evaluate antigen presentation by these cells in an indirect manner by deleting other classes of cells with antigen presenting ability. One question which is being investigated is whether the T-cell deficiency is selective or global.

The second project is on the biological significance of phenolic glycolipid antigen from M. leprae. The in vitro assay of cellular immunity with this antigen, as well as the production of monoclonal antibody to it, is in progress. Another project is on the development of M. leprae-specific human T-cell clones. Although healthy T-cell lines could be maintained, the cloning experiments were unsuccessful. Experiments have been initiated which may permit the growth of specific responsive T-cells utilizing a new protocol.

The above studies are being undertaken at AIIMS, New Delhi in collaboration with Dr. Cohn's and Dr. Brennan's laboratories.

In another project, studies are being conducted on the characterization of specific phenolic glycolipids in infected human tissue and human-derived M. leprae. Attempts are being made to obtain pure phenolic glycolipid (PGL) to develop a rapid and cheaper method of using PGL to monitor the presence of antibody to PGL in patients as a diagnostic tool and to prepare labelled methionine PGL to study its influence on macrophage metabolism.

The most recently implemented STI project involves studies of macrophage metabolism and function after M. leprae infection as an indication of host parasite interaction. Some initial results have been obtained in the area of hydrolytic enzyme and oxidative radicals. These two projects are being undertaken at FMR Bombay in collaboration with Dr. Brennan's and Dr. Cohn's laboratories.

Collaboration on leprosy underway under the auspicies of the S&T Subcommission includes a study on the use of biochemical and radioisotopic methods for developing improved techniques for in vitro detection for drug resistance and screening of new drugs in leprosy. The main objective of the study is to develop a rapid assay for determining DDS drug resistance, to elucidate metabolic pathways in order to understand the pathogenesis of drug resistance, and to characterize new compounds for use in leprosy chemotherapy. The study so far has established the usefulness of uptake of DOPA for determining the viability of M. leprae obtained from drug-treated patients and correlating this in the in vitro system. The enzyme studies have identified gamma-glutamyl transpeptidase in mycobacteria including M. leprae which may be used as a possible marker for both viability and drug resistance by developing a suitable assay procedure. Also the studies on cholesterol metabolism in mouse peritoneal macrophages in presence of M. leprae provides a method for screening of drug sensitivity/resistance of M. leprae to any known or unknown compound. Several new drugs are being screened by the above methods.

Another study concerning genetics of leprosy is based on HLA and B-cell typing. Here the objective of the study is to find the association of a specific HLA and B-cell antigen with different types of leprosy. Multiple participants have been fully screened for HLA, B & C loci antigens in 30 families, and the results are awaited.

The role of transfer factor in the management of leprosy cases has been just initiated as a collaborative study also.

TUBERCULOSIS

Here the major project is on the development of immuno-diagnostic techniques for the rapid diagnosis of clinical tuberculosis. This is a collaborative project between AIIMS, New Delhi and TRC Madras in collaboration with the State University of New York and VA Medical College and Hospital, New York. As a result of this work, a radioimmunoassay (RIA) technique has been developed against a component of secretory protein (PPD) with a view to the measurement of antigens of M. tuberculosis in biological fluids of patients with pulmonary tuberculosis. Attempts are being made to further improve the sensitivity of the method and its application to other biological fluids besides sputum, such as serum, CSF, urine and ascitic fluid. Studies are also being conducted on the further characterization of the antigen, development of the assay for various other antigens, and development of a second antibody (anti-goat in the donkey).

FILARIASIS

There are five joint research projects under this collaboration in the field of filariasis. These include a study of antigen, antibody and immune complex profile as applied to the immunodiagnosis of human filariasis. The presence of filarial antigen in filarial urine samples is being detected by double antibody sandwich ELISA and by immuno-radiometric assays (IRMA) using 125 I Rabbit Ig4 antibodies to B. malayi antigen. Preliminary results suggest the useful potential of this technique for using urinary specimens as an initial screening in filarial surveys. This is a collaborative project of Mahatma Gandhi Institute of Medical Science, Wardha with the University of Texas at Houston.

Another study is on the detection of circulating parasite antigen as a clinical and epidemiological tool for filariasis. Here immunodiagnostic techniques such as ELISA and CIEP are being used to screen serum samples from patients with clinical filariasis, asymptomatic microfilaremia, and normals living in endemic areas. Umbilical cord samples from newborns and pregnant mothers living in the endemic areas are also being studied.

Another collaborative study of NICD, Delhi with the University of Michigan School of Public Health is on immuno response dynamics in filariasis, characterization of immuno-suppression, and evaluation of antibody-mediated killing of W. bancrofti infective larvae. The preliminary results show a predominance of T suppressor cells among microfilaria carriers. These subjects will be followed at periodic intervals over the years to determine the usefulness of the monoclonal antisera with the help of immunofluorescent techniques.

Another project is with Tuberculosis Research Centre, Madras in collaboration with NIAID, Bethesda on immunopathogenesis in Bancroftian filariasis including the tropical pulmonary eosinophilia syndrome. The preliminary results indicate that patients with acute tropical pulmonary eosinophilia have an extreme eosinophilic alveolitis relative to all other clinical groups which may perhaps lead over the years to chronic lung disease. Patients with asymptomatic microfilaraemia show immunological unresponsiveness to parasite antigens while having otherwise normal immune responses. Microfilaria patients have factors in their serum that suppress their immune responses in-vitro systems and perhaps also in-vivo systems. In patients with tropical pulmonary eosinophilia, there is a marked elevation of total IgE as well as extreme elevation of specific antifilarial IgE, IgE, IgM and IgA. These elevations allow these patients to be differentiated from other clinical groups. Once treatment is instituted, these elevated levels drop to control values.

The other studies are also on immunological aspects of bancroftian filariasis in India, in collaboration with Government General Hospital, Madras with the NIH, Bethesda.

VIRAL HEPATITIS

This is a collaborative project of the National Institute of Virology (NIV), Puna with NIAID, Bethesda on the epidemiology of viral hepatitis and related problems. As a result of this collaboration, it became apparent that the massive outbreak of hepatitis during 1955-56 was neither due to hepatitis A or B. Further results indicate that non-A and non-B hepatitis is a common source of epidemic and sporadic hepatitis in India. Studies are in progress utilizing recombinant DNA technology on the evaluation of clinical specimens to identify the etiologic

factors responsible for epidemic non-A/non-B hepatitis. Using the samples from several epidemics in India, it has been possible so far to transmit epidemic viruses for non-A/non-B hepatitis and produce disease in two non-human models (chimpanzee and marmoset).

CONTRACEPTION

An Important area of collaboration is to develop a contraceptive vaccine which can produce reversable infertility in males or females. Early results at the Indian Institute of Science, Bangalore indicate that the active immunization of non-human primates with highly purified beta-FSH resulted in azospermia without adversely affecting the testicular disfunction. Further work is underway in collaboration with the LSU Medical School at New Orleans. A similar approach is being utilized to develop an anti-LHRH vaccine for male fertility regulation by the All India Institute of Medical Sciences/National Institute of Immunology, New Delhi in collaboration with the Population Council, New York. Another approach which is in the early stages of investigation is identification of specific zona pellucida antigen in female fertility regulation. The purified antigens prepared by the US scientists are being investigated in non-human primate models. Preliminary data shows that the zona pellucida antigen available at the present time completely blocks follicular growth and development and results in ovarian dysfunction. Attempts are being made to further purify zona pellucida antigen, which does not cause ovarian dysfunction but only specifically blocks the zona pellucida.

A Reagent Bank has been established at IRR, Bombay where matched assay reagents for reproductive hormones, LH, FSH, prolactin and HCG have been supplied by NICHD for distribution to qualified investigators in India. This bank has served a useful purpose and will enable the ICMR, in due course, to set up its own matched assay reagent and national quality control programme in this field.

The other collaborative area of research is testing of contraceptive drugs/devices developed by the NICHD or the ICMR. Already LHRH agonists supplied by NICHD have been studied in the different non-human primate models using either paraental approach or intra-nasal administration. In a study conducted in

male rhesus monkeys where an LHRH agonist was administered intranasally, the results suggested that male infertility occurred without adversely affecting the testicular function. This data is encouraging and, after reconfirmation with other institutions either in India or the US, phase I/II human clinical trials will be initiated under the aegis of the ICMR. Another drug which has completed a phase I clinical trials is a biological implant called Capronor which provides contraception protection for a period of 8-10 months. A phase II/III clinical trial will be undertaken with a longer Capronor device which may provide contraceptive protection for at least one year.

The NICHD facilities have been utilized for the reconfirmation of findings by Indian scientists in animal studies. For example, a gonadal peptide material called Inhibin prepared by IRR Bombay was recently investigated by the NICHD for its biological activity. The results indicated that the US laboratory could not confirm the Indian observations. Attempts are being made to further strengthen this collaboration.

Several useful workshops in India and the U.S. have already been held under this programme for technology transfer in the areas of reproductive immunology, implantation and animal genetics. The primary focus of these workshops has been on the demonstration of laboratory techniques rather than emphasis on lectures. It is proposed that workshops should be outlined in the areas of contraceptive research and product development.

MATERNAL & CHILD HEALTH

The ICMR has developed a collaborative research project with AID to study the interaction of maternal nutrition, infectious diseases status of women, and infant survival. The research design and protocol has been finalized for the study and is now awaiting final clearance from Government of India, which is expected by the end of this month. This study has a global and national significance in view of high infant mortality associated with low birth weight. In this study, attempts will be made to correlate urinary infection in the mothers with the incidence of low birth weight and also study the usefulness of nutritional supplementation to pregnant mothers for prevention of low birth weight. This is a multicentre and multi-disciplinary study where several institutions located in India in States like Maharashtra, Uttar Pradesh, Kerala, Tamil Nadu and Andhra Pradesh are participating.

BLINDNESS:

A collaborative hospital-based case control study of senile cataract is aimed at identifying risk factors on cataract, particularly nutrition and diet, personal and environmental factors. Biochemical studies on lens and red blood cells form a major component of the study. This is a collaborative project of AIIMS, New Delhi, RP Centre for Ophthalmic Sciences in collaboration with the National Institute of Occupational Health, Ahmedabad and the National Eye Institute in Bethesda. Another collaborative study with NEI is with the School of Biological Sciences, Madurai involving laboratory and clinical studies of Eale's disease. Here the major objective is to characterize the immune status of Eale's disease patients, to determine the angiogenic/anti-angiogenic factors present in the vitreous, to determine the nature of HLA associated pre-disposition to this disease and to evaluate the effectiveness of combined cryo-and photo-coagulation of specific lesions of the retina. Due to the rarity of this disease in India, about ten patients having Eale's disease in both eyes and four patients in one eye have been recruited so far into the clinical studies.

In the field of nutritional blindness, the National Institute of Nutrition, Hyderabad is also collaborating with NEI. The first is on anterior segment collagenase activity in keratomalacia. Here the objective of the study is to determine and to quantitate collagenase and alpha 2 macroglobulins in the tears of children with cornea dysfunction from nutritional eye diseases and to correlate this data with ophthalmic and nutritional factors. Various techniques necessary for the study have already been standardized which include estimation of vitamin A by HPLC, estimation of alpha macroglobulin with radical immunodefficient method, estimation of collagenases, conjunctional biopsy, and goblet cell counting as well as preparation of material for autoradiography. Another area of collaboration in this field is the study of absorption of vitamin A in patients having diarrhoea with or without rehydration. The present study is aimed to determine the extent to which the vitamin A supplement given with ORT would be available to children having diarrhoea. The preliminary results indicate that vitamin A absorption is lower in children with diarrhoea than in normal subjects. The ORT does not seem to have any affect on vitamin absorption.

Cancer

A large scale epidemiological study on oral pre-cancerous and cancerous lesions was initiated in 1966 with the Tata Institute of Fundamental Research, Bombay with an overall aim of demonstrating whether there is a reduction in the rate of oral precancerous lesions with a change of tobacco chewing habits. Phase I & II studies have been completed. Now phase III studies are ongoing and available information indicates a slight reduction in incidence of oral cancer due to gradual change of tobacco chewing habits in some of the areas in Kerala but not in the State of Gujarat.

ANNEX B

VACCINE RESEARCH AND DEVELOPMENT

The Subcommission recognizes that vaccines are among the most cost-effective and safe health technologies and that their universal use in India would reduce significantly the high burden of vaccine-preventable diseases. Today in India and throughout the world there is an encouraging resurgence of interest in attacking vaccine-preventable disease across the full spectrum of scientific, medical and public health activities.

The Subcommission notes that recent spectacular advances in biotechnology and recent developments in new and improved vaccines present a unique opportunity to proceed rapidly in a comprehensive attack on vaccine-preventable diseases and offer great promise for new vaccines which are safe, inexpensive and of greater stability at room temperature.

The Subcommission notes with satisfaction the several efforts currently underway or in the planning stage to advance vaccine development and immunization programmes, including efforts in EPI programmes to strengthen vaccine production capacity, enhanced coverage, quality control and increased attention to the important area of epidemiology and training in epidemiologic research.

The Subcommission has a significant programme in immunology and vaccine-related research against some of the major communicable diseases. Some of these are now included in STI programmes. There is clearly a need to expand and extend vaccine development technology as a crucial element in the vigorous assault on the vaccine-preventable diseases. The Subcommission therefore enthusiastically endorses with highest priority undertaking a vaccine development programme to complement the ongoing and proposed comprehensive immunization programmes.

The Subcommission recommends that both the Indian and U.S. sides at the highest level be informed of this unique, timely opportunity to initiate a major collaborative programme in vaccine development which might eventually include rabies, measles, pertussis, malaria, typhoid and polio.

The Subcommission further recommends that a small Indo-US working group prepare an approach paper outlining in detail the technical options to be considered in a workshop with wider participation of both Indian and U.S. scientists. Recognizing the urgency as well as the enormous opportunity in this area, the Subcommission urged that this approach document as well as the workshop be completed within 1985 and clear recommendations for further action be proposed for consideration by both governments.

ANNEX C

CORE PROVISIONS OF THE PLAN OF ACTION OF MUTUAL COOPERATION BETWEEN THE GOVERNMENT OF INDIA, MINISTRY OF SOCIAL AND WOMEN'S WELFARE, AND THE U.S. DEPARTMENT OF EDUCATION, NATIONAL INSTITUTE FOR HANDICAPPED RESEARCH, FOR THE REHABILITATION OF THE HANDICAPPED IN INDIA

The main provisions are:

1. Establishment of two pilot projects to extend comprehensive rehabilitation services in the rural areas of India;

2. Establishment of a Central Documentation and Information Centre in the Institute for the Physically Handicapped, New Delhi;

3. Establishment of a Research Centre on aids and appliances for the handicapped to be located in one of the national institutes for developing appropriate orthotic and prosthetic devices, equipment and techniques as well as evolving appropriate systems for production of aids and appliances;

4. Technical assistance in the transfer of technical know-how, technology and hardware support in the following areas:

   a. development and manufacture of hearing aids, screening audio-meters and impedance meters;

   b. securing calibration equipment and servicing equipment for impedance meters, audiometers and hearing aids for a few selected centres in India;

   c. Indian manufacture of aspheric plastic and crown blank lenses by continuous process technology and low cost spectacles (plastic lens moulded along with the frame).

5. Establishment of a job development centre to take up the task of job analysis, human factor assessment, improving productivity of the handicapped, etc. to develop the employment market for the handicapped; and

6. Strengthening the national institutes in India, in particular, development of professional staff, technical specialists, etc. by assisting in the organization of workshops and training programmes, provision of technical materials, technical consultants and the award of fellowships for study in the USA.

The Subcommission agreed to collaborative efforts between NIHR and MSWW in the above areas.

4/16/85

INDO-US COOPERATIVE VACCINE DEVELOPMENT ACTION PROGRAM

APPROACH PAPER

This "approach paper" puts forward a proposal to establish an Indo-US Cooperative Vaccine Development Action Program, or Vaccine Action Program for short. The Vaccine Action Program would encompass cooperation across the entire spectrum of vaccine-related technology, including research to develop new and improved vaccines and vaccine-related diagnostic methodology; vaccine field trails; vaccine production and quality control; and vaccine delivery methodology. The essential elements of this new cooperative program were endorsed by the Seventh Session of the Indo-US Science and Technology Subcommission held in New Delhi, April 8 - 10, 1985.

It is suggested that this proposed new program is of such significance in the history of scientific and technical cooperation between the United States and India that it should be announced jointly by Prime Minister Gandhi and President Reagan at the time of their meeting in Washington D.C. in June 1985.

Background and Rationale

Vaccines are among the most cost-effective of health technologies, and their widespread use in India would reduce significantly the high burden of vaccine-preventable diseases in the country. With increasing attention to health programs which promote child survival, there is a resurgence of interest throughout the world in attacking this important category of diseases across the full spectrum of scientific, medical and public health disciplines. Recent breakthroughs in biotechnology have stimulated a renewed interest in vaccine development, which had reached a technological plateau in recent years. The explosion of interest in immunization programs worldwide as attention is focussed on child survival technologies is readily apparent in India in the rapid expansion of immunization at the national level and in a concomitant increase in commitment of international health organizations and health assistance programs which are active in the country.

Today, the two lines of rapidly advancing technology and a growing commitment to immunization programs intersect in the context of Indo-US science and technology cooperation. Various research projects under the Indo-US S&T Subcommission and Science and Technology Initiative have demonstrated a productive collaboration in basic research related directly to vaccine development. The Indian national immunization program, which offers another example of significant Indo-US cooperation through USAID support, provides a solid base on which to build a comprehensive joint effort to combat vaccine-preventable diseases. Vigorous participation by scientists who are active in vaccine research and development would make a significant contribution to development of a successful, comprehensive program in the area.

The strong collaboration between Indian and U.S. scientists, particularly in the area of health, medical and life sciences, is a technological centerpiece in the relationship between the two countries. Based on a review of the progress in the vaccine-related fields of research of the Subcommission and STI programs, and in recognition of the commitment of the Government of India to expanding and strengthening immunization programs, the Subcommission strongly endorsed--with highest priority--the development of a major collaborative effort in the field of vaccine development.

The Vaccine Action Program outlined in this document is expected to emerge as a major, comprehensive effort to combat vaccine-preventable diseases. This comprehensive effort includes many currently active and planned activities such as those under the STI and being pursued between the U.S. Agency for International Development and the Ministry of Health and Family Welfare. The Subcommission noted these ongoing efforts with satisfaction and endorsed their further development as highly complementary to the proposed Vaccine Action Program.

The numerous opportunities presented for fruitful research and development in this field mandate a thoughtful but prompt identification of priorities. The limited availability of technical and financial resources will not allow investments in time and money to be made across the wide spectrum of opportunities and needs. Resources should be concentrated in those vaccine-preventable disease areas with highest priority to insure a significant and measurable effect.

To identify vaccine development priorities accurately and promptly, the Subcommission endorsed the concept of a workshop to expertly explore the wide range of activities relating to control of vaccine-preventable diseases. Emphasis should be placed on an assessment of the state-of-the-art in technology applicable to vaccine development, on an accurate description of the burden of vaccine-preventable diseases in the population, and on service-delivery issues in order to better estimate the potential impact of new and improved vaccines on reducing infant and young child mortality.

Program Scope:

1. Research and development on new and improved vaccines is the essential backbone of the Vaccine Action Program. There are many candidate vaccines and vaccine-preventable diseases which deserve consideration by the new VAP. Among the more promising candidates are vaccines for malaria (in which Indian and U.S. scientists are already collaborating), rotavirus, cholera, typhoid, shigellosis, cannine rabies, all types of hepatitis, and Hemophilus influenza type b. Significant improvement through application of modern biotechnology as well as more conventional research approaches may improve the effectiveness of immunization programs which deliver measles, pertussis and polio vaccines. Vaccines against parasitic diseases other than malaria and application or adaptation of available vaccines against both viral (influenza) and bacterial (pneumococcal) lower respiratory tract infections, a major cause of death in infants and young children, should also be pursued. Because research and development covers the entire spectrum of activities, this continuum may be divided into the following three discrete categories to facilitate establishing priority areas:

Category I: Collaborative research and development projects targeted on high-priority vaccines which can be developed or adapted to the Indian situation within a reasonable period of time and applied in national immunization programs. For example, if the field trials of the acellular pertussis vaccine prototypes now being conducted in Sweden are successful, they could be a major advantage to India's immunization programs. However, they would require extensive field trials in India before they could ethically be used in a national program.

Category II: Basic research leading to development of prototype vaccines for diseases of importance to India but which have been relatively neglected in research programs in the U.S. because the disease is not a high priority for domestic U.S. research agencies or for private sector biological product firms. For example, the basic immunological research in several infectious diseases under the STI and Subcommission programs would be considered eligible for consideration in this category. Malaria, shigella, cholera and typhoid vaccines would be examples of vaccines in this category.

Category III: Research on improved manufacturing technology including quality control capabilities. This category, located at the applied end of the spectrum, refers to the adoption of the most advanced state-of-the-art manufacturing technologies such as use of cell lines on microcarriers, newer down-stream technologies for vaccine purification, and vaccine formulations with greater stability and shelf life. Such a transfer of technology would assure that safe and efficacious vaccines will be available in adequate quantities for national immunization programs. Research on several candidate strains of measles vaccine, rabies, polio and Japanese encephalitis would be examples in this category.

II. Development of rapid diagnostics technology is closely related to vaccine research and development as they share many common R&D pathways in evolving products and technologies. Research on the immunology and other vaccine-related issues of infectious diseases provides the most specific and fruitful approach to development of diagnostics. In addition, independent research on diagnostics without corresponding research on vaccines may be a useful approach to make available the tools required for epidemiologic surveys and health program assessments. The success of any major effort to promote immunization programs will depend considerably on the availability of inexpensive, sensitive and specific diagnostic techniques to support the critical epidemiological studies. The Subcommission encouraged concurrent development of diagnostics and vaccines.

III. Clinical and population-based research provides accurate descriptions of vaccine efficacy, diagnostic technology sensitivity and specificity, and safety of vaccines and immunization programs. Expert clinical research is a critical element in the development of new and improved vaccines. For optimal assessment of the safety of vaccines in human beings, a capability in this area is essential. Population-based

research, preferably within a carefully defined population, is required to establish vaccine efficacy and to determine immunization program effectiveness. The Subcommission endorsed the proposal to develop vaccine-preventable disease study centers, for example in Trivalore where demonstrated epidemiological expertise and a well-defined rural population would play an important role in vaccine development activities.

IV. Vaccine delivery issues ultimately determine the effectiveness of immunization programs, and the impact of new and improved vaccines on reducing vaccine-preventable disease rates depends on efficient delivery of services to the target populations in a cost-effective and timely manner. The Subcommission encouraged research on both the technical limitations of current vaccines with regard to heat stability and the consequent dependence on a cumbersome, expensive cold chain, and on sociological and program implementation considerations. Both of these issues affect logistics and public acceptance of immunization programs.

V. Vaccine production and quality control capacity greatly strengthens national capability to combat vaccine-preventable diseases. Increasing production capacity is a national goal. A high-quality, ethical vaccine production industry requires a technically competent, independent quality control laboratory to insure the safety, efficacy and public confidence in vaccines and immunization programs.

Approach to the Establishment of an Indo-US Cooperative Vaccine Development Action Program

The establishment of specific activities in response to the concensus endorsement of the Subcommission for a Cooperative Vaccine Development Action Program should proceed at a rapid pace. Several complimentary activities are already underway and others are in the planning stage in other Indo-US collaborative programs. The Vaccine Action Program of the Subcommission should proceed, if possible, according to the following schedule:

April 24, 1985: A strategy planning session with appropriate representatives from the U.S. side during the planned visit of Dr. S. Ramachandran to Washington. At this time the initial reaction of both the Indian and U.S. sides to this approach paper will be discussed.

May 6-7, 1985: During the planned visit to Washington by Dr. S. Ramachandran and Dr. V. Ramalingaswamy, coinciding with that of Prof. M.G.K. Menon to the U.S., a meeting of leading scientists and science administrators on the U.S. side will provide the forum to further add specific items to the Vaccine Action Program. Preliminary plans for a workshop (see below) to be held in India in August/September will be made at this time.

May 6, 1985: Prof. Menon meets with Dr. George Keyworth to discuss the proposed Vaccine Action Program including the possibility of its announcement during Prime Minister Gandhi's visit to Washington in June.

June 11-15, 1985: Announcement by Prime Minister Gandhi and President Reagan of the Indo-US Cooperative Vaccine Development Action Program.

August or September 1985: Convening of a workshop with participation of both U.S. and Indian scientists, public health officials and program administrators to jointly plan the project-specific elements of the new program. This workshop would identify a focussed and meaningful joint program based on the results and conclusions arrived at during the meeting on global vaccine priorities and state-of-the-art in vaccine development held in August 1984 in Washington D.C. under the auspices of the U.S. National Academy of Sciences/Institute of Medicine. The major item for consideration during the workshop will be specific recommendations to both the U.S. and Indian sides for actions to be initiated before the end of calendar year 1985.

COPY

INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT

1818 H Street, N.W., Washington, D. C. 20433, U.S.A.

Area Code 202 · Telephone - EXecutive 3-6360 · Cable Address - INTBAFRAD

June 18, 1985

Ms. Adriana Vink
UNICEF
A-6-M
866 United Nations Plaza
New York, New York 10017

Dear Ms. Vink:

In reference to Ami Fullerton's conversation with you last week, I am pleased to advise you that the World Bank will make an advanced FY86 contribution of $50,000 towards the Task Force for Child Survival.

Ami Fullerton has contacted our Accounting Department to initiate the paperwork. A copy of the request is attached for your information.

If you have any questions, please call Ami Fullerton on (202) 676-1566.

With kind regards,

Sincerely,

John D. North
Director
Population, Health and Nutrition Department

Attachment

cc (without attachments): Dr. Measham
Mr. Hodgkinson
Ms. Fullerton

ATFullerton:cmk

Bellagio

The Task Force for Child Survival
1989 North Williamsburg Drive • Suite I • Decatur, Georgia 30033 (404) 325-2452 • Telex 8107518512
Administratively Affiliated with Emory University

TO: RECIPIENTS OF STATUS REPORTS

FROM: WILLIAM H. FOEGE, M.D.

DATE: JUNE 17, 1985

SUBJECT: STATUS REPORT

As we look forward to Bellagio II, in Cartagena, Colombia October 14-17, I am gratified at growing support for the effort begun at Bellagio I. This includes both national and international interest in expanding immunization activities.

The Task Force members feel that the five sponsoring agencies can and should continue to support the activities of The Task Force itself. All possible donors to immunization programs should be encouraged to continue to support the country program activities, hopefully through UNICEF, WHO and other established ongoing organizations.

PAHO POLIO ELIMINATION CAMPAIGN

On Tuesday, May 14th, Dr. Carlyle Guerra de Macedo of The Pan American Health Organization announced a campaign to eradicate polio from the Western Hemisphere by 1990. This is a courageous landmark decision. It provides a definite and understandable objective which can serve as a catalyst to improve all immunization activities. The plan of PAHO is to improve immunity levels for all of the childhood immunizations, improve surveillance for all vaccine-preventable diseases and investigate all cases of polio. Other regions will follow the progress with great interest to learn from the experience which will be gained in this effort.

ROTARY INTERNATIONAL AND POLIO 2005

Rotary International has announced a campaign they have entitled "Polio 2005," in which they are committing themselves to assist in eliminating polio from the world by their 100th anniversary in the year 2005. Mr. Herbert Pigman, General Secretary and Mr. John Stucky, Program Manager from Rotary visited the staff of The Task Force and The Centers for Disease Control in Atlanta on May 13th to discuss how work might be

coordinated in implementing their program. Not only is this one more indication of the interest being generated for immunization, but new lessons are being learned on how to combine this effort of a private organization into a global program to strengthen the whole and, at the same time, allow appropriate identification with a part.

APPLIED RESEARCH PRIORITIES

Using a paper developed by Dr. Rafe Henderson, Director of the Expanded Immunization Program, World Health Organization, we asked Drs. Don Francis and Roger Bernier to help develop a listing of the most important priorities. They polled workers with field experience in immunization programs, asking them to provide suggestions and ideas on the barriers they would most like to see eliminated. Using their report, we assembled the top 10 research needs and have circulated these to some 150 people. You should have received our letter on this subject by now. The response has been very good, giving us a better idea of who is interested in specific areas and raising possibilities for inclusion on the "second 10" list. We are now attempting the more difficult task of devising ways to link resources to specific research areas.

BELLAGIO II/CARTAGENA, OCTOBER 14th-17th

Plans for the Cartagena meeting are progressing quite satisfactorily. The letters of invitation have been sent, and the responses, to date, have been most encouraging. Mr. Watson, of The Task Force staff visited Colombia the week of May 20th to make final plans and decisions with respect to logistics, accommodations, etc.

WARM SPRINGS

The Roosevelt Warm Springs Institute held a special celebration on May 16, 1985, to launch a new phase in their long history of rehabilitative efforts. They are eager to make their facilities and experience available to other countries. Mr. Carlton Spitzer, American City Bureau, 505 South Omni International, Atlanta, Georgia 30303, can be contacted for additional information.

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The National Council for International Health sponsored a meeting at the Salk Institute in March on "Immunization and the Developing World: The Role of the Private Sector." Recommendations were made in these areas:

1. Research, Development and Manufacturing
2. Management of Distribution (Vaccine and Other Supplies)
3. Delivery and Use of Immunizations

A call for action was drafted to enlist additional involvement of the private sector:

I. Each year, 8 million children in the developing world die or are crippled as a result of six major vaccine-preventable diseases: tetanus, measles, polio, diphtheria, whooping cough, and tuberculosis. The means to prevent early disability, suffering and death from these diseases now exist.

II. A decade ago, the number of children immunized in developing countries was negligible. Today, because of the efforts of national and international agencies, nearly one-third of all children are immunized. These efforts, coupled with future biotechnical breakthroughs, will mean that the goal of immunizing all children in the developing world by 1990 is possible.

III. The advancement of this goal demands a renewed commitment and partnership by all sectors of society. Special efforts are appropriate to secure the full involvement of the private sector, whose potential in this area remains largely untapped. Leaders in both the public and private sectors are called upon to seek ways of improving their partnership in support of immunization services.

IV. This partnership will benefit all sectors of society, resulting in technological breakthroughs, expanded markets, improved management, and, most importantly, it will accelerate the immunization of the world's children.

V. Efforts, such as the La Jolla conference, should continue at the national and international levels to identify issues and resolve problems. As a result, leaders in the public and private sectors can be mobilized for more effective joint actions in the field of immunizations.

For more detailed information, contact Dr. Russell Morgan, National Council for International Health, 2100 Pennsylvania Avenue, N.W., Suite 740, Washington, D.C. 20037.

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Senegal

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COUNTRY REPORTS (continued)

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Burkina Faso

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The immunization program in El Salvador received a great deal of positive publicity, focusing on the fact that both sides were willing to stop hostilities during this campaign. The program successfully reached 300,000 children. Dr. Ciro de Quadros of PAHO reports that a good evaluation of the program is being done and will be available by the time of the Cartagena meeting.

India

India has taken many steps, in recent months, to accelerate immunization activities. National Program Managers met in New Delhi from April 30th to May 3rd to review the expanded program. Special emphasis has been given to 30 districts (about 70 million population) to conduct intensified surveillance, to eliminate polio and to reduce neonatal tetanus mortality to 1 per 1,000 live births (currently 3.2/1,000 in urban areas and 13.3/1,000 in rural areas). Measles vaccine has been officially added to the national immunization plan. India now has an operational handbook for immunization, recognition cards for disease surveillance, and is developing guidelines for each part of the program. Field testing of ice lined and solar refrigerators are being conducted, and a commitment has been made to operational research to find the most suitable techniques for delivery immunizations in India.

Sincerely,

Bill Foege

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Bellagio

INFORME PRELIMINAR

EVALUACION EPIDEMIOLOGICA DE LAS JORNADAS NACIONALES DE VACUNACION (23, JUNIO, 28 DE JULIO Y 25 DE AGOSTO 1984)

Trabajo realizado Por:

RODRIGO RODRIGUEZ,MD, E.S.P.
RODRIGO GUERRERO, MD, Dr. P.H.

UNIVERSIDAD DEL VALLE
Cali,Abril 29 1985

RESUMEN

El presente estudio se realizó con el objeto de evaluar las Jornadas Nacionales de Vacunación (JNV) que se llevaron a cabo los días 23 de junio, 28 de julio y 25 de agosto de 1984 en Colombia.

El objetivo de las Jornadas Nacionales de Vacunación fué aumentar en un 50% las coberturas existentes determinadas por el Programa Ampliado de Inmunizaciones (PAI) del Ministerio de Salud y fortalecer la estrategia de vacunación (llamada "de canalización"). Las coberturas determinadas por el PAI para 1983 eran en niños menores de 1 año: 43.7%, 43.3% y 43.4% para polio, DP y Sarampión respectivamente.

El presente trabajo se limita únicamente a la evaluación epidemiológica ya que la evaluación desde el punto de vista administrativo, financiero y de comunicación social se realizó independientemente y será motivo de otro informe.

Se tomó una muestra probabilística de 131 conglomerados representativos del país localizados en 105 municipios pertenecientes a 22 divisiones político-administrativos. Se visitaron todas las viviendas contenidas en los conglomerados seleccionados y se efectuó una encuesta en las viviendas con niños menores de 4 años en la fecha de la primera Jornada, dirigida a estimar la cobertura vacunal en los diferentes grupos de edad por cada biológico.

La muestra incluyó 12545 viviendas ocupadas en el 90% de las cuales se obtuvo una respuesta confiable. El 10% restante fueron descartadas por

ausencia de un informante digno de crédito principalmente y por re nuencia (1.4% de todas las viviendas).

Se obtuvo información sobre el estado vacunal en 6.312 niños, en el 94% de los cuales la información se obtuvo a partir del carnet de va cunación, información considerada de alta confiabilidad.

La cobertura en menores de un año observada al momento de la encuesta, esto es 2 ó 3 meses después de la última jornada fué de 67.3%, 66.8% y 81.6% para polio, DPT y Sarampión respectivamente.

Las cifras correspondientes pará menores de 4 años fueron 72.3%, 72.7% y 75.0% para polio, DPT y Sarampión respectivamente.

Comparando las coberturas previas a la JNV con las coberturas al momento de la encuesta se observó un incremento de 54.0%, 54.3% y 88.0% para polio, DPT y Sarampión respectivamente, lo cual supera las metas establecidas para los JNV.

Al hacer un análisis por cohorte de los niños nacidos en los últimos 3 años se observó que el porcentaje de cobertura al primer aniversario se ha incrementado en forma sustancial año a año, indicadores que deben interpretarse como una mejoría en el programa de vacunación, el cual fué reforzado grandemente con las JNV.

Los datos de cobertura obtenidos son compatibles con los datos de cober tura estimados a partir de los datos del subsistema de Información del Ministerio de Salud.

INTRODUCCION

En 1984 Colombia realizó una campaña masiva de vacunación denominada Jornadas Nacionales de Vacunación llevadas a cabo los días 23 de junio, 28 de julio y 25 de agosto y orientada a la población menor de cuatro años. Por primera vez en Latinoamérica y posiblemente en el mundo un país subdesarrollado emprendió la tarea de aplicar masivamente tres biológicos (Antipolio oral, DPT o triple y Antisampión) en el tiempo más corto permisible para completar el esquema de vacunación contra cinco enfermedades.

Esta experiencia suscitó la atención mundial, tuvo amplia difusión internacional y motivó la visita de funcionarios de diferentes países y de organismos internacionales.

Colombia contó con la colaboración y asesoría de la Organización Panamericana de la Salud (OPS), la UNICEF, del Programa de las Naciones Unidas para el Desarrollo (PNUD) y del grupo Bellagio (1).

Además, en la ejecución de las Jornadas Nacionales de Vacunación participaron otros sectores aparte del sector salud movilizando numerosos grupos de la población en calidad de voluntarios. También la empresa privada contribuyó en especie y en dinero que mejoró el apoyo logístico y, en particular, la prensa y la radio constituyeron el eje principal de la promoción del evento.

Otro aspecto digno de destacar es la combinación de la acción masiva simultánea con la estrategia de canalización. Esta estrategia permite detectar la población infantil sin vacunar a través de un censo sencillo

que cualquier funcionario de salud y aún voluntarios de la comunidad, como se evidenció en algunos sitios, puede aplicar. En esta labor participan líderes comunitarios de unidades espaciales o geográficas pequeñas (cuadra, manzana, sector, vereda). Los niños a atender son orientados hacia puestos de vacunación temporales dispuestos para las jornadas y hacia los organismos de salud con la participación activa del líder comunitario encargado de visitar nuevamente los hogares de aquellos niños que no cumplan la cita oportunamente y de motivar a los familiares para que en la fecha fijada asistan con los niños citados (2).

Las acciones directas de promoción a través del contacto del funcionario con la población estuvieron reforzados por la promoción a través de los medios masivos de comunicación, al parecer más determinantes estos que la comunicación interpersonal de la decisión de los adultos de hacer vacunar a los niños (3).

Los objetivos de las Jornadas Nacionales de Vacunación (JNV) fueron:

a) Ampliar la cobertura de vacunación un 50%, sobre lo existente, en los menores de cuatro años al cabo de los tres meses de las JNV.
b) Fortalecer la estrategia de canalización en donde estuviera operando e implantarla en la mitad de las áreas donde no se hubiera puesto en marcha (Bogotá, Medellín, Cali, Cundinamarca, Valle del Cauca y Meta). (4).

Las Jornadas Nacionacionales de Vacunación se interpretaron como una forma de acelerar el programa regular de vacunación aplicando ágil,

ordenada y masivamente la estrategia de canalización.

Las JNV permitirían captar niños y vacunarlos completamente en tres contactos separados entre sí por el intervalo mínimo aceptado de tiempo y, también recuperar niños que hubiesen iniciado su esquema de vacunación para terminarlo durante las JNV. Por otra parte, pretendía dejar otro grupo de niños para que culminaran su esquema después de las JNV por medio del programa regular utilizando el sistema de canalización que garantizara el mantenimiento o incremento de las coberturas alcanzadas durante las JNV (5)

El Doctor Carlyle Guerra de Macedo, Director de la Organización Panamericana de la Salud (OPS) ofreció al Doctor Belisario Betancourt, Presidente de la República de Colombia, los servicios de una comisión asesora internacional para colaborar en las actividades nacionales de evaluación de las JNV.

Para la evaluación se escogieron tres grupos de nacionales que no participaron en la organización, planeación y ejecución de las JNV para que evaluaran: a) la potencia de la vacuna, b) los aspectos administrativos, financiaron, de participación comunitaria, promoción y costos. c) la evaluación epidemiológica en términos de cobertura e impacto.
El presente informe se refiere a la evaluación epidemiológica.

Es de suponer que una vez comprobada la capacidad antigénica de los biológicos suministrados los datos de cobertura obtenida reflejarían los niveles de inmunidad resultantes, puesto que no hay razón para dudar de la comparabilidad de las condiciones inmunológicas de los niños

colombianos con las poblaciones donde se han realizado los estudios de eficacia de las vacunas. Por último, el análisis de los datos epidemiológicos junto con los proporcionados por el tercer grupo de evaluación completarían los elementos de juicio para la toma de decisiones de la política futura.

Aunque las condiciones de Colombia desde el punto de vista de su infraestructura sanitaria, su estado de desarrollo socioeconómico, características demográficas; la experiencia previa y grado de progreso del Programa Ampliado de Inmunizaciones afianzado en el montaje del sistema de canalización difieren de muchas de las condiciones de la vasta gama de países subdesarrollados, los resultados del esfuerzo de las JNV y los aspectos específicos de participación de la comunidad y promoción, entre otros, conforman puntos de referencia definitivo y obligado para muchas de las naciones que luchan por reducir la mortalidad y morbilidad causada por enfermedades inmunoprevenibles.

El presente es el informe de la evaluación epidemiológica basada primordialmente en una encuesta nacional. Esta investigación aprobada por la Comisión Asesora Internacional nombrada por la OPS en reunión realizada en Bogotá los días 1-4 de octubre de 1984 y acogió sus recomendaciones orientadas a lograr una metodología de evaluación epidemiológica rápida, simplificada y de costo razonable que puede ser aplicada por personal de los Servicios Locales de Salud. La metodología escogida es primera vez que se emplea en una evaluación de ámbito nacional (6)

La encuesta de cobertura permitió obtener datos poblacionales confiables

para salvar el obstáculo de trabajar con denominadores derivados de proyecciones de población a partir de los datos del censo de 1973. De ahí la incertidumbre existente con los calculos de las coberturas vacunales basadas en el método administrativo tradicionalmente usado.

Con este estudio se pretende aportar información confiable adicional al proceso de toma de decisiones sobre repetición de las jornadas nacionales de vacunación y su extensión a otros países.

OBJETIVOS GENERALES:

1. Medir la cobertura nacional alcanzada después de las Jornadas Nacionales de Vacunación en los menores de 4 años.
2. Probar un método simplificado de muestreo de costo razonable en una evaluación de ámbito nacional.
3. Comparar los resultados de la evaluación administrativa (cáculo de la cobertura basados en los registros de vacunación tomando el número de tres dosis de Polio y DPT o las dosis únicas de sarampión dividido por la estimación de la población de niños) con los de la encuesta.
4. Calcular el impacto de las Jornadas Nacionales de Vacunación en la vacunación.

OBJETIVOS ESPECIFICOS

1. Estimar la cobertura nacional alcanzada después de las Jornadas Nacionales de Vacunación por biológico en menores de un año, de 1, 2 y 3 años de edad.

2. Comparar las proporciones de deserción entre la 1a. y 3a. dosis de las vacunas de dosis múltiple (DPT y Polio) observadas antes y durante las Jornadas.
3. Comparar las actividades de vacunación en instituciones seleccionadas antes, durante y después de las Jornadas Nacionales de vacunación.
4. Aplicar un análisis de cohorte a la población muestral al estimar las coberturas en distintas épocas y diferentes aniversarios (edad, calendario versus edad cronológica).
5. Aplicar una aproximación al análisis de cohorte al estimar las coberturas en menores de un año después de cada jornada usando el método administrativo.
6. Estimar la proporción de la cobertura atribuida a las JNV.
7. Estimar la cobertura alcanzada con cuatro biológicos al ampliar el primer aniversario en las distintas cohortes de nacimiento y las alcanzadas al final de las JNV.
8. Describir tendencia de las enfermedades inmunoprevenibles objeto de las JNV con base en los datos del subsistema de Información del Ministerio de Salud hasta diciembre de 1984.
9. Identificar los Servicios Seccionales de Salud con las más bajas proporciones de niños menores de un año y compararlas con áreas que alcanzaron altas proporciones.

METODOLOGIA

Se efectuó una encuesta de prevalencia para estimar la cobertura vacunal del país según edad y biológico con exclusión de los Territorios Nacionales.

Para ello se aplicó una técnica de muestreo simple, práctica y de costo razonable que proporcionase resultados en corto tiempo.

Según reza en el informe preliminar sobre el diseño de la muestra (7) "escoger un esquema de muestreo, que comprenda muchas variables, susceptible de ser adaptado a una variedad de situaciones y destinado a ser ejecutado por usuarios que no posean experiencia en técnicas de muestreo significa, generalmente, sacrificar la eficiencia del esquema en beneficio de su simplicidad, flexibilidad y practicidad".

En la selección de la muestra probabilística se procedió de la siguiente manera:

A partir de un listado preparado por el DANE (Departamento Administrativo Nacional de Estadística) de los municipios y de las secciones en que se dividieron para el censo de 1973 con su respectivo número de viviendas y el número acumulado de viviendas, se seleccionaron sistemáticamente 136 secciones censales correspondientes a 105 municipios que resultaron incluidos con probabilidad proporcional al número de viviendas.

Identificados los municipios y secciones se solicitaron los croquis al DANE que fueron utilizados para conformar conglomerados con un número de vivienda alrededor del promedio esperado en 1984. En cada sección fué

muestreado aleatoriamente un conglomerado.

Cada conglomerado fué reconocido en toda su extensión y visitadas todas las viviendas dentro de los límites del conglomerado.

Se diseñaron dos formularios, uno para el control del trabajo de campo y otro para la recolección de los datos de la encuesta propiamente dicha que fueron aplicados por funcionarios de los servicios locales de salud conocedores de los conglomerados seleccionados. De esta manera, los encuestadores fueron promotoras de salud, vacunadores, promotores de saneamiento, auxiliares de enfermería y los supervisores fueron enfermeras y supervisores de vacunación quienes recibieron adiestramiento teórico-práctico previamente. Para el entrenamiento los encuestadores fueron reunidos en 8 ciudades haciendo hincapié en los objetivos de la encuesta, su importancia y aclarando que la muestra no era representativa de su municipio o Departamento sino únicamente del país. En esta fase colaboraron un funcionario y un asesor de la OPS.

Los formularios fueron enviados al Departamento de Medicina Social de la Facultad de Salud de la Universidad del Valle donde una vez revisados se enviaron a la Sección de Nutrición encargada de la elaboración del programa de archivo y salidas de los datos recolectados. El procesamiento de los datos se hizo siguiendo instrucciones preparadas antes (8) para obtener los cuadros básicos de salida que sirvieran para analizar los resultados.

Variables. La encuesta se aplicó a los niños nacidos después del 23 de junio de 1980, o sea, a niños menores de 4 años al momento de la primera jornada.

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Edad: Se trabajó con los años cumplidos a la fecha de las Jornadas Nacionales de vacunación y de la encuesta.

Vacuna o biológico: Antipolio, DPT, Antisarampión y BCG.

Aniversario: La edad se subdividió en períodos así:

Primer aniversario = 0- 364 días

Segundo aniversario= 365- 729 días

Tercer aniversario= 730- 1094 días

Relación con las Jornadas Nacionales de Vacunación: Se clasificó en: Antes, Durante y Después de las Jornadas dependiendo de la fecha de aplicación de la vacunación completa con cada biológico de la siguiente manera:

Antes: Cualquier fecha antes del 1o. de junio de 1984

Durante: Entre el 1o. de junio y el 31 de agosto de 1984

Después: Fecha posterior al 31 de agosto de 1984.

Definiciones Operacionales:

Vacunado: Al niño que hubiese recibido la dosis única o múltiples (Vacuna de Polio Oral y DPT) después de la edad mínima recomendada, cumpliendo con el intervalo mínimo aceptado entre una y otra dosis; Por ejemplo, la edad mínima para iniciar es 42 días para DPT y Polio y 240 días para Sarampión. El intervalo mínimo para considerar una dosis como adecuada en las vacunas de dosis múltiple debe ser de 28 días.

Vacunado con carnet: Presentación de certificado o documento que hiciese constar la aplicación de la dosis, expedido por cualquier institución (oficial, de la seguridad social o privada)

Vacunado completamente: Que hubiese recibido los cuatro biológicos (BCG, VOP, DPT y antisarampión) o tres (todos excepto BCG) antes de cumplir el primer año de vida.

Las otras definiciones (casa visitada, casa encuestada, número de niños en la vivienda) pueden encontrarse en los instructivos de los formularios que se anexan a este informe.

Por otra parte se obtuvieron los datos de dosis aplicadas a menores de un año en los Servicios Seccionales con municipios en la muestra durante 1983 y 1984 discriminados en la muestra durante 1983 y 1984 discriminados por meses y según instituciones oficiales, de la seguridad social y particulares.

Igualmente, en la Sección de Información del Ministerio de Salud se recogió la información del número de casos de poliomielitis, sarampión, tos ferina, difteria, tétanos neonatorum (a partir de 1983) y tétanos en menores de un año (hasta 1982) reportados en el Formulario de Notificación Obligatoria de Enfermedades, SIS- 12, del subsistema de Información, discriminados por período epidemiológico. Estos datos se suministraron al computador del Programa de Vigilancia Nutricional de la Universidad del Valle, se obtuvieron las curvas de tendencia para cada enfermedad según fórmulas establecidas en el programa de cómputo existente (9)

Para calcular las coberturas por el método administrativo y las tasas de incidencia de las inmunoprevenibles se usaron las poblaciones estimadas por el Departamento Nacional de Planeación (10).

RESULTADOS

Encuesta Nacional de Cobertura de Vacunación.

Datos Generales

La muestra consistió de 136 conglomerados pertenecientes a 105 municipios localizados en 22 departamentos y el Distrito Especial de Bogotá (únicamente faltó un departamento).

Ante la imposibilidad de conseguir el croquis fueron descartados cinco conglomerados (3 rurales y 2 urbanos) quedando 101 municipios de 22 divisiones político-administrativas.

El tamaño de la muestra calculado fué de 2000 niños de 1 año que a razón de aproximadamente 6.8 viviendas por niño de 1 año implicaba visitar 13.600 viviendas, o sea, 136 conglomerados de 100 viviendas en promedio.

En la tabla 1 observamos que se visitaron 13.432 viviendas en los 131 conglomerados y se encuestaron 1.561 niños de 1 año (tabla 2), es decir, 1 niño de esa edad por cada 8.6 viviendas, lo cual refleja la discriminación de la fecundidad después del censo de 1973.

El 93% de las viviendas estaban ocupadas y albergaban 6.801 niños menores de 4 años al inicio de las JNV, pero, de los cuales 623 pasaron a ser mayores de 4 años al finalizar las JNV (31 de agosto de 1984) cono se ve al comparar los totales de niños en las tablas 1 y 2.

En el 90% de las viviendas ocupadas se obtuvo información correspondiente al 93% de todos los niños residentes en las viviendas de la muestra.

Dos quintas partes de las viviendas ocupadas no fueron encuestadas por ausencia de los ocupantes y un tercio por falta de un informante digno de crédito. Solo hubo renuencia a colaborar en el estudio en un séptimo de las viviendas ocupadas no encuestadas que representó el 1.5% de todas las viviendas ocupadas. Esta despreciable e insignificante proporción de rechazo se debió posiblemente a la motivación y educación en materia de vacunación y al personal de encuestadores, familiarizados con la población por pertenecer a las unidades operativas asistenciales locales.

La validez y confiabilidad de los datos se constatan por el hecho de que el 94% de los niños encuestados proporcionaron información basada en carnet de vacunación (Tabla 1) .

La distribución de los grupos de edad estuvo de acuerdo a lo esperado.

Cobertura de vacunación por biológico y según edad al finalizar las Jornadas Nacionales de Vacunación (Tabla 2).

Para el conjunto de los menores de 4 años se encontraron similares proporciones de vacunados, alrededor de 70%. Las coberturas oscilaron entre 68.7% para sarampión y 71.1 para BCG.

El 95% de confianza la cobertura con cada biológico fué la siguiente: Polio 70.7 ± 3.6 , DPT 69.8 ± 3.6 , Sarampión 68.7 ± 3.0 y BCG 71.1 ± 4.0

Llama la atención la casi ninguna diferencia de las coberturas de cada biológico al comparar los grupos de 1, 2 y 3 años, más notorio en las vacunas objeto de las JNV.

Sorprende las diferencias de coberturas entre los menores de 1 año y los demás grupos y los porcentajes por debajo de lo esperado. A su vez las coberturas en los menores de 1 año son semejantes al comparar las distintas vacunas.

Efecto de las Jornadas Nacionales de Vacunación.

En la tabla 3 tenemos a las coberturas acumuladas en relación con las Jornadas Nacionales de Vacunación por grupo de edad y biológico.

Los menores de 4 años incrementaron su cobertura de 42.9% a 31 de mayo de 1984 a 64.8% a 31 de agosto de 1984, o sea, que la cobertura aumentó a raíz de las Jornadas Nacionales de Vacunación en un 51% sobre lo existente antes de ellas. Durante los tres meses siguientes a las JNV hubo 4.9% de cobertura adicional. En términos generales, las JNV explican el 31.4% de la cobertura observada al momento de la encuesta y el programa regular de vacunación explica el 61.5% de esa cobertura lograda en cinco meses antes de las JNV y el 7% de la cobertura en tres meses después de las Jornadas.

Analizando por grupos de edad, notamos que el efecto de las Jornadas sobre la cobertura con vacuna oral de polio es mucho menor en los niños de 2 y 3 años de edad. En estos grupos los incrementos por las JNV fueron de 12.8% y 15.7% que representan el 23.9% y el 28.3% de aumento sobre la cobertura existente antes de las Jornadas Nacionales de Vacunación.

En cambio, en los niños de 1 año las Jornadas Nacionales de Vacunación elevaron la cobertura de 45.5% antes a 66.8% después de ellas, es decir, que se cumplió la nota de incremento en un 50% la cobertura existente antes de las JNV (el incremento fué de 46.8%).

El efecto es mucho más notorio en los menores de un año a pesar de no haber alcanzado coberturas similares a las de otros grupos de edad. En gran parte, el beneficio se debe al aceleramiento del proceso para completar el esquema al acortar el intervalo entre dosis. En la actividad regular del Programa Ampliado de Inmunizaciones (PAI), Programa del Ministerio de Salud, un niño puéde demorar 6 meses para cumplir las tres dosis de VOP iniciadas a los 3 meses de edad, mientras que con las JNV un niño de 2 meses podía completar su esquema en tres meses. Otra consecuencia del aceleramiento del PAI para este grupo de edad fúe el perfil de número de dosis aplicadas al terminar las JNV lo cual permitió que después de las JNV el PAI regular pudiese en los tres meses siguientes a las Jornadas Nacionales de vacunación completar esquemas. Se ahí que sea este grupo el único que presenta una cobertura adicional apreciable (16.7%) en el período post-JNV que explica el 24.8% de la cobertura al momento de la encuesta comparado con el aumento de 46.4% de la cobertura durante las Jornadas que explica el 68.9% de la cobertura final al momento de la encuesta.

La encuesta permite detectar la bajísima vacunación de los menores de un año, antes de las Jornadas Nacionales de Vacunación, principal grupo objeto del PAI. A pesar de haber aumentado 12 veces la cobertura existente antes de las JNV, no se obtuvieron las coberturas alcanzadas en otros grupos de edad.

Con la triple o DPT observamos cifras similares y los comentarios hechos a la VOP son pertinentes y válidos en el análisis de este biológico. En cuanto a la vacuna antisarampión vemos un efecto parecido con coberturas algo mayores, particularmente en menores de un año. Para el conjunto de los menores de 4 años, observamos que previo a las Jornadas Nacionales de Vacunación existía una cobertura un poco mayor que la de las vacunas de dosis múltiple. Con las JNV la cobertura de base (48.2%) aumentó en un 42.1%, o sea, 20.3% adicional para una cobertura al terminar las JNV de 68.5%. La cobertura agregada en los tres meses siguientes a las JNV es poco significativa en los menores de cuatro años y al discriminar por grupos de edad excepto en los menores de un año.

Al analizar los datos por grupos de edad es necesario separar los niños de 2 y 3 años de los de 1 y menores de 1 año. Para los de dos y tres años, las JNV agregaron 12.8% y 13.9% a las coberturas existentes (56.2% y 60.8% respectivamente) que significaron incrementos en el 22.8% y 22.9% sobre las coberturas antes de las Jornadas.

Para los niños de 1 año las JNV agregaron 23.5% a la cobertura existente de 45.2% que significó un incremento del 52%, o sea, que se cumplió el objetivo de las Jornadas Nacionales de Vacunación.

En los menores de un año la cobertura previa a las JNV era insignificante (1.4%) y fué incrementada 35 veces hasta lograr el 51.2% de cobertura al terminar las JNV. Nuevamente, observamos un incremento apreciable en el período post JNV de tres meses, durante el cual hay una adición de 30.4% a la cobertura y obtener una cobertura de 81.6% al momento de la

encuesta. Posiblemente, a consecuencia de la promoción durante las JNV y de la experiencia de la población en sus contactos con el sistema organizado para las JNV se logró captar un número apreciable de niños menores de un año y aplicarles este biológico después de las JNV fuese aislado o simultáneamente con las dosis pendientes para completar el esquema de dosis múltiple de DPT y Polio. Así, tenemos que las JNV explican el 61% de la cobertura prevalente al momento de la encuesta y el PAI regulan post JNV explica el 37.2% de esa cobertura.

Se incluyeron las coberturas con BCG, biológico excluido de las JNV, para comparar su variación. Claramente se observa que los cambios durante los tres meses correspondientes a las JNV y los tres meses posteriores siguieron ritmos iguales o un poco menores que los experimentados antes de las JNV, lo cual refleja la acción del PAI regular. La cobertura en menores de un año antes de las JNV es mayor que la de los otros biológicos como era de esperar por tratarse de una vacuna de dosis única que se aplica desde recién nacidos.

Análisis por Cohorte de Nacimiento

Uno de los objetivos del PAI es vacunar a los niños en su primer año de vida asignándoles su protección a las edades de mayor riesgo epidemiológico.

En la tabla 4 presentamos las coberturas de los niños de 1, 2 y 3 años para cada biológico en porcentajes acumulativos en los sucesivos aniversarios. Esta tabla y la gráfica 1 y 2 permiten mostrar la experiencia vacunal de los niños de una edad determinada, comparar esa experiencia

de niños de diferente edad para una edad cronológica determinada y analizar la evolución del PAI en diferentes años calendarios y su efecto medido por las coberturas observadas.

Para el caso de la VOP, también extensivo a la DPT, tenemos que la experiencia vacunal de los niños de 3 y 2 años al terminar las JNV es bastante diferente a la de los niños de 1 año. La conclusión anterior se deriva al comparar las coberturas al primer aniversario. Mientras para los niños de 3 y 2 años la cobertura al año de vida era de 24.8% y 29.7%, es decir, el funcionamiento del PAI daba ese resultado, los niños de 1 año experimental una cobertura de 46.8%, casi el doble, que significa progreso en el desempeño del PAI. Este salto coincide con el fortalecimiento y extensión de la estrategia de canalización a partir de 1982. Por ello vemos que los niños de tres años necesitaban de 36 meses para alcanzar una cobertura (57.3%) similar a la lograda en niños de dos años (55.7%) al cabo de 24 meses de vida, cobertura no muy alejada del 46.8% prevalente en los niños de un año al final de sus primeros 12 meses de vida.

En resumen, concluimos que el PAI ha mejorado en su capacidad operativa que le permite cumplir más oportunamente con la captación y seguimiento de los adherentes hasta completar el esquema de vacunación. Este servicio más oportuno es evidente al comparar las coberturas al primer aniversario de grupos de diferente edad y coincide con la época de afianzamiento de la estrategia de canalización.

Al practicar igual ejercicio con los datos sobre la vacuna Anti-sarampión notamos una tendencia similar con coberturas mayores. Así los niños de dos años reportan cobertura de 63.9% al cabo de 24 meses de vida cuando igual resultado (65.8%) requería 36 meses para los niños de 3 años al terminar las JNV. Por otra parte, la cobertura de los niños de tres años de 50.6% al cumplir su segundo aniversario es idéntica a la de los niños de 1 año, 49.6%, tienen al llegar a su primer aniversario, a su vez, dos veces mayor a la existente dos años atrás (24.4%) en los niños de 1 año que para el momento de las JNV tenían tres años de edad.

Una vez más se confirma el avance del PAI en la oportunidad de la vacunación acercándose a la meta de proteger a la mayoría de los niños antes de cumplir su primer año.

Cobertura de la Población Elegible.

Por tratarse de un grupo de alta prioridad se profundizó en el análisis de los menores de un año para indagar la cobertura en este grupo con VOP y el perfil de vacunación de aquellos con esquema incompleto. En otras palabras, se intenta conocer el grado de contacto de los niños con las Jornadas.

Para ellos definimos la población a riesgo que denominamos los niños elegibles constituidos por los niños que el 1o. de junio de 1984 tenían 42 a 30 días de edad y, por lo tanto, estaban en edad de recibir la VOP. Era la población potencialmente beneficiaria que al final de las Jornadas tenía menos de 1 año.

En la tabla 5 y gráfica 3 se presentan los estados vacunales comparativos de los niños elegibles antes y después de las Jornadas Nacionales de Vacunación (Agosto 31/84). Entre los datos positivos tenemos la proporción de niños que completaron su esquema: 5.9% con tercera dosis de VOP antes de las JNV que se incrementó ocho veces para una cobertura de 49.5% al concluir las Jornadas. El efecto parece deberse principalmente a la contribución de las Jornadas para completar los esquemas de vacunación acelerando el proceso.

Sinembargo es preocupante el hecho de que tres de cada cinco niños sin dosis alguna no hubiese tenido contacto con las Jornadas Nacionales de Vacunación quedando un 29.7% de los niños con opción potencial de ser vacunados por fuera del beneficio de este extraordinario esfuerzo. Lo anterior debe ser motivo de estudio para identificar los factores que impidieron el acceso a las Jornadas dependientes de la demanda y de la oferta del servicio para, posterior o concomitantemente, se desarrollen investigaciones sobre estrategias únicas o combinadas que permitan superar la barrera de las coberturas alcanzadas cuando llegan a un tope del 75%, no solo en programas de inmunización sino en algunos otros de atención a las personas.

TABLA 1. DISTRIBUCION DE VIVIENDAS Y NIÑOS INCLUIDOS EN LA MUESTRA. EVALUACION JORNADAS NACIONALES DE VACUNACION. COLOMBIA 1984

I Viviendas			
Total Viviendas Visitadas			13.434
Desocupadas	6.6%	889	
Ocupadas	93.4%	12.545	
Ocupadas y con respuesta	89.7%	11.250	
Ocupadas sin respuesta	10.3%	1.295	
Subtotal	100.0%		12.545

Razón de no respuesta	No.	%
Sin informante confiable	931	71.9
Rechazos	185	14.3
Desconocida	179	13.8
Total	1.295	100.0

II Niños Menores de 4 Años al Momento de la primera JNV (23 de junio,1984)	No.	%
Total de Niños	6.801	100.0
Con información sobre Estado Vacunal*	6.312	92.8
Sin información sobre estado vacunal	489	7.2

* De los 6.312 niños sobre los cuales se obtuvo información en un 93.6%, esta información se obtuvo a partir del carnet de vacunación.

TABLA 2. PROPORCION DE VACUNADOS POR BIOLOGICO SEGUN EDAD AL FINAL TERCERA JORNADA NACIONAL DE VACUNACION (31 AGOSTO, 1984) EVALUACION JORNADAS NACIONALES DE VACUNACION. COLOMBIA 1984.

EDAD (Años)	POLIO	DPT	SARAMPION	BCG	POBLACION ELEGIBLE
< 1	53.1	51.5	55.1	52.9	916 [a] 490 [b] 1.833 [c]
1	74.6	73.0	76.7	81.1	1.561
2	73.9	72.9	78.1	78.9	1.460
3	74.4	74.2	77.6	75.8	1.313
4	70.7	69.8	68.7	71.1	5.250 [a] 4.824 [b] 6.167 [c]

a. Para polio y DPT

b. Para Sarampión

c. Para BCG

TABLA 4. COBERTURA DE NIÑOS VACUNADOS AL CUMPLIR EL 1°, 2°y 30 ANIVERSARIO.
ANALISIS POR COHORTES.
EVALUACION JORNADAS NACIONALES DE VACUNACION. COLOMBIA 1984.

COHORTES		3 AÑOS				2 AÑOS				1 AÑO			
BIOLOGICO		POLIO	DPT	SARAMP.	BCG	POLIO	DPT	SARAMP.	BCG	POLIO	DPT	SARAM.	BCG
ANIVERSARIO	1°	24.8	24.4	24.6	51.8	29.7	29.7	33.0	57.9	46.8	45.6	49.6	72.1
	2°	43.5	44.2	50.6	62.1	55.7	56.2	63.9	70.5				
	3°	57.3	57.7	65.8	70.6								

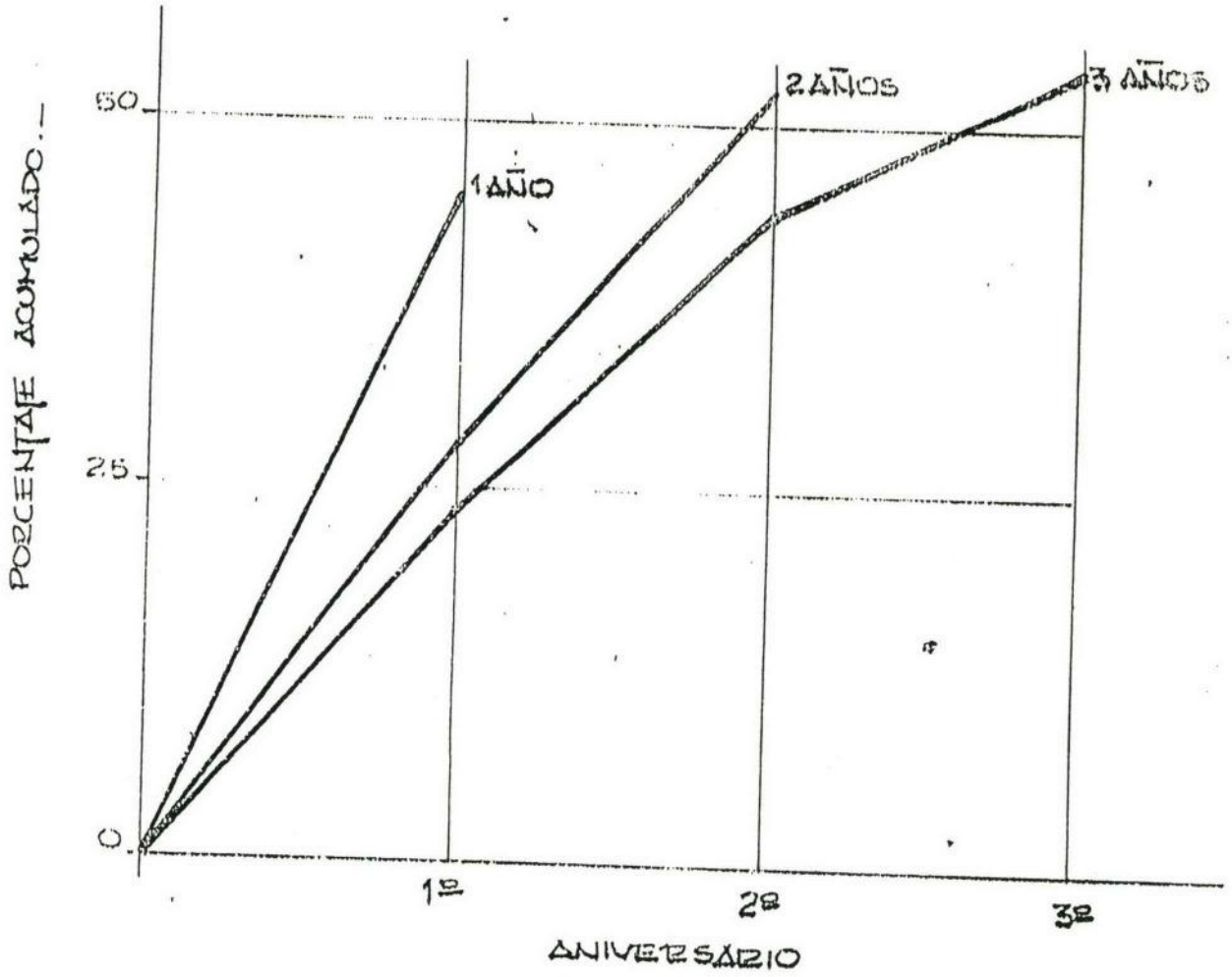
* Para la cohorte de 3, 2 y 1 Años el número de años fué 1.396, 1.448 y 1.557 respectivamente.

TABLA 3. COBERTURA ACUMULADA DE VACUNACION POR BIOLOGICO Y POR EDAD EN RELACION CON LAS JORNADAS

EVALUACION JORNADAS NACIONALES DE VACUNACION. COLOMBIA 1984.

EDAD	POLIO			DPT			SARAMPION			BCG		
	ANT.	DUR.	DESP*	ANT.	DUR.	DESP*	ANT.	DUR.	DESP.*	ANT	DUR.	DESP.*
<1	4.2	50.6	67.3	4.4	50	66.8	1.4	51.2	81.6	34.0	49.0	61.8
1	45.5	66.8	70.2	43.9	65.4	68.7	45.2	68.7	71.2	68.0	72.4	74.2
2	53.6	66.4	68.7	52.9	65.5	67.8	56.2	69.0	70.1	63.8	67.5	69.9
3	55.4	71.1	72.3	55.6	71.2	72.7	60.8	74.7	75.0	61.8	64.3	64.3
Todas las edades	42.9	64.8	69.7	42.3	64.1	69.1	48.2	68.5	72.8	55.5	62.5	67.3

(*) Después, hace referencia al período entre la última Jornada (Agosto 31/84) y la fecha de la encuesta (Nov.-Dic./84)



PORCENTAJE ACUMULADO DE NIÑOS VACUNADOS AL CUMPLIR EL 1º, 2º Y 3º ANIVERSARIO RESPECTIVAMENTE POR GRUPO DE EDAD - POLIO Y DPT.- COLOMBIA 1984.-

BIBLIOGRAFIA

1. Minsalud. Jornadas Nacionales de Vacunación: Resumen de la Experiencia, Logros y Perspectivas. Bogotá, Colombia. 1984.

2. Programa Ampliado de Inmunizaciones con la Nueva Estrategia "Canalización", Minsalud, Asesoría OPS/OMS.

3. Pabón H., de Restrepo V., Muñoz R. Influencia de los Medios de Difusión Masiva en la Cobertura de Inmunizaciones, 1984. En prensa.

4. Ibid 1, pág. 8

5. Ibid, Pág. 8.

6. Tstepehn Jones, Jacques Manceau, Joao Baptista Risi. Informe preliminar de la Comisión Asesora Internacional a la Evaluación de las Jornadas Nacionales de Vacunación de Colombia. Mimeografiado. Octubre de 1984. Bogotá, Colombia.

7. Ibid 6.

8. Manceau, J. N. Informe Preliminar sobre el Diseño de la Muestra destinada a estimar la cobertura de vacunación en Colombia después de las Jornadas de Vacunación. Mimeografiado. Nov. de 1984.

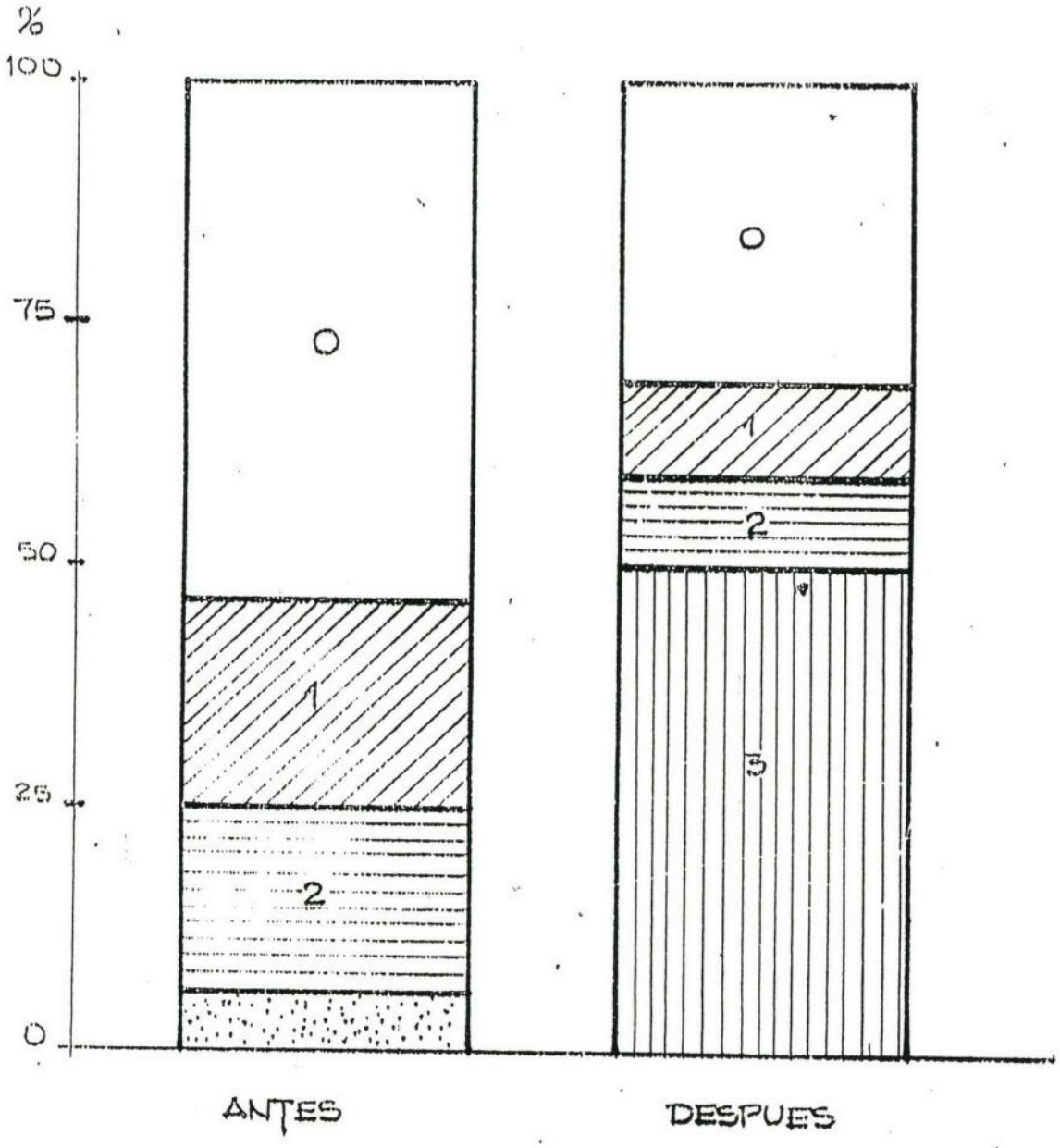
9. Fajardo L., Vigilancia Epidemiológica Nutricional. Departamento de Pediatría, Sección de Nutrición. Universidad del Valle, Cali, Colombia. 1985.

10. Departamento Nacional de Planeación. Tablas de Proyección de la Población de Colombia por quince años.

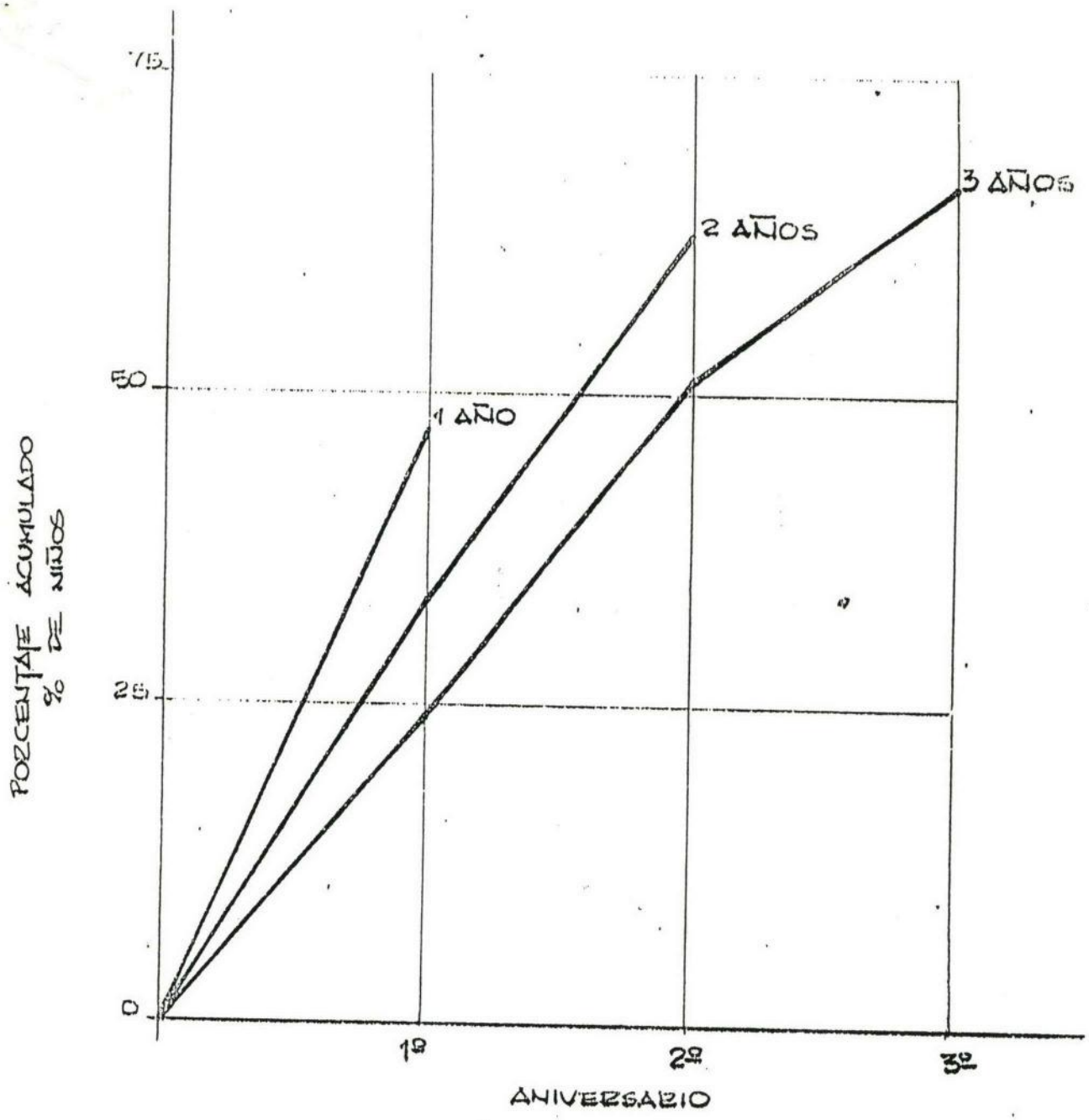
TABLA 5. ESTADO VACUNAL CONTRA POLIO EN NIÑOS ELEGIBLES* MENORES DE UN AÑO CON RELACION A LAS JORNADAS. EVALUACION JORNADAS NACIONALES DE VACUNACION. COLOMBIA 1984

ESTADO VACUNAL	ANTES JNV %	DESPUES JNV %
0 Dosis	53.5	29.7
1 Dosis	21.9	10.3
2 Dosis	18.7	10.5
3 Dosis	5.9	49.5
TOTAL	100.0	100.0

(*) 1.547 niños de 42 a 309 días de edad a 1o. de junio de 1984.



COMPARACIÓN DE LAS DISTRIBUCIONES PORCENTUALES DE 1.456 NIÑOS EN EDAD DE BENEFICIARSE CON LAS I. N.—



PORCENTAJE ACUMULADO DE NIÑOS VACUNADOS CONTRA SARAMPIÓN AL CUMPLIR EL 1ER, 2º Y 3ER ANIVERSARIO RESPECTIVAMENTE POR GRUPO DE EDAD.

COLOMBIA 1984.

Dr. Ramalingaswami
Fr. Bellagio
Meas.

August 29, 1985

Mr. Bevan E. Waide
Chief, Resident Mission
World Bank
55 Lodhi Estate
New Delhi -3
India

Dear Bevan:

This is to inform you of recent developments with the Task Force for Child Survival relating to India, and to request your assistance to Dr. P. Diesh, who has just been appointed as special consultant to the Task Force, resident in Delhi.

Attachment I provides some general background on the Task Force and its activities since it was created in March 1984. Mr. Clausen attended the Bellagio meeting in March 1984 and the Bank joined forces with WHO, UNICEF, UNDP and the Rockefeller Foundation to form the Task Force. Each of the members has provided financial support as outlined in Attachment I (para. 11). Mr. Clausen and three other Bank staff will attend the follow-up conference scheduled to take place in Cartagena, Colombia in October, 1985.

India was one of the three countries invited to Bellagio I and singled out for special emphasis by the Task Force. (The other two were Colombia and Senegal). Dr. Ramalingaswami represented India at Bellagio I.

Dr. P. Diesh has been appointed as special, part-time consultant to the Task Force to facilitate its work in India. His terms of reference are to collect information regarding Government's plans and needs to strengthen the immunization effort. He will develop an inventory of groups interested or involved in immunization programs and of their current and intended activities. The Task Force hopes that he will be able to set the stage for a meeting at all interested parties with the Ministry of Health to arrive at an agreement on how the various groups will contribute to the national immunization effort.

Attachment II is the minutes of the most recent Task Force meeting in July 1985 which provides additional background information. Please see pages 3-4 regarding India and information on the forthcoming Cartagena conference on pages 4-6.

We shall be grateful for any assistance you can provide to Dr. Diesh. His address is:

Consultant, Public Health Adviser
Office of Health and Nutrition
Agency for International Development
American Embassy, West Building
Chanakyapuri, New Delhi 110021

With best personal regards,

Yours sincerely,

Huw M. Jones
Acting Chief, Div. I
Population, Health and Nutrition Department

cc: Dr. William Foege
The Task Force for Child Survival
1989 North Williamsburg Drive
Suite I, Decatur
Georgia 30033
U.S.A.

cc: Mr. North, PHN (o/r)
Dr. Measham, PHN
Dr. Clarkson, PHN
Dr. Porter, PHN (o/r)
Mrs. Plunkett, PHN
Mrs. Asher, ASAIN
Files

INDIA:PHN
AMeasham/HMJones:sr

THE WORLD BANK INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

Date: February 26, 1985

To: Mr. A.W. Clausen (through Mr. Ernest Stern, SVPOP and Mr. S. Shahid Husain, VPOPS)

From: John D. North, Director, PHND

Extension: 61573

Subject: Report on Activities of the "Task Force for Child Survival"

1. This memorandum provides a brief review of the activities of the Task Force for Child Survival since the Bellagio I meeting which you attended in March 1984.

2. Dr. William Foege, you will recall, was chosen to lead the Bellagio Task Force composed of WHO, UNICEF, UNDP, the Rockefeller Foundation and the Bank. Dr. Foege is devoting half of his time to this effort, with his salary paid by the Centers for Disease Control, where he is a special adviser to the Director, having himself previously served as director for six years. He is assisted by a manager and a small office staff.

3. As planned, the Task Force is devoting most of its attention to catalyzing nationwide immunization efforts in Colombia, Senegal and India. Dr. Foege has spent much of his time in these efforts, plus, more recently, on similar activities in Burkina Faso. In addition, requests for assistance have led to small-scale involvement in Nigeria, El Salvador, and Ethiopia.

4. Colombia. Preliminary indications are that this is the most successful national immunization effort assisted by the Task Force to date. With strong backing from President Betancur and impressive mobilization of the armed forces, police, and voluntary organizations, Colombia staged three immunization campaign jornadas (days) in June, July and August 1984. Over 800,000 children were immunized on each of the three days and over five million doses of vaccine were given. The three campaign days helped to boost immunization coverage to about 60%, up from 43% in 1983 and 27% in 1982. A careful evaluation has been carried out by the Colombian authorities, with technical assistance from the Pan American Health Organization (PAHO) and the Task Force. The evaluation report should soon provide the kind of evidence regarding impact, cost-effectiveness and the applicability elsewhere of lessons learned that will be critical to the long term prospects of the Bellagio effort.

5. Colombia is naturally very proud of its success and eager to go beyond immunization to other aspects of primary health care, again with Task Force assistance. The invitation to hold Bellagio II in Cartagena in October 1985 is a tangible expression of the enthusiasm generated by this successful effort.

6. Senegal. The Task Force considered the original proposal from Senegal, which was presented at Bellagio I, to be infeasible. Accordingly, a short-term consultant sponsored by the Task Force and financed by

UNICEF, assisted the Senegalese authorities to develop a less ambitious and costly proposal, aimed at providing immunization coverage to one quarter of the country's six million population. UNICEF is expected to fund the revised proposal and a two year assignment of the consultant. While UNICEF is likely to finance the first year of the project, years two and three might be funded from savings in the ongoing Bank-financed health project, if this is requested by the Senegalese authorities.

7. India. Less progress is evident so far in India. Task Force efforts to arrange a meeting to discuss India's national program have not yet borne fruit. However, there is a significant Indian interest and Dr. Bisht, Director General of Health, recently visited Atlanta. In addition, UNICEF Executive Director, James Grant has suggested to Prime Minister Rajiv Gandhi that the expanded immunization effort be made a "living memorial" to Mrs. Gandhi. Dr. Foege will coordinate efforts to arrange a meeting in India as soon as possible. One possibility discussed was for the Task Force to see if the Indian authorities would welcome discussions with donors interested in providing assistance in the immunization push (SIDA, Denmark, AID, CIDA and Rotary International have expressed interest). Another option discussed was to hold a future Task Force meeting in Delhi.

8. Burkina Faso. Early returns show that Project "Commando" achieved the following:

Vaccine	No. Vaccinated	% of Target
Measles	1,035,515	79
Yellow Fever	1,804,519	69
Meningitis	2,307,163	89

These figures appear to indicate success in the campaign effort, although more information is needed to corroborate this impression. The Burkina Faso program came about as a result of discussions between James Grant and President Sankara, and was assisted by the Task Force.

9. Task Force Meetings. There have been four one-day meetings so far, including two hosted by the Bank. Attendance has been good and enthusiasm has grown over time as it became apparent that the Task Force was proving to be an important catalyst of increased immunization efforts. Dr. Luis Fernando Duque, director of the Colombian campaign and coordinator of Bellagio II, will attend the next meeting, scheduled for 1-1/2 days at the Bank, April 4-5, 1985. You may wish to meet with Dr. Foege and Dr. Duque at that time.

10. Role of the Bank. Our main role in the Task Force has been to stress the need for careful evaluation of immunization "projects" it sponsors: the coverage achieved compared to targets, the appropriateness of the targets, the health impact, replicability elsewhere, and, above all, the cost-effectiveness of the effort. We have also emphasized the need to make careful comparisons of the relative contributions of

campaigns and regular programs, and the conditions likely to favor one approach over the other in various countries. The extensive evaluation of the Colombian effort resulted, in considerable measure, from our suggestions. We intend to continue to press for rigorous evaluation.

11. Task Force Budget. Operations began with contributions from WHO and UNICEF ($50,000 each) and $35,000 from the Rockefeller Foundation. The budget for the period October 1, 1984 through December 31, 1985 is approximately $345,000, of which the Bank has been asked to contribute $75,000. (It was agreed at Bellagio I that the five members of the Task Force would each contribute to the budget). We are, therefore, processing a grant of $25,000 from the PHN budget for FY 1985, and have requested $50,000 for this purpose in our FY86 budget submission.

12. Progress. The Task Force started relatively slowly, as one would expect given the lead time required to make initial country visits, hire the small staff, and set up an office in Atlanta (Emory University is providing some administrative support there). The effort developed real direction and momentum during the summer of 1984, when the Colombian campaign took place, and has maintained this momentum ever since, as more requests for assistance have come in. The experience so far permits several preliminary generalizations about the utility of the Task Force. First, the Task Force represents a very useful and highly flexible mechanism for donor coordination. This is most evident in the collaboration between the Task Force, WHO and UNICEF. The small size of the group and inclusion of key actors at UNICEF and WHO, have facilitated quicker and arguably more appropriate responses than would be possible working through regular bureaucratic channels. Second, experience to date supports the proposition that major advances in immunization coverage are much more likely when there is a political commitment from the highest level, and that this political commitment is more likely to occur when fostered by a group like the Task Force, working within a small network of key contacts in donor organizations, the scientific community, and developing countries.

13. A third preliminary conclusion is that immunization campaigns, complete with banners, hoopla and heavy media coverage, may deserve a larger role in the scheme of things than most technical people were inclined to believe. Campaigns lend themselves to a vivid demonstration of political commitment and have the potential of adding a major impetus to regular activities. When used as a complement to, and not a substitute for, regular programs, they may be a cost-effective strategy. Fourth, the Colombian experience provides support for the notion, debated in relation to Bellagio I, that immunization is an excellent entry point for other selected health interventions. Colombia, flushed with the success of its immunization effort, now wants to expand other areas of primary health care. Within the Task Force there is an emerging consensus that immunization, diarrheal disease control and family planning represent a critical triad of interventions on which to base the effort to reduce illness and death, and lower fertility.

14. A final preliminary conclusion based on Task Force experience to

date is that the contribution of the Bellagio effort may lie less in mobilizing additional donor resources, than in catalyzing political commitment and reallocation of resources at country level. It is clearly too early to foreclose on the options for consideration at Bellagio II and beyond. But it is possible that Bellagio II should focus on expanding the current role of the Task Force - in fostering political commitment, ensuring rapid donor response, and demonstrating impact and cost-effectiveness - rather than in attempting to mobilize additional donor resources or adding to the existing international bureaucracy. The Task Force appears to perform a valuable set of functions from within the interstices of existing organizations. The challenge now is to find a way to extend this role effectively to a larger number of beneficiary countries.

cc: Mr. van der Tak
Dr. Measham
Dr. Sai
Mr. Berg
Dr. Liese
Mr. Hodgkinson
Ms. Birdsall/Ms Hall
Mr. Schebeck
Ms. Husain
Mr. Denning

ARMeasham/rmf

The Task Force for Child Survival
1989 North Williamsburg Drive • Suite I • Decatur, Georgia 30033 (404) 325-2452 • Telex 8107518512
Administratively Affiliated with Emory University

August 20, 1985

Mr. John North
Director
Health, Population and Nutrition
The World Bank
1818 H. Street, N.W.
Washington, D.C. 20433

Dear John:

Enclosed is a draft of the minutes of The Task Force meeting held in New York on July 23-24, 1985. I would appreciate your giving me any comments or suggestions for additions and/or changes.

There are two attachments: the statement drafted by Rafe Henderson and me about the purposes of the Cartagena meeting and the latest version of the agenda for that meeting.

Please note that Dr. D. A. Henderson was added as Chairperson of the Opening Session on Wednesday morning. This was decided after telephone discussions between Drs. Warren and Foege.

We would appreciate receiving a copy of the notification to your representatives in India regarding Dr. Diesh (see Page 3 of the minutes).

We still have not heard from anything further from EEC. Do you have any additional information?

Our best estimate as of now is that the Cartagena meeting will cost the Task Force approximately $65,000. If we cannot cover these expenses with our current budget, I will let you know.

Sincerely,

Bill

William C. Watson, Jr.
Project Manager

Enclosures

MINUTES OF THE TASK FORCE FOR CHILD SURVIVAL MEETING
JULY 23-24, 1985
NEW YORK, NEW YORK

The sixth meeting of The Task Force for Child Survival was held at The Rockefeller Foundation in New York City on July 23-24, 1985.

In attendence were: Dr. Ralph Henderson--WHO, Dr. Ciro de Quadros--WHO/PAHO, Dr. Steve Joseph and Mr. Newton Bowles--UNICEF, Mr. John North--The World Bank, Mr. Tim Rothermel and Dr. Mike Sacks--UNDP, Dr. Ken Warren--The Rockefeller Foundation, and Dr. William Foege and Mr. Bill Watson--The Task Force staff. Dr. Philippe Stoeckel of APMP, Paris, France joined the meeting in the late morning of the first day.

Dr. Henderson stated that Dr. Mahler had asked for a short written statement setting forth the objectives of the upcoming Cartagena meeting. The group asked Dr. Henderson and Mr. Watson to collaborate in developing such a statement.*

Dr. Henderson began the formal part of the agenda with a discussion on possibilities for global surveillance. It was his feeling that as the global immunization effort accelerates, better forms of global surveillance will be necessary. He suggested that such systems use sentinel reporting points which would, hopefully, give quick measures of trends in capitol cities. There was some discussion as to whether a more ambitious surveillance system should not be undertaken. Much of the data and information already exists at regional, provincial and national levels. However in many instances, this information is not forwarded to WHO or its regional offices for worldwide analysis and compilation.

Dr. Ken Warren gave a detailed and comprehensive report on what is occurring in basic research on vaccines and immunization. He had recently attended a meeting at Bristol-Myers and had also participated in meetings on vaccines at Cold Spring Harbor. From these meetings, it was his feeling that the big pharmaceuticul companies are more interested in vaccines and that developments in this field are accelerating rapidily. From the aforementioned meetings, as well as visits to Scripps and the Salk Institute, and his knowledge of prepublication materials in the field, Dr. Warren is of the opinion that great improvement of some of the poorer existing vaccines is in the offing, and that as many as 20 new vaccines may be forthcoming. Dr. Henderson inserted a word of caution indicating that some people, in the face of such an optimistic report, might want to "wait on the scientist", rather than proceed with immunization programs now with existing tools. Dr. Joseph stated that we should somehow try to communicate the excitement at Cartagena. Mr. North asked whether the new and improved vaccines would call for a radically different delivery system from that now existing. Drs. Warren and Henderson indicated that the world would continue to need a delivery system, quite similar to what is needed now, to take advantage of the new developments.

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*This has been done and a copy is attached.

Dr. Foege reported as follows on developments in the applied research area: 1) He distributed a matrix indicating responses to date on interest in various aspects of the "top 10" applied research needs. 2) Academic groups are willing to pursue the questions and field areas are available in India, Egypt and other countries. 3) A possibility of a matching grant from The Rockefeller Foundation exists to direct money to key applied research needs (see also page 6). Matching funds might be available from other foundations, USAID, etc. The Task Force is cooperating with Merck, Johns Hopkins and CDC on plans for field testing the Ezeject system in Guatemala.

There was discussion about the possible involvement of the Soviet Union in the field trials of new vaccines. Mr. Rothermel reported that UNDP has a ruble account in the U.S.S.R. which might be useful in this connection.

Dr. Warren reported on a meeting held at the Salk Institute on July 18, 1985, on the development and application of advanced vaccines. This meeting resulted in a plan for the participants to develop a protocol for testing adjuvants, (materials capable of enhancing the immunogenicity of currently available and future new antigens). Initial efforts would focus on antigens for hepatitis B, pertussis, measles, tetanus, malaria and polio. Dr. Warren stated that this effort was a major and positive step in the right direction.

Dr. Foege reported on the meeting of the International Physicians for the Prevention of Nuclear War, Inc. (IPPNC), held in Budapest, Hungary on June 29, 1985. Drs. Mahler, Warren, Joseph, and Henderson, Mr. Grant and others associated with the immunization-child survival effort attended this meeting. Dr. Foege delivered a speech at the meeting, in which he advocated that the IPPNC actively support the accelerated immunization effort. In spite of the fact that some of the participants reacted negatively to this proposal and saw it a diversion from their main mission, the Executive Board voted to support the proposal. Dr. Sacks stated that this was an exceedingly important development and that The Task Force should follow up actively on this matter. It was decided to invite the Co-Presidents of the IPPNC, Dr. Bernard Lown and Dr. Evgueni I. Chazov, to the Cartagena meeting.*

Dr. Joseph reported that the Italian Initiative had added $100 million to the UNICEF/Child Survival effort, largely for Africa and initially, at least, largely for accelerating immunization programs. The Western European UNICEF Committees are mounting an effort to raise an additional $100 million. With these sizable increases in resources forthcoming, Mr. Grant has sent a letter to the UNICEF field staff, and Dr. Mahler is sending a communication to all WHO Regional Directors alerting them to these developments and soliciting their support.

Dr. de Quadros reported on the newly announced PAHO campaign to eliminate polio from the Western Hemisphere. An Inter-Agency Coordinating Committee, which Bill Foege chairs, has been established. The Committee met on July 29th with possible donors to try to generate support for the campaign.**

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* Invitations have been sent.

** Pledges at this meeting appeared to be sufficient to support the PAHO polio campaign.

At this point, Dr. Foege proposed that perhaps it was time to think about a global polio elimination campaign. The consensus of the group was that such a campaign was premature, and only Dr. de Quadros spoke in favor of it.

Dr. Foege reported that indications are that there will be another increase in next year's USAID budget for child survival-immunization activities. This comes on top of the $75 million increase in the current year's budget, of which $7.5 million went to UNICEF and $3.5 million to UNDP. USAID has published a "Request for Proposal" for a contract similar to the one under which Pritech operates. Pritech has concentrated largely in the diarrheal diseases area. The intention is that the new contractor will concentrate largely on immunizations. Mr. Watson has been asked by USAID to serve on the panel to review the contract proposals.

Dr. Stoeckel gave a brief report on program developments in Senegal, Mauritania and Burkina Faso. Mr. Watson reported that Mr. Mark LaPointe is scheduled to go to Senegal in early September for a 2-year tour for UNICEF. Dr. Stoeckel reported that Mauritania is apparently considering an immunization day-type campaign and expressed some concern about the feasibility of such an approach in that country. He reported that Burkina Faso is following up its commando-type campaign conducted earlier in the year with plans for a continuing program. The World Bank, WHO and UNICEF will collaborate to evaluate the Burkina Faso effort to date.

Dr. de Quadros reported that Dr. Andrew Creese is going to Colombia in August under the sponsorship of the World Bank, to assist with a final evaluation report prior to the Cartagena meeting. Colombia is planning another round of journados in September, October and November of this year. These campaigns are aimed primarily at the children 2 years of age and under. El Salvador is also planning another immunization campaign next year.

There was another long discussion about the importance of evaluations and the difficulty in getting good evaluations done. It was suggested that this subject probably warranted a special meeting, in view of its importance, and Dr. Joseph was asked to take the lead in getting this done.

India

Dr. Foege distributed several documents pertaining to developments in India. He reported that Dr. P. Diesh had agreed to serve as a consultant to The Task Force and should be particularly helpful in providing information on the various efforts in India at the present time. It was agreed that Dr. Foege would provide The Task Force members with terms of reference for Dr. Diesh's assignment, and the four UN agencies would inform their staffs in India accordingly.* UNICEF has agreed to support 15 new professionals in the immunization program at the central level in the Indian Ministry of Health. UNICEF has also agreed to supply measles vaccine in India. The current plan is for 42 districts to serve as pilot projects.

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*The terms of reference were provided in a letter from Dr. Foege dated August 6, 1985.

Mr. Ghandi and Mr. Reagan signed an agreement for a vaccine action program during the former's recent visit to the United States. Mr. North indicated that Mr. Clausen would be visiting India soon. Dr. Foege stated that Mr. Clausen could make a important contribution by emphasizing the importance of India in the total global immunization effort.

Nigeria

Dr. Joseph reported that the program in Nigeria continues to make progress. UNICEF is conducting a rapid assessment of the program now which, hopefully, will be completed by the time of the Cartagena meeting.

Turkey

Dr. Joseph reported that on September 11, Turkey will begin the first of three week-long campaigns which will be 1 month apart. The Turkey campaign is costing a lot of money, but there are great expectations for it.

Sudan

Mr. Joseph Giordano, who is in Sudan for The Task Force, at the request of UNICEF, has called and sent a telex indicating that the Ministry of Health requests assistance of an outside international consultant, for 3 to 6 months' duration, to assist in developing a plan to be submitted to UNICEF by September 15th for funding under the Italian Initiative.* Mr. North asked how one copes with Sudan. There was a consensus that this is an extremely difficult country in which to operate, and an extraordinary effort would be needed to mount a meaningful program there. Dr. Sacks made a plea for efforts in countries without health infrastructure. Dr. Stoeckel indicated that there are positive developments in some of the West Africa francophone countries, in that the OCCE/WHO/CDC efforts there do appear to be making some progress.

The meeting then adjourned for the day. Dr. Warren and The Rockefeller Foundation hosted a delightful dinner Tuesday evening at Windows on the World in the World Trade Center.

Cartagena Meeting

The discussion about the Cartagena meeting began around the question of objectives. It was agreed that, although the primary focus in Cartagena would be on immunizations, we should not lose sight of the promotion of primary health care in broader terms.

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*This has been arranged. Mr. Larry Dodd departed for Sudan on August 14th for a 4-months' assignment. Mr. Dodd is a CDC Public Health Adviser on loan to UNICEF for this consultancy.

Responses to the invitations to Cartagena were reviewed, and it was decided that individual follow up was needed in some instances. Responsibilities for follow up were agreed to as follows:

Australia.....Dr. Warren (through Dr. Nossal)

The Netherlands.....Dr. Henderson
Norway
Sweden
Japan

Italy.....Dr. Joseph

Brazil.....Dr. de Quadros

EEC.....Mr. North

India.....Dr. Foege (through Dr. Diesh)

Pakistan.....Mr. Watson
Bangladesh

(We have received positive responses from The Netherlands and Bangladesh and a negative response from Australia.)

In addition to the Co-Presidents of IPPNC, already mentioned, it was decided to issue additional invitations to the Ministers of Health of Peru, Mexico and Turkey and to the President of The Save the Children Federation.*

After a brief discussion, it was decided that it was no longer feasible to think of conducting the Cartagena meeting only in English, and that simultaneous translation in English, Spanish and French should be provided. It was decided that if The Task Force budget could not cover the additional costs involved in providing simultaneous translation and supporting additional invitees, The Task Force staff should inform the sponsoring agencies and that they would cover the additional cost.

It was decided that The Task Force staff should attempt to secure papers from the people giving formal presentations prior to the meeting so they could be provided to participants. It was recognized that in most instances these papers could not be translated into other languages and would be provided in English only. It was decided that papers should be received by the Task Force office in Atlanta no later than September 20.

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*These invitations were mailed on July 31, 1985.

Invitees from the 14 developing countries should be informed that there will be no country presentations per se, (except for Colombia), but that they could bring papers of any length which would be distributed at the meeting, and that there would be one session for interchange of ideas and experiences on country programs.*

The agenda for the meeting was approved (copy attached). It is essentially the same as developed at the previous Task Force meeting in April. Dr. John Evans was proposed as Rapporteur to summarize and wrap-up the meeting. Mr. Watson was to contact him.**

As had been requested at the last Task Force meeting in April, in Washington, D.C., Dr. Foege and Mr. Watson distributed a proposed 3-year budget for The Task Force. This prompted a spirited discussion about the role and future of The Task Force. The discussion became even more spirited after Dr. Warren described plans which he and Dr. Foege were developing to use The Task Force as a vehicle for supporting applied research efforts with Rockefeller funds.

During this discussion, Dr. Foege enunciated his view of the role(s) of The Task Force and was asked to include this in the minutes. "Our view of The Task Force is to provide a forum for the major agencies to discuss global immunization programs and jointly plan future immunization activities. This has been facilitated by quarterly Task Force meetings. Second, The Task Force should act as a catalyst. In Senegal for instance, an acceptable plan has now been developed, and the assignment of Mr. Mark LaPointe under UNICEF auspices is expected. A catalytic role in applied research is also anticipated. Third, The Task Force should be a resource to fill gaps. The use of Mr. Joe Giordano to provide a rapid survey in Sudan is an example of this service. Finally, as a service resource to the agencies, The Task Force could provide an opportunity for innovations and pilot projects which might be difficult to carry out through a single agency."

It was decided to defer any decisions about the future of The Task Force until after the Cartagena meeting. It was decided that The Task Force would attempt to meet both before and after the formal sessions in Cartagena. Decisions on the budget for The Task Force for future years were deferred until after these meetings. Assurances were given that the sponsors would provide funding for 6 months after Cartagena, to provide for an orderly phase-out if it is decided to discontinue The Task Force. Mr. Watson stated that the only commitment which would have to be made beyond that period of time was the office lease in Atlanta. The lease is for a 12-month period, beginning October 1st, 1985 and will have to be renewed before Cartagena. It also was agreed that UNICEF would provide the additional costs incurred by The Task Force as a result of the Italian Initiative.

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*A letter to this effect was sent on August 6, 1985.

**This has been done, and Dr. Evans has accepted.

EXPECTATIONS--CARTAGENA CONFERENCE

Members of the Task Force agreed that the primary purpose of the Cartagena Conference should be to seek consensus on actions needed to meet the 1990 objectives of providing immunization for all children of the world. A secondary purpose was to review how the global actions taken in support of national immunization programs could be broadened so as to support other elements of primary health care. The conference would not be a forum in which specific pledges for support would be sought from participating development agencies.

It is hoped that representation from the development agencies will be at the Agency Head level, because what is desired is the clarification of what is needed to improve the collaborative and complementary actions taken by these agencies, the governments concerned and the organizations sponsoring The Task Force for Child Survival: WHO, UNICEF, UNDP, The World Bank and The Rockefeller Foundation.

The meeting agenda calls for a review of the current status of the global immunization initiative, and of the developments which have taken place since the March 1984 meeting held in Bellagio. The review will cover the status of research and development in the immunization field as well as the status of program implementation. Representatives of the host country, Colombia, will present some of their activities and accomplishments to the conference. A larger number of developing countries (12-15) will be represented rather than the three in Bellagio and will have an opportunity to briefly comment on their activities and aspirations in the immunization field. There will be specific reports on family planning and diarrheal disease control as illustrations of other primary health care initiatives.

The Cartagena meeting will be somewhat different from the original Bellagio meeting which was organized with the intention of promoting intimate and informal interactions amongst the participants. Partially as a consequence of the first Bellagio meeting, the immunization initiative is receiving markedly increased support and seems well on its way to success. The interest by governments, individuals and groups has increased dramatically. The Cartagena conference will, therefore, involve almost double the number of participants and will try to capitalize on this interest and momentum.

The deliberations at Cartagena are expected to determine the future of The Task Force for Child Survival. Its efforts, to date, have been to act as a catalyst in promoting coordinated global action in support of immunization. The Cartagena deliberations will be useful in determining what coordination and catalytic efforts will be needed to maintain the momentum being generated to immunize the world's children, how that momentum can be utilized to enhance the total primary health care effort and whether The Task Force is still an appropriate mechanism for accomplishing this.

July 30, 1985

MONDAY, OCTOBER 14

5:30 - 6:30 PM	REGISTRATION - Second Floor Lobby	
6:30 - 8:30 PM	SOCIAL HOUR/DINNER HOSTED BY THE TASK FORCE FOR CHILD SURVIVAL - Hotel Capilla del Mar Restaurant	

CHAIRPERSON -- DR. KENNETH WARREN

8:30 PM	OPENING SESSION - SPIRIT OF BELLAGIO Neptune Room	

TUESDAY, OCTOBER 15

8:00 - 8:30 AM	REGISTRATION - Jupiter Room	

CHAIRPERSON -- DR. KENNETH PREWITT
GENERAL SESSION - Neptune Room

8:30 - 9:00 AM	WELCOME AND OPENING REMARKS	PRESIDENT BELISARIO BETANCUR CUARTAS
9:00 - 9:30 AM	GLOBAL OVERVIEW - EPI	DR. RALPH H. HENDERSON
9:30 -10:00 AM	TASK FORCE UPDATE	DR. WILLIAM H. FOEGE
10:00 -10:30 AM	BREAK	
10:30 -11:00 AM	WESTERN HEMISPHERE PERSPECTIVE	DR. CARLYLE GUERRA DE MACEDO
11:00 -12:30 PM	NATIONAL VACCINATION CRUSADE - COLOMBIA	DR. RAFAEL de ZUBERIA AND STAFF
12:30 - 2:00 PM	LUNCH - Hosted by PRESIDENT BELISARIO BETANCUR CUARTAS - Club de Pesca	
2:00 - 3:00 PM	QUESTIONS RAISED/LESSONS LEARNED	DR. STEPHEN C. JOSEPH
3:00 - 3:30 PM	BREAK	
3:30 - 4:30 PM	OTHER ASPECTS OF PRIMARY HEALTH CARE - FAMILY PLANNING AND DIARRHEAL DISEASE CONTROL	DR. FRED T. SAI DR. MICHAEL H. MERSON

CHAIRPERSONS -- DR. RAFAEL de ZUBERIA
DR. TERESA ALBANEZ BARNOLA

4:30 - 6:00 PM	COUNTRY PERSPECTIVES ON MEETING THE 1990 OBJECTIVES	
6:00 PM	FREE EVENING	

WEDNESDAY, OCTOBER 16

CHAIRPERSON -- DR. DONALD A. HENDERSON
General Session - Neptune Room

8:30 - 9:30 AM	BASIC RESEARCH UPDATE	DR. KENNETH S. WARREN
9:30 -10:15 AM	APPLIED RESEARCH NEEDS	DR. WILLIAM H. FOEGE
10:15 -10:45 AM	BREAK	

CHAIRPERSON -- DR. KENNETH S. WARREN

10:45 -11:30 AM	FUTURE DIRECTIONS FOR CHILD SURVIVAL EFFORTS	DR. WILLIAM H. FOEGE
11:30 -12:30 PM	DISCUSSION	
12:30 - 2:00 PM	FREE TIME	
2:00 - 3:00 PM	DISCUSSION	
3:00 - 4:30 PM	COMMENTS	MR. A. W. CLAUSEN MR. JAMES P. GRANT DR. HALFDAN MAHLER MR. BRADFORD MORSE DR. KENNETH PREWITT
5:00 - 5:30 PM	SUMMARY AND CONCLUSIONS	DR. JOHN EVANS RAPPORTEUR
7:00 PM	SOCIAL HOUR/DINNER HOSTED BY THE TASK FORCE FOR CHILD SURVIVAL - Casa de Huespedes	

July 16, 1985

Mr. John D. North

John:

I spoke today with Bill Watson in Atlanta. Dr. Foege will meet tomorrow and Thursday in D.C. with Dr. Bisht, Director-General of Health Services in India. Watson believes there may be developments that would be relevant to Mr. Clausen's visit. He will ask Dr. Foege to contact you Thursday or Friday. Other than that, the attached paragraph from Foege's June 17, 1985 report is the latest on India.

Regarding the Italian donation, Steve Joseph reports that this aid is relatively tied. A Dr. Murzi heads up the program and will visit the U.S. later this month. Rafe Henderson speaks highly of Murzi. UNICEF will coordinate his visit to New York, D.C. and Atlanta. I said you might wish to meet with Dr. Murzi if his schedule permits.

Tony.

The Task Force for Child Survival
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Administratively Affiliated with Emory University

~~LOU~~ FOR NYC

July 11, 1985

NOTE TO JOHN NORTH

Tony told me he would not be able to attend. Sorry he won't be able to make it. We look forward to seeing you.

Bill
Bill Watson

Sponsoring Agencies: WHO UNICEF World Bank UNDP RF

The Task Force for Child Survival
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July 10, 1985

Mr. John North
Director
Health, Population and Nutrition
The World Bank
1818 H Street, NW
Washington, D. C. 20433

Dear John:

The next meeting of The Task Force for Child Survival is scheduled to be held on July 23-24 at The Rockefeller Foundation headquarters in New York. We will plan to begin at ~~9:00~~ 16:00 A.M. and adjourn at 4:00 P.M. each day.

Enclosed is a copy of the proposed agenda. You will note that The Rockefeller Foundation plans to host lunch on both days and a dinner on Tuesday evening, July 23.

We look forward to seeing you at the meeting.

Sincerely,

Bill Walton

for William H. Foege, M.D.
Executive Director

Enclosure

THE TASK FORCE FOR CHILD SURVIVAL
THE ROCKEFELLER FOUNDATION
1133 Avenue of the Americas
New York, New York
JULY 23, 1985
9:00 A.M.-4:00 P.M.

I. GLOBAL SURVEILLANCE POSSIBILITIES -- DR. HENDERSON

II. UPDATE ON BASIC RESEARCH -- DR. WARREN

III. UPDATE ON APPLIED RESEARCH -- DR. FOEGE

IV. SALK INSTITUTE MEETING -- DR. WARREN

12:00 - 1:30 P.M. **LUNCH - HOSTED BY THE ROCKEFELLER FOUNDATION**

V. DONOR STATUS REPORTS

A. ITALIAN INITIATIVE
B. PAHO/IDB
C. PEW MEMORIAL TRUST
D. ROTARY INTERNATIONAL
E. USAID
F. OTHER

VI. PROGRAM STATUS REPORTS

A. PAHO-POLIO
B. SENEGAL
C. COLOMBIA
D. INDIA
E. NIGERIA
F. BURKINA FASO
G. EL SALVADOR
H. TURKEY
I. SUDAN
J. OTHER

EVENING - **DINNER HOSTED BY THE ROCKEFELLER FOUNDATION**

JULY 24, 1985
9:00 A.M. - 4:00 P.M.

I. BELLAGIO II MEETING

A. UPDATE ON ARRANGEMENTS
B. RESPONSES TO DATE
C. AGENDA
D. PAPERS
E. OTHER ITEMS

12:00 - 1:30 P.M. **LUNCH - HOSTED BY ROCKEFELLER FOUNDATION**

II. ADMINISTRATIVE MATTERS

A. STATUS REPORT -- MR. WATSON
B. REQUESTED BUDGET PROJECTION
C. DATE AND LOCATION OF NEXT MEETING

ADJOURN

7/10/85

Informed Olga Duarte in Dr. Knox's office about conference to be held in Cartagena Oct. 14-17 & that Dr. Clausen will attend.

Ruf

FOR NYC
7-23/24

THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

Date: June 27, 1985

To: Mr. John D. North, Director, PHND

From: Anthony R. Measham, Health Adviser, PHNDR

Extension: 61573

Subject: Task Force for Child Survival

No outline of Steve Joseph's paper (Lost to Law) been distributed to ARM & R.H.)
Minimal role for ARM?

1. The main topic for the July 23-24, 1985 meeting in New York clearly will be the $100 million for child survival to be provided by the Government of Italy. Bill Watson of the Task Force told me on June 26 that negotiations between the Italian authorities and UNICEF are underway this week in Rome. His understanding is that the funds will be given to UNICEF, for use mainly in Africa. UNICEF has asked the Task Force to play a major role in programming the funds, which must be obligated within eighteen months. UNICEF will add temporary staff, Rafe Henderson has assigned two senior staff members and the Task Force is gearing up for a major effort. Italy apparently has a priority list of 29 countries, from which WHO and UNICEF have suggested the following ten be given priority: Uganda, Somalia, Ethiopia, Bangladesh, Nepal, Bhutan, Sudan, Burkina Faso, Senegal and Niger.

2. Marco Vienelli of UNICEF's co-financing office contacted Emmerich Schebeck on June 24 with an urgent request for PHN suggestions for co-financing candidates. (Vienelli left for Rome on June 26). Emmerich provided him on June 25 with the following possible candidates and indicative amounts:

Country	Approximate Project Cost US$ million	Proposed Co-financing US$ million
Zambia	8	2-3
Nepal	13	3-4
Rwanda	8	Unspecified amount
Ethiopia	35	5 plus 0.5 for project preparation
Malawi	25	3-4
Kenya	30	5
Ghana	17.5	4.5
Ivory Coast		Unspecified amount
Nigeria (Sokoto)	52.9	2
Liberia	9.4	0.8
Senegal	16.7	2
Gambia	9.6	2

Grant Sinclair's memo to Emmerich Schebeck is attached.

3. The Italian contribution means that the Task Force will not be concerned with the need to generate additional resources in the short run. I asked Bill Watson how else the Bank might assist in assuring that the $100 million is well spent. He said he saw an important potential role for us in evaluation. You may want to consider the possibility of us making available to the Task Force, the part-time (or even full-time) services of a PHN staff member or someone financed by the Bank. Perhaps the Policy

Create, Watson agrees

Unit would wish to become involved in this exercise. Certainly much should be learned from the infusion of this substantial sum. It may be possible for some of the funds to be allocated for operational research and evaluation.* Another thought is a possible role for Alan Berg, since the Italian funds are designated for action on "child survival and hunger".

4. The other important agenda item for New York will be finalizing the program for the Cartagena meeting in October. The invitations have been sent out by the Colombian Government and the logistics are on track.

cc: Mr. Berg, Dr. Sai. Ms. Birdsall, Mr. Denning, Mr. Schebeck, Mr. Sinclair

ARMeasham/rmf

* If funds for evaluation were given to the Task Force, they could reimburse the Bank and hire additional people for this purpose.

THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

DATE June 25, 1985

TO Mr. Emmerick Schebeck, Acting Director, PHN

FROM Grant Sinclair, Acting Chief, PHND2

EXTENSION 61594

SUBJECT Possible Italian Government Co-Financing for PHN Projects in West Africa Region

1. I checked with Ms. Bruna Vitagliano of WA2DB who is familiar with the operations of this particular fund. She advises that the fund is administered through the Ministry of Foreign Affairs by a "Secretariat for Hunger." Funds have already been appropriated by parliament and should be spent within a two-year period from approval i.e. by the end of CY 1986. She advises however, that this secretariat has not yet been installed in offices and is only marginally organized. If we wish to obtain any support from them we would have to present very detailed financing proposals and we should expect to spend a great deal of personal follow-up time.

2. Should the Italians be interested, we could provide more specific details. The projects we propose are attached.

Attachments

cc: Ms. I.Z.Husain o/r ; Messrs. Kisa, Williams, Prost, Jancloes, Carlson, Radel, Scheyer

/srm

GHANA

1. A health project was approved in early June 1985 and is scheduled to become active towards the end of this calendar year. The project objectives are broadly threefold:

(a) to provide emergency assistance to the Ministry of Health and Education in accordance with their priority needs;

(b) to help the Ministry of Health rehabilitate and improve the delivery of basic health and family planning services; and

(c) to help the Ministry of Health prepare a long-term health sector investment plan for consideration by the Bank and other donors.

2. The project support inter-alia (i) urban national and child care and treatment of severe malnutrition in Accra and Kumasi; and (ii) rural health and nutrition through extension of the coverage of rural health programs (maternal and child care, immunization, control of diarrhea disease, nutrition and family planning through contribution to the UNICEF-supervised medium term plan.

3. Additional donor financing could be applied as follows in order of priority.

(1)	Expansion of the UNICEF rural health program at the district level	$2.0 million
(2)	Technical assistance to a newly established planning unit in the Ministry of Health	$0.5 million
(3)	Reconstruction and construction of urban polyclinics in Accra and Kumasi	$2.0 million

IVORY COAST

1. A Health Project requiring a loan of $20 million; project is due to become effective by December 1985. The major objectives of the project are to assist:

(a) strengthening manpower development by expanding and improving the pre- and in-service training of nurses to meet current shortages, to make training more responsive to the Government's priority objectives for population, health and nutrition and to help develop long-term manpower planning system; and

(b) improvement of MOPHP management capability and efficiency of the health service at all levels, through programs in management and administration for Central Directorates of the Ministry, through development of cost-containment programs, in particular, in the principal hospitals and through improved supervision and staff training selected basic health centers.

2. Specifically, the project would focus on the in-service training program and supervision of the staff of 70 health centers located in the nurse field training areas. These centers which report to 10 medical districts cover about one-third of Ivory Coast's rural population. The health centers will be expected to provide basic health care, including ante- and post-natal care and immunization, as well as advice to mothers on breast feeding, weaning practices, birth spacing and nutrition. The health center staff will be trained to carry out home visits to identify malnourished children, inform mothers about immunization needs, to identify cases of infectious diseases and provide health and personal hygiene education linked to water supply, and advise mothers on family planning. These activities will be integrated into a national five-year project supported by UNICEF and into a Public Health project, supported by the Belgian Technical Cooperation Program in the Korhogo training area. This component includes about $900,000 equivalent for a program to renovate and equip about 70 rural health centers and could be suitable for co-financing.

HEALTH PROJECT, SOKOTO STATE, NIGERIA

1. In April 1985, a joint World Bank-UNICEF mission to Sokoto State in Northern Nigeria determined that primary care in rural areas is being severely handicapped by lack of drug supplies. The Bank-funded Sokoto Health Project, signed during May 1985 has been designed to strengthen a very weak maternal and child health program, particularly immunization. The project does not include drugs, as this was not considered a constraint when the project was designed several years ago. Subsequently, due to Nigeria's deteriorating financial situation, resources for health programs have drastically declined. In principle, the state authorities agreed with the mission to establish revolving drug funds, but an initial infusion of "seed stock," estimated at US$ 1.5 million equivalent, is essential for this purpose, along with about $0.5 million for technical assistance and training in management of the new system. Provision of a reliable and cost-effective supply of drugs along these lines is essential to the adequate functioning of the overall system of maternal and child care under development.

2. Items proposed for co-financing:

(a)	Revolving Fund for drug provision	$1.5 million
(b)	Technical Assistance for Training and Management of Drug System	$0.5 million
	TOTAL	$2.0 million

LIBERIA

1. A Proposed Population and Health Project -- was appraised during May 1985 and is due to be effective during mid-1986.

2. The objectives of the project are twofold: (a) to assist the GOL by providing training, technical assistance, equipment, materials and funds for operating costs through MPEA in developing a national population policy and formulating a program to implement the policy; and (b) to assist the MHSW through training, technical assistance, equipment, materials and funds for operating costs in its efforts to develop an institutional capacity for mobilizing resources to finance health care by establishing drug revolving funds and fee-for-service schemes. Consonant with these objectives, the components of the project are divided into two parts as follows:

Part A: Promoting the Development of a National Population Policy and Program. Under this part of the project, assistance would be provided for: (a) strengthening the capacity of MPEA to undertake population analysis and program development; (b) increasing awareness of the consequences of rapid population growth; and (c) implementing community-based family planning activities in selected rural areas. Implementation of this part of the project would be carried out by various government ministries in collaboration with non-governmental organizations (NGOs).

Part B: Institutional Development for Mobilizing Health Resources. This part of the project would consist of four components: (a) establishing drug revolving funds at county and community level; (b) instituting partial cost-recovery through fees-for-service; (c) developing county health boards; and (d) strengthening information, education and communication activities intended, among other things to promote public understanding of the rationale for cost-recovery. In addition to the above components, the project would provide support at the central level for management and monitoring project activities.

3. The following items could be suitable for Italian Aid during CY 86.

1. Cost of stocks for setting up drug revolving funds in 4 counties — $0.5 million

2. Materials and medical supplies — $0.5 million

3. Technical assistance for:

   (a) developing accounting procedures within the Ministry of Health headquarters (six man months costed at $15,000 each) — $90,000

   (b) management of project implementation (12 man months costed at $15,000 each) — $180,000

Total for Liberia $1.27 million.

SENEGAL

A. Pharmaceuticals.

1. The IDA financed Rural Health Project (Cr. 1310-SE) provides inter alia for:

(i) Minor upgrading/renovation and equipping of the central Pharmacie Nationale d'Approvisionnement (PNA) and three regional pharmacies; together with vehicles for the national PNA;

(ii) Equipment to develop a PNA drug testing and quality control laboratory;

(iii) Specialist services, teaching and research materials and incremental operating costs for preparation of an essential prescription manual, and for orientation of doctors, nurses and midwives in its use; and

(iv) Three years of specialist services to audit the PNA accounts; improve PNA's management and distribution capability; train PNA staff; and develop a national pharmaceutical policy.

2. The PNA is currently in a deep financial and management crisis, with debts estimated as high as US$3 million equivalent. Available stocks are down to a month's supply. The paucity of drugs and medical materials in health facilities was identified as a key issue behind a 10-day general strike of doctors, nurses and support staff throughout Senegal in May 1985. The PNA's inability to ensure an adequate stock of vaccines and essential drugs impairs Senegal's attempt to strengthen its primary health care program and to launch a national EPI program (Senegal having been selected as a pilot EPI country at Bellagio.

3. To pull the PNA out of its crisis requires immediate technical assistance to engineer a structural adjustment in terms of (a) changing the PNA's legal and organizational structure; (b) paying and/or writing off outstanding debts; (c) establishing a revolving fund; and (d) retraining staff and instituting sound financial and management practices.

4. Italian assistance may be provided as follows:

(a) Three man-years of technical assistance to the PNA in organization, management and policy formulation (US$0.3million);

(b) Provision of an initial stock of drugs to help set up a PNA revolving fund (US$1.0 million);

(c) Development of a PNA drug testing laboratory to support the procurement of low-cost generic and brand-name drugs through international competitive bidding (US$0.5 million).

B. Immunization

5. The Government of Senegal is finalizing a revised proposal for funding a national EPI program. There is a small gap in funds for renovating dispensaries (US$0.05 million) and an unidentified amount for operating costs (logistics).

THE GAMBIA

1. A health project is due to be appraised during November 1985 and although the project is not expected to be effective before the end of CY 1986, it may be of particular interest to the Italian Government for co-financing.

2. The Gambia typifies many countries of Sub-Saharan Africa in combining very high fertility and mortality rates with widespread malnutrition and morbidity. The project structure and estimated costs have been prepared on the assumption that the African Development Bank (ADB) and at least one other co-financing partner will participate. A detailed project brief is available, project costs are as follows:

PROJECT STRUCTURE AND ESTIMATED COST (IN MILLION)

A. Strengthening Health, Family Planning and Nutrition Services	
1. Primary health care (including family planning and nutrition)	2.0
1.1 National extension of village health care system programs	
1.2 Health Education, including targetted mass communication	
1.3 Peri-urban primary health care	
2. First referral level	3.5
2.1 Basic health services construction	
2.2 Vehicles, spare parts, fuel	
2.3 Equipment	
3. Second referral level	1.3
3.1 Bansang Hospital construction	
3.2 Equipment (Bansang and Royal Victoria Hospital)	
4. Drugs and consumables	1.3
4.1 Establishment buffer stock	
4.2 Central Medical Stores (construction)	
B. Strengthening Long-Term Capacity	
5. Training	.5
5.1 Construction, consolidated nurse training facility	
5.2 In-Service trainings various levels	
6. Telecommunications	.15
6.1 Radio System	
7. Strengthening planning capacity	.4
7.1 Economist, Health Planning Unit	
7.2 Nutrition and Food Policy Unit, M.E.P.I.D.	
7.3 Population planning capacity, M.E.P.I.D.	
8. Strengthening research and evaluation	.1
9. PPF	.4
	9.6*

*With physical and inflation contingencies, would exceed $10 million.

The Task Force for Child Survival
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Administratively Affiliated with Emory University

CC: FS ARH ✓ AB NB EHS IZH SHD 7/11

915

TO: RECIPIENTS OF STATUS REPORTS

FROM: WILLIAM H. FOEGE, M.D.

DATE: JUNE 17, 1985

SUBJECT: STATUS REPORT

As we look forward to Bellagio II, in Cartagena, Colombia October 14-17, I am gratified at growing support for the effort begun at Bellagio I. This includes both national and international interest in expanding immunization activities.

The Task Force members feel that the five sponsoring agencies can and should continue to support the activities of The Task Force itself. All possible donors to immunization programs should be encouraged to continue to support the country program activities, hopefully through UNICEF, WHO and other established ongoing organizations.

PAHO POLIO ELIMINATION CAMPAIGN

On Tuesday, May 14th, Dr. Carlyle Guerra de Macedo of The Pan American Health Organization announced a campaign to eradicate polio from the Western Hemisphere by 1990. This is a courageous landmark decision. It provides a definite and understandable objective which can serve as a catalyst to improve all immunization activities. The plan of PAHO is to improve immunity levels for all of the childhood immunizations, improve surveillance for all vaccine-preventable diseases and investigate all cases of polio. Other regions will follow the progress with great interest to learn from the experience which will be gained in this effort.

ROTARY INTERNATIONAL AND POLIO 2005

Rotary International has announced a campaign they have entitled "Polio 2005," in which they are committing themselves to assist in eliminating polio from the world by their 100th anniversary in the year 2005. Mr. Herbert Pigman, General Secretary and Mr. John Stucky, Program Manager from Rotary visited the staff of The Task Force and The Centers for Disease Control in Atlanta on May 13th to discuss how work might be

coordinated in implementing their program. Not only is this one more indication of the interest being generated for immunization, but new lessons are being learned on how to combine this effort of a private organization into a global program to strengthen the whole and, at the same time, allow appropriate identification with a part.

APPLIED RESEARCH PRIORITIES

Using a paper developed by Dr. Rafe Henderson, Director of the Expanded Immunization Program, World Health Organization, we asked Drs. Don Francis and Roger Bernier to help develop a listing of the most important priorities. They polled workers with field experience in immunization programs, asking them to provide suggestions and ideas on the barriers they would most like to see eliminated. Using their report, we assembled the top 10 research needs and have circulated these to some 150 people. You should have received our letter on this subject by now. The response has been very good, giving us a better idea of who is interested in specific areas and raising possibilities for inclusion on the "second 10" list. We are now attempting the more difficult task of devising ways to link resources to specific research areas.

BELLAGIO II/CARTAGENA, OCTOBER 14th-17th

Plans for the Cartagena meeting are progressing quite satisfactorily. The letters of invitation have been sent, and the responses, to date, have been most encouraging. Mr. Watson, of The Task Force staff visited Colombia the week of May 20th to make final plans and decisions with respect to logistics, accommodations, etc.

WARM SPRINGS

The Roosevelt Warm Springs Institute held a special celebration on May 16, 1985, to launch a new phase in their long history of rehabilitative efforts. They are eager to make their facilities and experience available to other countries. Mr. Carlton Spitzer, American City Bureau, 505 South Omni International, Atlanta, Georgia 30303, can be contacted for additional information.

SALK INSTITUTE MEETING

The National Council for International Health sponsored a meeting at the Salk Institute in March on "Immunization and the Developing World: The Role of the Private Sector." Recommendations were made in these areas:

1. Research, Development and Manufacturing
2. Management of Distribution (Vaccine and Other Supplies)
3. Delivery and Use of Immunizations

A call for action was drafted to enlist additional involvement of the private sector:

I. Each year, 8 million children in the developing world die or are crippled as a result of six major vaccine-preventable diseases: tetanus, measles, polio, diphtheria, whooping cough, and tuberculosis. The means to prevent early disability, suffering and death from these diseases now exist.

II. A decade ago, the number of children immunized in developing countries was negligible. Today, because of the efforts of national and international agencies, nearly one-third of all children are immunized. These efforts, coupled with future biotechnical breakthroughs, will mean that the goal of immunizing all children in the developing world by 1990 is possible.

III. The advancement of this goal demands a renewed commitment and partnership by all sectors of society. Special efforts are appropriate to secure the full involvement of the private sector, whose potential in this area remains largely untapped. Leaders in both the public and private sectors are called upon to seek ways of improving their partnership in support of immunization services.

IV. This partnership will benefit all sectors of society, resulting in technological breakthroughs, expanded markets, improved management, and, most importantly, it will accelerate the immunization of the world's children.

V. Efforts, such as the La Jolla conference, should continue at the national and international levels to identify issues and resolve problems. As a result, leaders in the public and private sectors can be mobilized for more effective joint actions in the field of immunizations.

For more detailed information, contact Dr. Russell Morgan, National Council for International Health, 2100 Pennsylvania Avenue, N.W., Suite 740, Washington, D.C. 20037.

COUNTRY REPORTS

Senegal

The Ministry of Health has developed an immunization program proposal which has now been sent by the Ministry to UNICEF. UNICEF has agreed to support the program for the first year. There are hopes for support, in future years, by USAID, France, the World Bank, and others. Dr. Philippe Stoeckel has been instrumental in pursuing the commitment and plan for a national immunization program. The assignment of Mark LaPointe to Senegal, under the sponsorship of UNICEF, is part of the proposal.

COUNTRY REPORTS (continued)

Nigeria

We have recently received a personal communication from Paul Litchfield, a UNICEF representative in Lagos, who is assigned full time to the immunization program. Paul reports that the Nigerian program is proceeding very satisfactorily, and that he is optimistic about its future. Early data indicates that immunization levels of 80% are being achieved in target areas. There is also a well developed plan to integrate these campaigns into the ongoing primary health care program. Nigeria has the largest population of any country in sub-Sahara Africa, and the development of a model program there could be important to the entire continent. Dr. Stan Foster has recently reviewed the program for UNICEF and reports that vaccine supply is now adequate, the cold chain is exceptionally good, immunization levels are rapidly improving, the target age group has become more specific (aiming at children under 24 months) and that the program workers are optimistic and energetic.

Burkina Faso

As reported earlier, the indications are that the program in Burkina Faso met the goals which were set. A team has been in Burkina Faso assisting with a sample survey which will help in evaluating the coverage achieved and assist in determining what needs to be done in the way of a continuing program.

Turkey

The Turkish government is planning a campaign-type program starting in late 1985. The campaign will not be conducted in single days, as was done in Colombia, but there will include 10-day type campaigns. Richard Reid, the UNICEF representative, who was so instrumental in assisting with the Nigerian program, is being transferred to Turkey. He and a delegation of eight people from Turkey visited the UNICEF headquarters in New York, the Centers for Disease Control in Atlanta and Colombia during April.

El Salvador

The immunization program in El Salvador received a great deal of positive publicity, focusing on the fact that both sides were willing to stop hostilities during this campaign. The program successfully reached 300,000 children. Dr. Ciro de Quadros of PAHO reports that a good evaluation of the program is being done and will be available by the time of the Cartagena meeting.

India

India has taken many steps, in recent months, to accelerate immunization activities. National Program Managers met in New Delhi from April 30th to May 3rd to review the expanded program. Special emphasis has been given to 30 districts (about 70 million population) to conduct intensified surveillance, to eliminate polio and to reduce neonatal tetanus mortality to 1 per 1,000 live births (currently 3.2/1,000 in urban areas and 13.3/1,000 in rural areas). Measles vaccine has been officially added to the national immunization plan. India now has an operational handbook for immunization, recognition cards for disease surveillance, and is developing guidelines for each part of the program. Field testing of ice lined and solar refrigerators are being conducted, and a commitment has been made to operational research to find the most suitable techniques for delivery immunizations in India.

Sincerely,

Bill Foege

William H. Foege, M.D.
Executive Director

ORLD HEALTH ORGANIZATION ORGANISATION MONDIALE DE LA SANTE

Téléphone Central/Exchange: 91 21 11
Direct: 91 2632

Dr F. Psai
Population, Health and Nutrition
Department
The World Bank
1818 H Street, N.W.
Washington, D.C.20433

In reply please refer to : CDD
Prière de rappeler la référence :

27 June 1985

Dear Fred,

... Please find enclosed a few pages on the CDD Programme to be included in the paper you are preparing for the Cartegena meeting. I would appreciate having an opportunity to review a draft of the entire paper when it is available.

Yours sincerely,

Dr M. H. Merson
Director
Diarrhoeal Diseases Control Programme

cc: Mr J.D. North
Dr R. Henderson, Director, EPI
Dr W. Foege

... ENCL:

DRAFT

Cartagena Meeting

Dr M.H. Merson

27 June 1985

1. The Problem of Diarrhoea and Prospects for Control

According to a recent WHO estimate (1), every child under 5 years of age in the developing world suffers from, on average, 2 to 3 episodes of diarrhoea a year; in the first two years of life as many as 20 per 1000 may die from diarrhoea. This means that the acute diarrhoeal diseases cause an estimated 750 to 1000 million episodes of illness and some 4 to 5 million deaths each year in children under 5 years of age. Moreover, these repeated attacks of disease predispose children to malnutrition through food withdrawal, food refusal, and malabsorption; in turn, malnutrition exacerbates diarrhoea, setting up a vicious circle that can have long-lasting effects on the quality of life of the child. Another aspect of the problem is that diarrhoea cases in many countries still account for 30 per cent or more of hospital attendances or admissions, thereby creating a heavy burden for limited national health budgets. In older children and adults, cholera continues to be a cause of special concern as the seventh pandemic, which began in 1961, has now spread to 92 countries. Travellers' diarrhoea is also an important health problem, as well as an economical one, in view of its repercussions on business and tourist travel.

Until recently, it was believed that little headway could be made against the diarrhoeal diseases in the developing countries until socio-economic development reached the level it has attained today in the industrialized nations. Fortunately, however, a number of significant advances in knowledge have been made in the past two decades with major implications for improved treatment and prevention. First, recognition of the role of new viral and bacterial agents - such as rotavirus, enterotoxigenic Escherichia coli and Campylobacter jejuni - has made it possible to identify the etiological agents in about 70 to 80 per cent of diarrhoea cases visiting health centres, as compared with some 20 per cent a decade ago. Second, a better understanding of the pathogenesis of many of the acute diarrhoeas and of the intestinal immune response has offered new possibilities for developing better methods of treatment and prevention, including antisecretory drugs and vaccines. Third it has been shown that, except in extremely severe cases, dehydration in all diarrhoeas, whatever their etiology, can be safely and effectively treated or prevented, in all age groups by the simple method of oral rehydration therapy (ORT); fourth, there is now good evidence that the effective implementation of other existing strategies (e.g. breast-feeding) can further reduce diarrhoea mortality as well as diarrhoea morbidity.

2. Control Strategies

2.1 Case Management - Proper case management of diarrhoeal diseases can prevent an estimated two-thirds of diarrhoeal deaths. It comprises:

- the prevention of dehydration with ORT by use of locally appropriate, home-prepared solutions early in the course of diarrhoea
- the treatment of dehydration with ORT using Oral Rehydration Salts (ORS)* provided throughout the health care services
- the promotion of continued proper feeding during and after diarrhoea
- the selective use of intravenous fluids and antibiotics.

ORT has been described as "potentially the most important medical advance of this century" (2). The reasons for this are the following:

(a) ORT can be used alone to successfully rehydrate 90% of patients with dehydration due to acute diarrhoea. In patients requiring intravenous fluids, ORT can be used after the initial deficit has been corrected.

(b) In hospitals with high case-fatality rates due to inadequate intravenous therapy and poor overall case management, use of ORT can reduce case-fatality rates by 40-50% (3).

(c) ORT can reduce diarrhoeal disease hospital admission rates by 50-60% (4). In this way the child and mother are spared the trauma of hospitalization and hospital costs are reduced by as much as 80%.

(d) When ORT is used at home in the early stages of the diarrhoeal episode to prevent dehydration, it can substantially reduce the number of visits to treatment facilities and overall diarrhoea mortality (5).

(e) Active feeding during and after diarrhoea, according to established guidelines, can limit the weight loss often associated with diarrhoea (6), which reduces the ill-effects of diarrhoea on nutritional status and the susceptibility of the child to other infections.

*Refers to the formulation recommended by WHO and UNICEF and composed of (per liter): glucose 20 gms, Trisodium Citrate dihydrate 2.9 gms, Sodium Chloride 2.5 gms, and Potassium Chloride 1.5 gms.

(f) ORT is one of the least expensive health interventions. It is estimated that the average cost of treating a case of diarrhoea with ORS is between $0.75 and $2.50, and the cost of preventing a death from diarrhoea with ORS is $200-$300 (7). These costs can be markedly reduced if household solutions are extensively used to prevent dehydration.

(g) Finally, ORT is simple, can readily be administered by mothers and other family members, and produces results that can be observed rapidly. As such, it is a technology highly suited for the primary health care approach, and is a useful entry point for the introduction of other critical interventions for child survival (8).

2.2 Other Strategies - Recently WHO undertook a detailed and systematic analysis of the effectiveness, feasibility and cost of 18 potential interventions (other than case management) for reduction of diarrhoea morbidity and mortality, especially in young children (9). Five interventions have been identified as feasible and cost-effective for diarrhoeal disease control. These interventions are:

(i) Promotion of breast-feeding: Despite various methodological difficulties in the studies conducted to date, the promotion of breast-feeding can have an important impact in reducing diarrhoea incidence and mortality in areas where bottle-feeding is common, and especially during the first 6 months of life (10).

(ii) Improved weaning practices: Provided that activities are directed towards specific target groups and the advice given is practical and appropriate, this strategy may improve nutritional status and thus have an impact on diarrhoea mortality. Some operational research is needed to develop recommendations for the implementation of this intervention in different settings.

(iii) Promotion of personal and domestic hygiene: There is encouraging evidence that increased attention to hand-washing in the home is a valid strategy for the reduction of diarrhoea incidence, especially that due to shigellosis (11).

(iv) Water supply and sanitation: Experience has shown that well-designed water supply and sanitation projects can substantially reduce diarrhoea morbidity and mortality, especially if they include appropriate "software" - namely educational elements - to ensure their proper use.

(v) Measles immunization: While the relation between measles, diarrhoea, and malnutrition has long been known, the recent introduction of a vaccine with better heat stability and the implementation of national expanded programmes on immunization (EPI) make this strategy particularly promising for the prevention of a large number of diarrhoea deaths; it should have an important impact on diarrhoea morbidity, particularly in Africa (12).

3. The Global WHO Diarrhoeal Diseases Control (CDD) Programme

Recognizing the significance of these new developments, the Thirty-first World Health Assembly in May 1978 called for a concerted attack on the diarrhoeal diseases as part of the global commitment to primary health care. The WHO Diarrhoeal Diseases Control (CDD) Programme was launched shortly thereafter, with the short-term objective of reducing mortality in infants and young children. Its long-term objective is to reduce the morbidity caused by diarrhoeal diseases and their associated ill effects, especially malnutrition, and to promote the self-reliance of countries in the provision of health and social services for their control.

In order to attain its objectives, the Programme has been built up on two main components: a health services component and a research component.

3.1 Health Services Component - The Programme is actively collaborating with Member States in the implementation of national CDD programmes as part of primary health care, alongside or as an "entry point" for other essential care activities. The major strategies being promoted for diarrhoeal disease control are the case management strategy and the other cost-effective strategies described in section 2.2 above. In most countries the case management strategy is at present being given the highest priority because of its potential impact.

In this component, the Programme has emphasized the development of sound managerial skills to carry out technically-sound activities. Figure 1 presents the targets and achievements for some important service component activities (13). For operational programmes, training and ORS production, the original targets have almost been reached and therefore have been increased. Progress in undertaking evaluation has been slower, but is accelerating as more programmes become operational.

Key indicators are, of course, access to and use of ORT and data on these parameters have been difficult to obtain to date. This situation will undoubtedly improve as more countries establish a better management information system for their programmes. The available data on ORS access indicate that there is an excellent possibility of reaching the Programme's 1989 target of 50% for ORT access. It is not yet clear whether the Programme's 1989 target of 35% for ORT use can be reached. To improve ORT use, priority must now be given to managerial and clinical training and improved supervision of health staff and promotion of ORT to the public through social marketing and other communication techniques.

3.2 Research Component - The Programme's research component has been designed to respond to the needs of national CDD programmes. Hence, support is being given to (1) health services (operational) research to determine the best ways of applying available knowledge in national programmes, and (2) biomedical research to find new tools for control, (e.g. vaccines). These research activities are managed by regional and global peer review groups and are assisted by a network of 11 global WHO Collaborating Centres. As of 31 December 1984, the Programme had awarded support to 294 projects. These have been undertaken in 76 countries by investigators from 77 countries, and 60 per cent are in developing countries.

Some biomedical research projects of note supported by the Programme are the following:

- Clinical trials are being carried out to examine the possibility of adding amino acids, dipeptides or starches (including cereals) to the current ORS formulation (14). A "Super ORS" of such composition may be able to reduce diarrhoea volume by 50 to 70% by increasing the absorption of sodium and water. When available, it will help popularize ORT and further discourage use of antidiarrhoeal drugs.

- In the important area of vaccine development, much progress has also been made in the development of vaccines against rotavirus diarrhoea and typhoid fever. Prospects are also good for discovering new vaccines against cholera and shigellosis.

- Multicentre studies are under way to assess simplified tests for diagnosis of enterotoxigenic E coli diarrhoea, a serotyping scheme for C. jejuni, and ELISA tests for detection of rotavirus and enteric adenoviruses.

- Several studies are under way, in collaboration with the pharmaceutical industry, to develop antisecretory agents for diarrhoea such as serotonin-antagonists, calmodulin inhibitors, and alpha-2 agonists.

3.3 Programme Management and Support - The Programme's scientific and technical aspects, general policies and directions, and budget are reviewed annually by its Technical Advisory Group, composed of eight scientists and eight public health administrators from outside WHO. Review of the overall management of the Programme is entrusted to a Management Review Committee made up of representatives of three United Nations organizations and specialized agencies who are actively collaborating with WHO in implementation of the Programme (UNDP, UNICEF, and The World Bank) and three governments who serve on a 2-year rotating basis. The deliberations of these two bodies are considered by the annual Meeting of Interested Parties, attended by representatives of governments and agencies that are current or potential contributors to the Programme, and by representatives of six developing countries which have active control programmes.

4. Conclusions

Because of the frequency of diarrhoeal diseases and the availability of cheap and effective strategies for their control that are applicable in the home, community and throughout the health care services, CDD warrants the highest priority by health planners and administrators. Successful implementation of CDD strategies now requires the commitment of health ministries to soundly managed programmes, and can provide a sound basis for primary health care. Research advances hold promise for development and application of additional control tools in the near future.

References

(1) Snyder JD, Merson MH. The magnitude of the global problem of acute diarrhoeal disease: a review of active surveillance data. Bull WHO 60: 605-613, 1982.

(2) Editorial. Water with sugar and salt. Lancet ii: 300-301, 1978.

(3) Impact of oral rehydration therapy on hospital admission and case-fatality rates for diarrhoeal disease; results from 12 hospitals. WHO Wkly epidemiol Rec 47: 361-363, 1984.

(4) Ashley DEC, Akierman A, Elliott H. Oral rehydration therapy in the management of acute gastroenteritis in children in Jamaica. In Holme, T, Holmgren J, Merson MH, Mölby R (eds). Acute Enteric Infections in Children. New Prospects for Treatment and Prevention. Amsterdam: Elsevier/North Holland, 1981, pp. 389-394.

(5) Kielmann AA. Control of diarrheal disease in the community. In Proceedings of the International Conference on Oral Rehydration Therapy, June 7-10 1983, Washington, D.C. Washington, D.C., Agency for International Development, 1983, pp. 36-39.

(6) International Study Group. A positive effect on the nutrition of Philippine children of an oral glucose-electrolyte solution given at home for the treatment of diarrhoea. Bull WHO 55: 87-94, 1977.

(7) Shepard DS. Procedures for assessing the cost effectiveness of a diarrheal disease control program based on oral rehydration therapy. In Proceedings of the International Conference on Oral Rehydration Therapy, June 7-10 1983, Washington, D.C. Washington, D.C., Agency for International Development, 1983, pp. 128-130.

(8) World Health Organization, United Nations Children's Fund. The Management of Diarrhoea and Use of Oral Rehydration Therapy: A Joint WHO/UNICEF Statement. Geneva: WHO, 1983.

(9) Feachem RG, Hogan RC, Merson MH. Diarrhoeal disease control: Reviews of potential interventions. Bull WHO 61: 637-640, 1983.

(10) Feachem RG, Koblinsky MA. Interventions for the control of diarrhoeal diseases among young children: Promotion of breast-feeding. Bull WHO 62: 271-291, 1984.

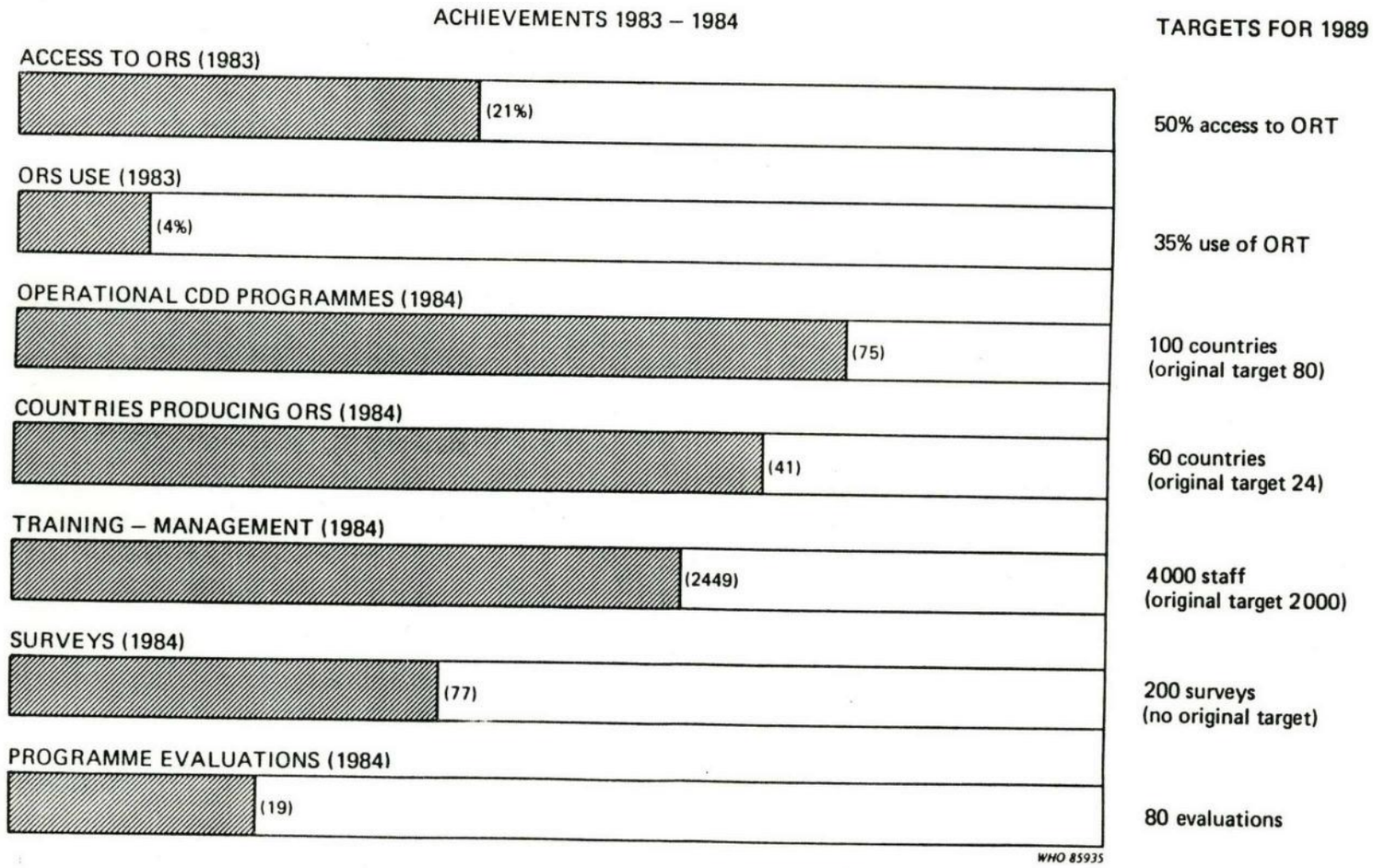
(11) Feachem RG. Interventions for the control of diarrhoeal diseases among young children: Promotion of personal and domestic hygiene. Bull WHO 62: 467-476, 1984.

(12) Feachem RG, Koblinsky MA. Interventions for the control of diarrhoeal diseases among young children: Measles immunization. Bull WHO 61: 641-652, 1983.

(13) World Health Organization. Diarrhoeal Diseases Control Programme. Fourth Programme Report, 1983-1984. Geneva: WHO (Unpublished Document No. WHO/CDD/85.13), 1985.

(14) Mahalanabis D, Patra FC. In search of a super oral rehydration solution: can optimum use of organic solute-mediated sodium absorption lead to the development of an absorption promoting drug? J Diar Dis Res 1: 76-81, 1983

FIG. 1 TARGETS AND ACHIEVEMENTS



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Bellagio II - Task Force for Child Survival - Volume 1	30117088

Document Date	Document Type
23 May, 1985	~~Memorandum~~ Letter

Correspondents / Participants

To : Mrs. Nafis Sadik, Assistant Executive Director, United Nations Fund for Population Activities

From : David Hodgkinson, Assistant to Director, Population, Health and Nutrition Department

Subject / Title

Re : Note to Understanding Concerning Financing of Consultancies for Mr. Mashler, Dr. Fathalla and Ms. Atkinson to Undertake R&D Work on Contraceptives

Exception(s)

Personal Information

Additional Comments

The item(s) identified above has/have been removed in accordance with The World Bank Policy on Access to Information. This Policy can be found on the World Bank Access to Information website.

Withdrawn by	Date
Chandra Kumar	13-Nov-14

República de Colombia

Presidencia

Bogotá, 11 de Junio de 1985
ACV-85

Mister
A W. Clausen
President
The World Bank
1818 H. Street, N.W.
Washington, D.C. 20433

Estimado Amigo:

Por medio de la presente quiero transmitirle en nombre de mi gobierno y del pueblo colombiano, mi invitación más cordial a participar en la conferencia que tendrá lugar en Cartagena de Indias a partir del 14 de octubre próximo.

Se le ha dado a este certamen la denominación de "Bellagio II" pues su tema central será, como el del efectuado en marzo en esa ciudad italiana, "La protección de los niños del mundo: vacunas e inmunización". Colombia efectuó recientemente un programa masivo de vacunación infantil, cuya evaluación comenzó a hacerse en Bellagio, y que fue una demostración colectiva de la preocupación que la sociedad y el gobierno de mi país experimentan ante los problemas de la supervivencia y de la salud de nuestros niños, y de los esfuerzos que, dentro de limitaciones e incluso dentro de coyunturas de carácter crítico de todos conocidas, hemos efectuado ya y estamos denodadamente empeñados en intensificar en un futuro inmediato.

El empeño urgente de reducir la mortalidad y la desnutrición infantiles no son sino casos extremos dentro del repertorio de cuestiones de toda índole que a la humanidad en general, y en particular y dolorosamente a las naciones en menor grado de desarrollo, le plantea la atención a la infancia. Su diagnóstico y su cuidado son obviamente decisivos en el porvenir que le aguarda no tanto a las naciones individuales sino al conjunto y al común de la especie. Es esa la más dramática de las circunstancias que inspiran esa reunión de Cartagena, y esa es también la razón principal por la cual espero que usted nos haga el honor de prestarnos su distinguido concurso en "Bellagio II".

Con los sentimientos de mi más alta consideración,

Belisario Betancur

UNOFFICIAL TRANSLATION FROM SPANISH
JULY 8, 1985

Mr. A.W. Clausen
President
The World Bank
1818 H Street, N.W.
Washington, D.C. 20433

Dear Friend,

Through this letter, and in the name of my Government and of the Colombian people, I wish to extend to you our cordial invitation to participate in the conference to take place in Cartagena starting this 14th of October.

This gathering has been labelled "Bellagio II", because its central theme will be the same discussed in that Italian city last March: "World child protection: vaccination and immunization". Colombia recently carried out an extensive infant vaccination campaign, whose evaluation started in Bellagio, and which was proof of the concern that the society and the Government of my country confront regarding the survival and health of our children, and, given the limitations and well-known difficulties and criticism, of the efforts we have carried out and are willing to intensify in the immediate future.

The urgent need to reduce infant mortality and malnutrition are only two of the many issues facing humanity in general, and developing countries in particular in addressing infant and child care. Its diagnosis and treatment are issues to be dealt with not so much individually as nations, but collectively as people. This is the striking circumstance that inspires this meeting in Cartagena, and is also the principal reason for which I hope you will honor us with your presence in Bellagio II.

Expressing my highest regard,

(signed)

Belisario Betancur

8 de julio 1985

Excelencia:

Por medio de la presente deseo agradecer en nombre de mis colegas, el Señor John North y el Dr. Anthony Measham, y en el mío propio la invitación que usted nos ha tan cordialmente extendido para participar en la conferencia denominada Bellagio II que tendrá lugar en Cartagena de Indias a partir del 14 de octubre próximo.

Nosotros, en el Banco Mundial, deseamos participar activamente en esa conferencia porque estamos convencidos de que ella constituirá un hito importante en el proceso de reducir la mortalidad y la desnutrición infantil en el mundo.

Estamos seguros de que la conferencia obtendrá sus objetivos, ya que Su Excelencia ha claramente demostrado su interés en mejorar la salud infantil en el mundo. Pruebas fehacientes de ese interés son la realización del programa masivo de vacunación infantil llevado a cabo recientemente en su país bajo sus auspicios y el empeño demostrado por Su Excelencia en que Bellagio II se celebre en Colombia.

Lo anterior hace que nos sintamos honrados de ser invitados y de poder participar en la conferencia de Cartagena. Por lo tanto, me es muy grato informar a su Excelencia que el señor John North, el Dr. Anthony Measham y yo tendremos el placer de asistir a tan importante evento.

Con los sentimientos de mi más alta consideración,

A.W. Clausen

Excelentísimo Señor
Don Belisario Betancur
Presidente de la República
República de Colombia

cc: Mr. Southworth, Mr. North, Dr. Measham

RCuca/JDNorth/rmf

UNOFFICIAL TRANSLATION FROM SPANISH
JULY 8, 1985

Your Excellency
Don Belisario Betancur
President
Republic of Colombia

Your Excellency,

Through this letter, I wish to thank you, in the name of my colleagues Mr. John North and Dr. Anthony Measham, and myself, for the invitation that you have cordially extended us to participate in the "Bellagio II" conference, which will take place in Cartagena starting this 14th of October.

We at the World Bank, wish to actively participate in the conference as we believe it will be an important milestone in the process of reducing mortality and malnutrition among the children of the world.

We are sure the conference will meet its objectives, as your excellency has clearly shown his interest in improving child health in the world. Authentic proof of such interest is the execution of the extensive infant vaccination campaign completed recently in your country under your auspices, and the effort shown by your excellency to have Bellagio II meet in Colombia.

The above makes us feel honored at being invited and being able to participate in the conference in Cartagena. Therefore, it is my pleasure to inform your excellency that Mr. John North, Dr. Anthony Measham, and myself will have the pleasure of attending this important event.

Expressing my highest regard,

A.W. Clausen

República de Colombia

Presidencia

Bogotá, 11 de Junio de 1985
ACV-85

Mister
John North
Director
Health, Population and Nutrition
The World Bank
1818 H. Street, N.W.
Washington, D.C. 20433

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Por medio de la presente quiero transmitirle en nombre de mi gobierno y del pueblo colombiano, mi invitación más cordial a participar en la conferencia que tendrá lugar en Cartagena de Indias a partir del 14 de octubre próximo.

Se le ha dado a este certamen la denominación de "Bellagio II" pues su tema central será, como el del efectuado en marzo en esa ciudad italiana, "La protección de los niños del mundo: vacunas e inmunización". Colombia efectuó recientemente un programa masivo de vacunación infantil, cuya evaluación comenzó a hacerse en Bellagio, y que fue una demostración colectiva de la preocupación que la sociedad y el gobierno de mi país experimentan ante los problemas de la supervivencia y de la salud de nuestros niños, y de los esfuerzos que, dentro de limitaciones e incluso dentro de coyunturas de carácter crítico de todos conocidas, hemos efectuado ya y estamos denodadamente empeñados en intensificar en un futuro inmediato.

El empeño urgente de reducir la mortalidad y la desnutrición infantiles no son sino casos extremos dentro del repertorio de cuestiones de toda índole que a la humanidad en general, y en particular y dolorosamente a las naciones en menor grado de desarrollo, le plantea la atención a la infancia. Su diagnóstico y su cuidado son obviamente decisivos en el porvenir que le aguarda no tanto a las naciones individuales sino al conjunto y al común de la especie. Es esa la más dramática de las circunstancias que inspiran esa reunión de Cartagena, y esa es también la razón principal por la cual espero que usted nos haga el honor de prestarnos su distinguido concurso en "Bellagio II".

Con los sentimientos de mi más alta consideración,

Belisario Betancur

Mr. North 6/19

8/20

Lt. Col.:

Appraisal starts
1/22 and ends 8/9.
I am booked to
leave Washington
7/18.

Thanks.

Tony.

Bill

FORM NO. 89
(2-83)

THE WORLD BANK

ROUTING SLIP	Date June 24, 1985

OFFICE OF THE PRESIDENT

Name	Room No.
Mr. North	N-437
RTF — Copies for Advisor & DC's. — return to me A.	

	To Handle		Note and File
	Appropriate Disposition		Prepare Reply
	Approval		Per Our Conversation
XX	Information		Recommendation

Remarks

RTF

Roy Southworth

Fi

CC: FS
ARH
AB
NB
EHS
IZH
SHD
7/11

The Task Force for Child Survival
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915

TO: RECIPIENTS OF STATUS REPORTS

FROM: WILLIAM H. FOEGE, M.D.

DATE: JUNE 17, 1985

SUBJECT: STATUS REPORT

As we look forward to Bellagio II, in Cartagena, Colombia October 14-17, I am gratified at growing support for the effort begun at Bellagio I. This includes both national and international interest in expanding immunization activities.

The Task Force members feel that the five sponsoring agencies can and should continue to support the activities of The Task Force itself. All possible donors to immunization programs should be encouraged to continue to support the country program activities, hopefully through UNICEF, WHO and other established ongoing organizations.

PAHO POLIO ELIMINATION CAMPAIGN

On Tuesday, May 14th, Dr. Carlyle Guerra de Macedo of The Pan American Health Organization announced a campaign to eradicate polio from the Western Hemisphere by 1990. This is a courageous landmark decision. It provides a definite and understandable objective which can serve as a catalyst to improve all immunization activities. The plan of PAHO is to improve immunity levels for all of the childhood immunizations, improve surveillance for all vaccine-preventable diseases and investigate all cases of polio. Other regions will follow the progress with great interest to learn from the experience which will be gained in this effort.

ROTARY INTERNATIONAL AND POLIO 2005

Rotary International has announced a campaign they have entitled "Polio 2005," in which they are committing themselves to assist in eliminating polio from the world by their 100th anniversary in the year 2005. Mr. Herbert Pigman, General Secretary and Mr. John Stucky, Program Manager from Rotary visited the staff of The Task Force and The Centers for Disease Control in Atlanta on May 13th to discuss how work might be

coordinated in implementing their program. Not only is this one more indication of the interest being generated for immunization, but new lessons are being learned on how to combine this effort of a private organization into a global program to strengthen the whole and, at the same time, allow appropriate identification with a part.

APPLIED RESEARCH PRIORITIES

Using a paper developed by Dr. Rafe Henderson, Director of the Expanded Immunization Program, World Health Organization, we asked Drs. Don Francis and Roger Bernier to help develop a listing of the most important priorities. They polled workers with field experience in immunization programs, asking them to provide suggestions and ideas on the barriers they would most like to see eliminated. Using their report, we assembled the top 10 research needs and have circulated these to some 150 people. You should have received our letter on this subject by now. The response has been very good, giving us a better idea of who is interested in specific areas and raising possibilities for inclusion on the "second 10" list. We are now attempting the more difficult task of devising ways to link resources to specific research areas.

BELLAGIO II/CARTAGENA, OCTOBER 14th-17th

Plans for the Cartagena meeting are progressing quite satisfactorily. The letters of invitation have been sent, and the responses, to date, have been most encouraging. Mr. Watson, of The Task Force staff visited Colombia the week of May 20th to make final plans and decisions with respect to logistics, accommodations, etc.

WARM SPRINGS

The Roosevelt Warm Springs Institute held a special celebration on May 16, 1985, to launch a new phase in their long history of rehabilitative efforts. They are eager to make their facilities and experience available to other countries. Mr. Carlton Spitzer, American City Bureau, 505 South Omni International, Atlanta, Georgia 30303, can be contacted for additional information.

SALK INSTITUTE MEETING

The National Council for International Health sponsored a meeting at the Salk Institute in March on "Immunization and the Developing World: The Role of the Private Sector." Recommendations were made in these areas:

1. Research, Development and Manufacturing
2. Management of Distribution (Vaccine and Other Supplies)
3. Delivery and Use of Immunizations

A call for action was drafted to enlist additional involvement of the private sector:

I. Each year, 8 million children in the developing world die or are crippled as a result of six major vaccine-preventable diseases: tetanus, measles, polio, diphtheria, whooping cough, and tuberculosis. The means to prevent early disability, suffering and death from these diseases now exist.

II. A decade ago, the number of children immunized in developing countries was negligible. Today, because of the efforts of national and international agencies, nearly one-third of all children are immunized. These efforts, coupled with future biotechnical breakthroughs, will mean that the goal of immunizing all children in the developing world by 1990 is possible.

III. The advancement of this goal demands a renewed commitment and partnership by all sectors of society. Special efforts are appropriate to secure the full involvement of the private sector, whose potential in this area remains largely untapped. Leaders in both the public and private sectors are called upon to seek ways of improving their partnership in support of immunization services.

IV. This partnership will benefit all sectors of society, resulting in technological breakthroughs, expanded markets, improved management, and, most importantly, it will accelerate the immunization of the world's children.

V. Efforts, such as the La Jolla conference, should continue at the national and international levels to identify issues and resolve problems. As a result, leaders in the public and private sectors can be mobilized for more effective joint actions in the field of immunizations.

For more detailed information, contact Dr. Russell Morgan, National Council for International Health, 2100 Pennsylvania Avenue, N.W., Suite 740, Washington, D.C. 20037.

COUNTRY REPORTS

Senegal

The Ministry of Health has developed an immunization program proposal which has now been sent by the Ministry to UNICEF. UNICEF has agreed to support the program for the first year. There are hopes for support, in future years, by USAID, France, the World Bank, and others. Dr. Philippe Stoeckel has been instrumental in pursuing the commitment and plan for a national immunization program. The assignment of Mark LaPointe to Senegal, under the sponsorship of UNICEF, is part of the proposal.

COUNTRY REPORTS (continued)

Nigeria

We have recently received a personal communication from Paul Litchfield, a UNICEF representative in Lagos, who is assigned full time to the immunization program. Paul reports that the Nigerian program is proceeding very satisfactorily, and that he is optimistic about its future. Early data indicates that immunization levels of 80% are being achieved in target areas. There is also a well developed plan to integrate these campaigns into the ongoing primary health care program. Nigeria has the largest population of any country in sub-Sahara Africa, and the development of a model program there could be important to the entire continent. Dr. Stan Foster has recently reviewed the program for UNICEF and reports that vaccine supply is now adequate, the cold chain is exceptionally good, immunization levels are rapidly improving, the target age group has become more specific (aiming at children under 24 months) and that the program workers are optimistic and energetic.

Burkina Faso

As reported earlier, the indications are that the program in Burkina Faso met the goals which were set. A team has been in Burkina Faso assisting with a sample survey which will help in evaluating the coverage achieved and assist in determining what needs to be done in the way of a continuing program.

Turkey

The Turkish government is planning a campaign-type program starting in late 1985. The campaign will not be conducted in single days, as was done in Colombia, but there will include 10-day type campaigns. Richard Reid, the UNICEF representative, who was so instrumental in assisting with the Nigerian program, is being transferred to Turkey. He and a delegation of eight people from Turkey visited the UNICEF headquarters in New York, the Centers for Disease Control in Atlanta and Colombia during April.

El Salvador

The immunization program in El Salvador received a great deal of positive publicity, focusing on the fact that both sides were willing to stop hostilities during this campaign. The program successfully reached 300,000 children. Dr. Ciro de Quadros of PAHO reports that a good evaluation of the program is being done and will be available by the time of the Cartagena meeting.

India

India has taken many steps, in recent months, to accelerate immunization activities. National Program Managers met in New Delhi from April 30th to May 3rd to review the expanded program. Special emphasis has been given to 30 districts (about 70 million population) to conduct intensified surveillance, to eliminate polio and to reduce neonatal tetanus mortality to 1 per 1,000 live births (currently 3.2/1,000 in urban areas and 13.3/1,000 in rural areas). Measles vaccine has been officially added to the national immunization plan. India now has an operational handbook for immunization, recognition cards for disease surveillance, and is developing guidelines for each part of the program. Field testing of ice lined and solar refrigerators are being conducted, and a commitment has been made to operational research to find the most suitable techniques for delivery immunizations in India.

Sincerely,

Bill Foege

William H. Foege, M.D.
Executive Director

Mr. North

WORLD BANK / INTERNATIONAL FINANCE CORPORATION

6/19

John:

Unfortunately, I shall not be able to attend the next Task Force meeting because of my commitment to Mr. Mullis and Emmerich for the Zimbabwe appraisal.

Larry.

What is current appraisal schedule?

P-1852

The Task Force for Child Survival
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June 14, 1985

NOTE TO TONY MEASHAM

The enclosed proposal for an applied research program was developed at the suggestion of Drs. Halstead and Warren. We will have more information by the time of the next Task Force meeting scheduled for July 23 and 24.

Sincerely,

Bill

William C. Watson, Jr.
Project Manager

Enclosure

The Task Force for Child Survival
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Scott Halstead, M.D.
The Rockefeller Foundation
1133 Avenue of the Americas
New York, New York 10036

Dear Scott:

As you requested, enclosed is a proposal for an applied research program to be administered by The Task Force for Child Survival. We are excited by this prospect.

If we can provide further information, let us know.

Sincerely,

Bill

William H. Foege, M.D.
Executive Director

Enclosures

PROPOSAL TO THE ROCKEFELLER FOUNDATION FOR APPLIED RESEARCH PROGRAM

The Task Force for Child Survival was formed at a Bellagio conference on the subject of protecting the world's children through vaccines and immunizations, held on March 13th-15th, 1984. The Task Force is composed of representatives from its five convening agencies: WHO, UNICEF, World Bank, UNDP and The Rockefeller Foundation. Its staff (based in Atlanta, Georgia) and activities are supported by these five organizations.

One of the specific mandates of The Task Force, as determined by the Bellagio conference was "reviewing present research needs (in the immunization field) both in biotechnology and operational/delivery areas, and reviewing currently available resources and research gaps." After reviewing the information available, The Task Force has decided to concentrate its efforts on applied research needs.

To define applied research priorities, The Task Force provided Drs. Don Francis and Roger Bernier of the Centers for Disease Control with a recent report on this subject developed by Dr. Rafe Henderson of the World Health Organization in Geneva. Drs. Francis and Bernier polled workers with immunization field experience to provide ideas on the barriers they would most like to see eliminated or obviated. Using their report, we then developed a list of the top ten research needs as follows:

ENGINEERING

1) Inexpensive single-dose self contained delivery system.
2) Simplified cold chain (fueless, reduced maintenance, etc.)
3) Simplified jet injectors.

BIOCHEMICAL

1) Improved high potency 1- or 2-dose pertussis vaccine.
2) High potency stable measles vaccine.
3) Simplified diagnostic methods.

FIELD RESEARCH

1) Early vaccine administration (prenatal or early months).
2) Two-dose total immunization schedule.
3) Operations research: management schemes and training, improved surveillance, compliance and evaluation.
4) Strategies for polio eradication.

This list was, in turn, circulated to more than 100 people around the world who are involved in immunization activities and/or related biological research. From the replies received to date, several things have become apparent:

1) There is surprising agreement with the list as developed, although there is feeling that in the future the list will need to be expanded.

2) There is a great deal of interest on the part of competent scientists in working on the areas identified.

3) There is work already going on in some of these and related areas.

4) However, some highly promising leads, are not being pursued because institutions and individual scientists perceive that there is no monetary payoff in end products.

5) There is a heartening consensus that, with support, these research needs can be addressed with promising results.

There are powerful new technologies available in all three areas of research needs: engineeering, biochemical and field research. If these technologies are exploited, we could revolutionize the operation of immunization programs.

However, there are very real barriers to expeditious exploitation of these technologies. The vaccine development area is illustrative. As Dr. G.J.V Nossal has said, "even though academics are buzzing with bright ideas about new vaccines, their capacity to translate a research breakthrough into a marketable product is notoriously limited, and partnerships with industry will be difficult to forge in this traditionally low profit arena. Will academics have the patience to see a vaccine through to the development phase, and to conduct the extensive clinical trials which will be needed? This is much less heady work than the original genetic engineering, but just as essential." Much of the costly, fundamental research in all three areas has already been done. Now, support is needed to improve and expedite the process of actual vaccine use, delivery systems, operations, strategies and schedules.

It is probable that relatively modest support to selected scientists and institutions would yield results of great benefit to immunization programs around the world.

The Task Force For Child Survival is an appropriate institution through which to channel support for such research efforts. The five sponsoring agencies have approved the recruitment of a respected scientist to assist in the research area. With such a person on the staff, and in view of the information network already generated, The Task Force is in an ideal position to identify scientists and institutions worthy of support. Conversely, it is in a position to know which efforts are not worthy of support. It could also draw on the best institutional and individual scientific talent available in the world to review research proposals. Initially, it would attempt to do this by having scientists evaluate and rank proposals by mail. The Task Force itself could then make final determinations about which projects should be supported.

It is anticipated that a mechanism for proposal requests, peer review, exchange of information and project selection could be developed for $150,000 per year including salary and support for the scientist conducting the effort. Initial support of the top ten needs would require about $200,000 for engineering projects, $400,000 for biochemical projects and $200,000 for field research projects. Additional resources, when available would be used to expand such areas as operations research and to begin development of the next top 10 research priorities.

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May 15, 1985

TO: Persons Interested in Immunization Activities

Recently, The Task Force for Child Survival has re-examined the highest priority applied research needs for current immunization programs. We used as a starting point a recent report by Dr. Rafe Henderson on applied research needs, and then asked Drs. Don Francis and Roger Bernier to poll workers with field experience to provide ideas on the barriers they would most like to see eliminated. Using their report, we have assembled the "top 10" research needs. We would now like to make certain that these "10" are adequately addressed before we assemble the next priorities. We are particularly interested in the following:

(1) Do you know of work being done in these areas?

(2) Are you doing work in any of these areas or would you be interested in developing research projects relating to 1 or more of the 10?

  (a) If so, do you already have funding?

  (b) If not, could you do this work if funding would be provided?

(3) Are you willing to provide funds for specific research projects if we could identify competent, interested researchers?

The immunization initiative around the world is gaining momentum. An accelerated applied research effort provides yet another mechanism to speed-up the goal of universal immunization.

Thanks for your help.

Sincerely,

Bill Foege

William H. Foege, M.D.
Executive Director

Enclosure

HIGH PRIORITY APPLIED RESEARCH NEEDS FOR GLOBAL IMMUNIZATION PROGRAMS

ENGINEERING:

1. Inexpensive, self-contained, single injection device for administering vaccines.

2. Simplified cold chain (fueless, reduced maintenance, etc.)

3. Simplified jet injectors.

BIOCHEMICAL:

1. Improved high potency 1- or 2-dose vaccines (e.g. pertussis).

2. High potency stable viral vaccines (e.g. measles).

3. Simplified diagnostic methods (e.g. pertussis).

FIELD RESEARCH:

1. Earlier age of vaccine administration for all commonly used antigens.

2. Two-dose total immunization schedule.

3. Operations research: management schemes and training, improved surveillance, compliance and evaluation.

4. Strategies for polio eradication.

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IN ARM FILE
Copy to EDTS done 4/26

April 19, 1985

NOTE TO TASK FORCE MEMBERS

The Science and Technology Subcommission met in New Delhi last week. I co-chaired the Health Work Group with Dr. Ramalingaswami. The Work Group selected immunization as the #1 priority for Indo-U.S. collaboration in the immediate future, and it is possible that Prime Minister Ghandi will bring this as a specific item to the attention of President Reagan in June when he visits Washington, D.C.

Although the last 9 months have seen a change in the Minister of Health, the Secretary of Health, the Director of MCH and the Director of the EPI, India now has a National Immunization Plan, which they intend to distribute in April. The Secretary of Health is very interested in pursuing the Immunization Initiative, and Dr. Bisht, the Director-General, continues his strong support.

A Pritech team will be going to India next week to provide ideas in three states. A variety of groups are providing assistance in different ways, and to sort this out, we are making arrangements to get a short-term Indian consultant to summarize what is now being done and what needs India has for outside support in order to carry out their National Plan. This consultant will also get a copy of the India National Plan, which we will share with you as soon as it is available.

Sincerely,

Bill

William H. Foege, M.D.
Executive Director

The Task Force for Child Survival
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April 18, 1985

Anthony Measham, PhD.
Health Adviser
Health, Population and Nutrition
The World Bank
1818 H Street, N.W.
Washington, D.C. 20433

Dear Tony:

Enclosed is a draft of the minutes of the Task Force meeting held in Washington on April 4th and 5th, 1985. I would appreciate your giving me any comments or suggestions for additions or changes.

The agenda for the Cartagena meeting is also enclosed as an attachment to the minutes. It is my understanding that you are responsible for the following in connection with the program:

1. Participating with Steve Joseph and Rafe Henderson in the 2:00 p.m.-3:00 p.m. session on Tuesday, October 15th. Steve has the lead responsibility for the session.

2. Inviting Dr. Sai to make a presentation on Family Planning and PHC at the 3:30 p.m.-4:30 p.m. session on Tuesday, October 15th. Dr. Mike Merson will also make a presentation on Diarrheal Disease Control at that session. Rafe Henderson is responsible for inviting him to do this.

Final decisions about who will chair the various sessions will be made at the July meeting in New York.

If we can be of assistance in any way, please let me know.

Sincerely,

Bill Watson

William C. Watson, Jr.
Project Manager

Enclosures

MINUTES OF THE TASK FORCE FOR CHILD SURVIVAL MEETING
APRIL 4 - 5, 1985
WASHINGTON D.C.

A fifth meeting of The Task Force for Child Survival was held at The World Bank in Washington, D.C., on April 4th and 5th, 1985.

In attendance were: Dr. Ralph Henderson, WHO; Dr. Steve Joseph, Mr. Newton Bowles, and Mr. Peter Adamson of UNICEF; Dr. John North and Dr. Tony Measham, World Bank; Mr. Tim Rothermel and Dr. Mike Sack, UNDP; Dr. William Foege and Mr. Bill Watson, of The Task Force staff; Dr. Ken Warren, Rockefeller Foundation attended the session on April 5. Dr. Ciro de Quadros, WHO/PAHO, attended the afternoon session on April 4.

A joint meeting with staff from Pritech, AID and the Diarrheal Disease Program from WHO was held the morning of April 4th in the Pritech offices. This was a very informative meeting in which the participants exchanged information about their activities. It was agreed that no minutes of the meeting would be kept and that such a meeting should be held approximately once each year.

The afternoon session at The World Bank began with a status report on the Colombia program and the status of the evaluation of that program. Dr. Duque, of Colombia, had been scheduled to make the presentation in collaboration with Dr. Ciro de Quadros, of PAHO. Mr. Watson explained that he had been informed by the new Minister of Health, Dr. Rafael de Zubiria, that it was impossible for Dr. Duque to attend. Dr. de Zubiria had also indicated to Mr. Watson that he would like to receive a report directly about the decisions made at The Task Force meeting with respect to the October meeting in Colombia.

Dr. de Quadros did not have a great deal to add to the report given to The Task Force at its meeting in Atlanta on January 11th, by Dr. Steve Jones. The Task Force representatives, particularly those from The World Bank, expressed concern that even though data necessary for an evaluation seem to exist, there is still no good definitive description of what has come out of the effort in Colombia. There was strong feeling that good evaluations of the Colombia program and the programs in Burkina Faso and El Salvador were necessary by the time of the meeting in Colombia in October. The World Bank volunteered to assist by making services of an economist available. It was agreed that the letter to Dr. de Zubiria should indicate the feeling of The Task Force about the need for further work on the evaluation.

The meeting then turned to consideration of the October Cartagena meeting. Mr. Watson, who had visited Colombia the week of March 18th, had developed a document setting forth several options with respect to holding the meeting in Colombia. After discussion of these options, it was proposed that a final decision be deferred until a proposed agenda was developed. The remainder of the afternoon was devoted to such a discussion. By Friday morning, April 5th, Dr. Henderson had developed an agenda based on these discussions, which he put on the chalkboard for consideration. After further discussion, a proposed agenda was agreed upon (Attachment I).

(At lunch, the discussion returned to the logistics of the meeting. It was agreed that the meeting would be held in the Capilla del Mar Hotel in Cartagena and that all of the participants would stay in the hotel.)

The question of spouses accompanying participants was addressed, and it was decided that there would be no prohibition but no encouragement.

The question of security for the meeting was discussed. It was agreed that publicity about the meeting would be downplayed, and that press conferences and press interviews would be deferred until the end of the meeting. (Mr. Watson had made this proposal to the Colombian officials during his recent visit, and they had reluctantly agreed.) Mr. Watson reported that he had called the Colombia desk of the U.S. State Department, and they had advised that, in their opinion, it was safe to hold the meeting in Cartagena. Dr. Joseph was asked to seek the advice of the United Nations security staff, and Mr. Watson was requested to do the same with the U.S. Government.

The remainder of the discussion during Friday morning and afternoon focused on activities which have occurred during the year since Bellagio I and the question of future directions. There were reports on activities in various countries, as follows:

Senegal

Mark LaPointe developed a program proposal during his recent visit to Senegal, which he left with the Ministry of Health. UNICEF has agreed to support the program, as developed, for the first year. There are indications of support in future years by USAID, the French and the World Bank. The program is now awaiting the transmittal of the first year's proposal from the Ministry of Health to UNICEF, Dakar. The assignment of Mark Lapointe to Senegal under the sponsorship of UNICEF, is a part of the proposal.

Burkina Faso

While there are indications that "a lot of people" were vaccinated in the Burkina Faso campaign, there is concern about whether the program will be appropriately evaluated and a good continuing program developed. A sample survey is planned in Burkina Faso in April.

Nigeria

The Nigerian program is proceeding satisfactorily. There is some concern about the impact of Richard Reid's proposed transfer to Turkey. The Turkish government is planning a campaign-type program starting in late summer. The campaign will not be conducted in single days, as was done in Colombia, but there will be 10-day type campaigns. Richard Reid is being transferred to Turkey as the UNICEF representative, and it is expected that his presence will be salutary with respect to the campaigns. Mr. North reported that the health and population survey in Turkey by The World Bank is upcoming.

Turkey

Dr. Henderson raised the question of the impact of the now proposed campaign on the World Health Organization's push, over the last several years, for a total primary health care program there. Richard Reid and a delegation of 8 people from Turkey are currently visiting CDC, Colombia and UNICEF as a preliminary to beginning the campaign.

El Salvador

The El Salvador program has apparently been very successful, reaching an estimated 300,000 children. Dr. Measham again raised the question of getting good cost data and evaluation of this program.

India

Dr. Foege was going directly from the meeting to India to attend the Science and Technology Subcommittee Meeting on Public Health as a representative from the U.S. Public Health Service. He expects to have discussions while in India about the status of the immunization program and report on this when he returns.

Research

Several people in attendance had attended the meeting in La Jolla. There was a concensus that the informal output of this meeting was probably as important as the formal, and that hopefully it represented a first step toward private sector involvement. Dr. Warren cautioned against premature optimism and recited some less than satisfactory experience by the Rockefeller Foundation with the pharmaceutical industry.

Dr. Foege reported that he had asked several knowledgeable people to provide him a list of priority needs in applied and basic research. From their replies, he had developed his own top 10 priority list which he then shared with the group (Attachment II).

Dr. Warren agreed to serve as The Task Force's coordinator on basic research, but indicated that we should look for someone to operate in the applied research area, and that perhaps we should consider sponsoring a meeting on this subject.

At Bellagio, there had been some discussion about the need for a Global Science Advisory Committee. There was a concensus in the group that, at this time, they saw no need for a new advisory committee. It was the feeling that SAGE could serve many of the purposes of such a committee, and it was agreed that Dr. Ken Warren would serve as the basic research coordinator for The Task Force.

Support for Immunization Activities and Future Directions

Dr. Joseph reported that he was very gratified at the support being generated in many quarters for immunization activities. In view of this fact, he sees no need to establish an advisory committee or any other formal mechanism for fund-raising purposes. It was his feeling that the appropriate stance at Cartagena, vis-a-vis possible donors, is that the five sponsoring agencies can and should continue to support The Task Force activities, and that donors should be encouraged to continue to support program activities in a bilaterial fashion, hopefully through UNICEF, WHO and other established ongoing organizations as is happening now.

The group indicated that the future efforts of the Task Force should include the following:

1. Continue the commitment to immunization and attainment of the 1990 objective.

2. Play a supporting role in fund raising.

3. Expand ability for assisting in implementation activities in selected countries. (consider adding a person to coordinate implementation activities).

4. Develop system for better utilization of the private sector.

5. Provide assistance in developing reservoir of consultant talent.

6. Develop program for identifying applied research priorities and attempt to secure funding for promising activities (consider adding a person to coordinate this activity).

7. Examine other areas where assistance might be useful, such as evaluation.

Dr. Foege was asked to develop a 3-year budget proposal predicated on this, for review and consideration at the next meeting which is scheduled on July 23rd and 24th.

Miscellaneous:

Dr. Foege reported on a recent PAHO meeting in which he participated. At this meeting Dr. Macedo, the Director of PAHO, informally agreed to a proposal that PAHO take the lead in an effort to eradicate polio from the Western Hemisphere. The Inter-American Development Bank has indicated to Dr. Foege an interest in supporting this effort. Plans are being developed by PAHO and the IDB.

Drs. Foege and Warren testified before the Subcommittee on Oversight and Investigation of the Committee on Energy and Commerce of the Senate on March 13, 1985. Copies of their testimonies were distributed.

There was very strong sentiment in favor of The Task Force recruiting staff who are not Americans, if staff expansion is contemplated. It was suggested that WHO/UNICEF might assign young staff members to The Task Force as part of their career development.

It was decided that persons asked to present papers at Cartagena should be requested to provide drafts by the first of July.

It was decided that the next Task Force meeting would be held July 23rd and 24th as previously discussed, in New York City and hosted by the Rockefeller Foundation.

Mr. Watson was asked to invite Dr. Ciro de Quadros to attend that meeting and discuss with him the possibility of Dr. Macedo's attendance.

PROPOSED AGENDA
CARTAGENA, COLOMBIA
OCTOBER 14th - 16th, 1985

MONDAY, OCTOBER 14

6:30p - 8:30p	SOCIAL HOUR/DINNER	
8:30p - 10:00p	INFORMAL MEETING	

TUESDAY, OCTOBER 15

8:30a - 9:00a	GLOBAL OVERVIEW	**DR. HENDERSON**
9:00a - 10:00a	TASK FORCE UPDATE	**DR. FOEGE**
10:00a - 10:30a	BREAK	
10:30a - 11:00a	PAHO PERSPECTIVE	**DR. MACEDO**
11:00a - 12:30p	COLOMBIA	**DR. de ZUBIRIA and STAFF**
12:30p - 2:00p	LUNCH	
2:00p - 3:00p	QUESTIONS RAISED/LESSONS LEARNED	**DR. JOSEPH** **DR. MEASHAM** **DR. HENDERSON**
3:00p - 3:30p	BREAK	
3:30p - 4:30p	INTEGRATION - PRIMARY HEALTH CARE	**DR. SAI** **DR. MERSON**
4:30p - 6:00p	COUNTRY PERSPECTIVES ON MEETING THE 1990's OBJECTIVES	**DR. de ZUBIRIA**
6:00p	SOCIAL HOUR/DINNER	

PROPOSED AGENDA
CARTAGENA, COLOMBIA
OCTOBER 14th - 16th, 1985

WEDNESDAY, OCTOBER 16

8:30a - 9:30a	RESEARCH & DEVELOPMENT	**DR. WARREN**
9:30a - 10:15a	NEEDS FOR 1990	**DR. FOEGE**
10:15a - 10:45a	BREAK	
10:45a - 11:30a	FUTURE OF THE TASK FORCE FOR CHILD SURVIVAL	**DR. FOEGE**
11:30a - 12:30p	DISCUSSION	
12:30p - 2:00p	LUNCH	
2:00p - 3:00p	DISCUSSION	
3:00p - 4:30p	COMMENTS BY AGENCY HEADS	**MR. CLAUSEN** **MR. GRANT** **MR LYMAN** **DR. MAHLER** **MR. MORSE**
5:00p - 5:30p	SUMMARY & CONCLUSION	**DR. HAMBURG** RAPPORTEUR

* Possible place(s) for participation by President Betancur.

HIGH PRIORITY APPLIED RESEARCH NEEDS FOR GLOBAL IMMUNIZATION PROGRAMS

ENGINEERING:

1. Inexpensive single-dose self-contained delivery system.
2. Simplified cold chain (fueless, reduced maintenance, etc.)
3. Simplified jet injectors.

BIOCHEMICAL:

1. Improved high potency 1- or 2-dose pertussis vaccine.
2. High potency stable measles vaccine.
3. Simplified diagnostic methods.

FIELD RESEARCH:

1. Early vaccine administration (prenatal or early months).
2. Two-dose total immunization schedule.
3. Operations research: management schemes and training, improved surveillance, compliance and evaluation.
4. Strategies for polio eradication.

The Task Force for Child Survival
1989 North Williamsburg Drive • Suite I • Decatur, Georgia 30033
(404) 325-2452 • Telex 8107518512
Administratively Affiliated with Emory University

TESTIMONY BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATION
OF THE
COMMITTEE ON ENERGY AND COMMERCE

MARCH 13, 1985

WILLIAM H. FOEGE, M.D.
EXECUTIVE DIRECTOR
THE TASK FORCE FOR CHILD SURVIVAL

Sponsoring Agencies: WHO UNICEF World Bank UNDP RF

I. INTRODUCTION

The past two decades have witnessed a remarkable improvement in vaccine development, manufacturing capability, and delivery of immunizations, both domestically and internationally. Interest has increased in many countries in improving primary health care programs, often with immunizations as the cutting edge of health delivery.

Twenty years ago, conditions were favorable for an international coalition to eliminate smallpox from the globe. Conditions are now right for an international coalition to change childhood immunization from a promise to a reality for all children of the world. Success in this venture would have a major impact on childhood mortality, as well as on the quality of life for children and parents.

A three-point program has been proposed:

(1) Accelerate the expansion of immunization coverage to those developing countries where children contribute disproportionately to vaccine-preventable disease mortality;

(2) Simultaneously provide increased support for immunization services to all other developing countries, to assure that they are not constrained by the lack of vaccine, supplies, equipment, or technical assistance;

(3) Intensify research and development to improve current immunization and delivery system technology

These actions should be designed and made available in such a way as to contribute to the the development of national health infrastructures.

II. DOMESTIC EXPERIENCE

A. Immunization Program

National immunization programs are relatively new in public health as practiced in the United States. The diphtheria, tetanus and pertussis vaccine was first licensed as a trivalent vaccine in 1949. Inactivated polio vaccine was licensed 6 years later in 1955. Oral polio vaccine was first licensed in 1961, and a trivalent preparation containing all three types of oral polio vaccine was licensed in 1963. Measles vaccine was first licensed in 1963, but not until 1971 was a triple vaccine containing measles-mumps-rubella available for use. While major gains were achieved in reducing disease incidence for all of the above diseases before 1977, the Nation lacked a unified system with maximum efficiency and effectiveness for disease control. For example Federal funding would rise and fall and the introduction of new vaccines sometimes led to the elimination of Federal funds for vaccines previously supported. A decreased disease incidence often led to complacency regarding maintenance with a reduction in funding, less attention to program activities and apathy on the part of parents in seeking immunizations.

During fiscal years 1969, 1970 and 1971, no Federal grant money was provided for measles control. Subsequent increases in measles cases led to the reestablishment of Federal assistance in measles control.

In 1977, a National Childhood Immunization Initiative was developed to provide a national approach, long-range planning and adequate resources. Two major objectives were adopted in 1977: (1) To increase immunization levels from the existing 60-75% to 90% by October of 1979; and (2) To develop a maintenance system to assure that those levels would continue in the future. In 1978, an additional objective was adopted, namely, to eliminate indigenous measles transmission in the United States. It was recognized that as long as measles exists in the remainder of the world, we will continue to have importations; therefore, total elimination of the disease is not possible in this country.

B. Results

These innovations of selecting targets, focusing on particular problems such as measles, and providing national support, including money and people, had dramatic results. Coverage rates not only reached the objective of 90% but have continued to improve to the point, that, at the present time, 97-98% of all children entering school have been immunized against diphtheria, tetanus, pertussis, polio, measles, mumps and rubella. Because there will always be children who have medical reasons for not receiving vaccine, and because some parents have religious convictions against accepting immunization, we are very close to the maximum coverage possible. Indeed, the United States is close to perfection in providing immunization to its children (Attachment I).

Disease rates were falling even before the 1977 Initiative. For most of the vaccine-preventable diseases, declines of over 99% have been recorded in the last decades. For example by 1977, diphtheria, the scourge of children early in this century, had declined to 84 cases. However, in 1984 there was only a single case of diphtheria in the entire country. Rubella cases fell from over 20,000 in 1977 to 745 in 1984, and measles declined from over 57,000 cases in 1977 to 2,534 in 1984 (Attachment II).

Any parent who has nursed children through episodes of these diseases would willingly pay money in excess of treatment costs, if only they could have prevented the episode. Happily, the immunization program has not only prevented millions of cases of illness and thousands of deaths, but has also saved this country considerable sums of money. An independent study done by Schoenbaum in 1976, concerning the savings associated with the rubella vaccine program, indicated the benefit-cost ratio of rubella immunization given in combination with measles vaccine to be 23:1. A recent study soon to be published, concerning measles-mumps-rubella vaccine in 1983 indicated without an immunization program, an estimated 3.3 million cases of measles would have occurred as compared to the 2,872 that actually occurred in 1983. Instead of an expected 1.5 million rubella cases, only 3,816 cases were reported in 1983. Mumps cases were lowered from 2.1 million to 32,850 actual cases. Comparable reductions in the disease-associated complications, sequelae and deaths were realized because of the immunization program. Without an immunization program, costs for these three diseases would have been approximately $1.4 billion.

Based on the actual incidence of disease in 1983, costs were estimated to be approximately $14.5 million, resulting in savings of over $1.3 billion. Expenditures for immunization, including vaccine and administration costs, and the cost associated with vaccine reactions, totaled $96 million. The resulting benefit-cost ratio, for the measles-mumps-rubella immunization program was approximately 14:1. In other words, for every dollar invested in the measles-mumps-rubella program by Federal, State and local programs, the United States realized a savings of $14.

Similar savings have been documented for polio immunization in this country, with benefit-cost ratios in the range of 10:1. No vaccine is perfect, and the benefits enjoyed by the society are purchased with some risks to a small number of individuals. For many vaccines, including mumps, measles and rubella, the risks are very small. Even with pertussis vaccine, a highly favorable benefit-cost ratio is realized in this country. A study published on June 15, 1984, in the Journal of the American Medical Association, calculates that a program reaching 90% of children with pertussis vaccine, even when calculating the costs of hospitalization and maintenance of children who suffer vaccine complications, would still provide a benefit-cost ratio of 11:1 providing $11 of benefit for every dollar invested in the program (Attachment III).

C. Remaining Problems

For all the improvements in the program, the benefits achieved and the lessons learned, there are still major problems to be overcome. The decrease in companies willing to produce vaccines because of low profits, fear of litigation, etc. is of concern. When only a single manufacturer provides a vaccine, and stockpiles are insufficient, a single lot that does not pass quality or safety standards or a fire in a warehouse, can result in disruptions in our ability to protect America's children. We will continue to have a need for new vaccines, improved vaccines and, in some cases (such as hepatitis B) less expensive vaccines. There will also continue to be a need to produce vaccines with fewer adverse reactions. The current reactions to pertussis vaccine provide an urgent reason for finding an improved product.

D. Lessons

A number of lessons have been learned but will be mentioned only briefly:

(1) The need for broad-based professional support. Professional groups, such as the American Medical Association, the American pediatric community, nurses, educators, etc. have all provided indispensable support.

(2) The support of legislative bodies in requiring that a child be immunized prior to school attendance has been crucial in achieving this public health miracle.

(3) The selection of immunization coverage rate targets has provided a simple mechanism for focusing activities and for measuring and comparing the success of programs. The selection of indigenous measles elimination as a target served as a leading edge, which has accelerated the remainder of the immunization program in its wake. For example, in order to eliminate measles transmission, immunization coverage rates had to exceed 90%. Immunizing children against measles has brought other vaccine coverage rates to record-high levels as well. In order to measure measles activity, surveillance systems had to become increasingly sensitive, and this sensitivity had a favorable effect on other disease surveillance systems.

(4) The cooperation and coordination, which has developed between Federal, State and local juristictions has been one of the best in public health. Again, clear objectives and dependable Federal funding have made it possible for State and local health departments to do better planning. Likewise, the coordination between public and private groups, and between medical and non-medical groups has been exemplary, and has provided a model for program development in other public health activities.

(5) We have learned that the infrastructure provided by delivering one vaccine is easily expanded to make maximum use of new vaccines as they are developed. For example, it was easy to add rubella and mumps to the ongoing program by simply combining vaccines. Even when vaccines could not be combined, it has been much easier to add a new vaccine to the schedule than to develop entirely new programs. This would suggest that the United States would realize the earliest possible benefits from the development of future childhood vaccines.

(6) It has also been clear that immunization programs do not reach their maximum efficiency and effectiveness if simply added to other public health programs, with the hope that they will receive adequate attention. There must be people at Federal, State and local levels who are identified as having immunization as their absolute priority, and who are held accountable for the program results.

III. INTERNATIONAL EXPERIENCE

A. The Problem

The size of the global problem is hard to overstate. Some diseases, such as measles, are so ubiquitous that every child born in the world can expect to have measles if they do not die of some other reason first, or if they have not been immunized. But in addition, a disease such as measles is more severe and causes greater mortality in children suffering from other problems, including malnutrition. For example in West Africa, death rates from measles as high as 5-10% have been recorded on many occasions, and during times of famine, mortality rates exceeding 25% have been observed. It is estimated that 5 million children die annually due to the vaccine-preventable diseases. Attachment IV shows the estimated number of annual deaths from only three causes, neonatal tetanus, measles and pertussis, for 25 countries. In these 25 countries, 2 million children die each year from measles alone.

But death is not the only cost of these diseases. It is estimated that an additional 5 million children are crippled each year, many from polio. Others suffer mental retardation or blindness due to measles. The burden imposed on society by long-term crippling and by the diseases themselves provide an unnecessary barrier to life quality. Health, disease and population have complex interactions. However, it is clear that the traditional disease burden in Third World countries heavily involves infectious diseases, malnutrition and population pressures. While malnutrition makes many infectious diseases worse, it is also clear that repeated infectious diseases, including measles and diarrheal diseases, in turn, contribute to malnutrition, both by requiring excess calories for a diseased child, and also because of the loss of calories through diarrhea and the restricted intake of calories because of illness. By the same token, population pressures often facilitate disease transmission or impair sanitation, making infectious diseases worse.

The paradox is that increasing childhood mortality does not lead to reductions in population pressures, indeed, the converse appears to be true. The highest net increases in population are now seen in the countries with the highest infant and child mortality rates.

Death control appears to be an important ingredient in birth control and must be pursued vigorously. Ideally, maximum assistance should be given to countries to reduce unnecessary deaths, to reduce unnecessary illness, and to provide knowledge about and supplies for family planning. If children are saved from a measles death will they simply die of something else? That is an argument advocated by some who doubt the wisdom of immunization programs. The answers are far from complete, but it is clear that:

(1) Much crippling can be reduced.

(2) Not all spared from vaccine preventable diseases will succumb to other childhood diseases.

(3) Children dying of measles never have the luxury of testing their survivability from other conditions.

(4) The remarkable increase in life expectancy this century in the United States (over 25 additional years at birth) is the result of one advance after another cumulating to an additional quarter century of life. The infants spared did not necessarily die in childhood of other diseases.

B. The Response

The current response to the global problem of immunization is laudable in terms of the number of agencies involved, and the rapid increase in activities. The World Health Organization has pioneered programs throughout the world. The majority of countries in the world have some immunization activities. UNICEF has greatly strengthened its capacity to promote immunization, and has targeted immunizations as one of the key programs in its "child survival" strategy.

Bilateral immunization activities are sponsored by many countries; and foundations, voluntary agencies and service organizations are increasingly selecting immunization as a key activity. Despite the great increase in interest, the percentage of children in Third World countries receiving immunizations is only about one-third of all children needing immunizations. While we can take comfort in the rapid increase in coverage from 10% or less to approximately one-third, the inescapable fact is two-thirds of the children of the world receive no benefit from these technological marvels.

We know that much more is possible. In Colombia, an attempt to increase immunization coverage from about 40% to over 60% in 1984 was successful. President Betancur provided personal leadership, and on special immunization days, actually immunized a child on national television to demonstrate the importance to his country. As in the United States, the Colombians mobilized medical and non-medical resources, including radio and television stations, the police, the military, churches, etc.

Senegal is currently launching a program to make immunizations part of the ongoing primary health program as are Nigeria and India, and other countries are planning a rapid expansion of immunization activities.

In an effort to improve coordination, the World Health Organization, UNICEF, the World Bank, the UNDP and The Rockefeller Foundation have formed The Task Force for Child Survival to assist in program operations in selected countries, and to look more broadly at barriers to immunization, research needs and operational techniques that might improve global immunization.

C. Barriers

Current abilities and experience indicate there is much more that could be done to improve immunization levels. In addition, there are barriers that, if surmounted, could facilitate the process. These barriers can be classified under the general headings of engineering, biotechnical and operational.

Some problems appear to be straightforward engineering questions. If sufficient interest and resources were developed, answers could be expected in a relatively short-time period. For example, how do we improve and simplify the cold chain, that is, the system that keeps vaccines cold from the time of manufacture through shipment and distribution until actually injected into a child under village conditions? It includes improvements in insulation material, power sources, devices for recording temperature, etc. Another engineering problem is the need for a simplified method of injecting vaccine. Answers could range from an inexpensive single-dose disposable needle and syringe to simplified jet injectors useful under field conditions.

Biotechnical barriers include the need to develop vaccines with more stability, ideally requiring no refrigeration at all. If the cold chain could be totally eliminated, operations would be greatly simplified. Improved vaccines that are not only more stable, but more potent, requiring fewer doses, and smaller quantities--vaccines with fewer adverse reactions--vaccines that could be combined physically--and vaccines that could be given earlier in life should be developed.

Operational barriers include the need for simplified surveillance systems, discovering what is needed to insure better compliance, better health education techniques, improved evaluation, simplified managerial programs, etc.

IV. WHAT NEEDS TO BE DONE?

(A) The possibilities must be understood. The possibility of a global collaborative effort to significantly reduce the burden of vaccine-preventable diseases sounds difficult, if not impossible. However, we have a model to follow. Twenty-years ago, delegates from the United States and from the Soviet Union presented a convincing argument to the World Health Assembly that smallpox could be eliminated from the world. A resolution was passed by the member countries, and in late 1966, program activities began. For a decade member countries, under the auspices of the World Health Organization, identified problems, identified resources, and brought those resources to bear on the smallpox problem. Year by year, the number of infected countries declined, until by 1977 only one country, Somalia, continued to have smallpox (Attachments V and VI). In October 1977, the last naturally-occurring case of smallpox was reported, and the world became smallpox free. Ironically because of the improved surveillance system for detecting cases of smallpox that would have gone unreported in earlier years, the reported cases of smallpox increased in the years immediately prior to world eradication (Attachment VII). This program established that it is possible for the countries of the world to set global health objectives, work together collaboratively and reach global targets.

(B) Benefits must be understood. While the entire world benefited from the elimination of the threat of smallpox, U.S. economic benefits were very direct. The United States spent approximately $150 million a year to keep smallpox out of this country during the 1960's, despite the absence of cases in the United States since 1949. An investment of approximately $27 million over a 12-year period helped achieve global elimination. This means that the United States is recouping its investment every 3 months at the present time. Because of smallpox eradication,the United States now saves more money each year than we invest in the World Health Organization.

Benefits to Third World countries from immunization programs are substantial. Not only is the clinical burden of vaccine-preventable diseases eliminated, freeing up medical resources that can be used in other ways, but immunization programs provide an ideal entry program for primary health care.

Immunization programs are relatively inexpensive. They also become the vehicle for the development of logistics systems, managerial systems, surveillance capabilities, and a framework on which other programs can be added. In addition, as mentioned earlier, immunization programs provide an important ingredient in improving the climate for family planning and population control.

(C) Goals must be articulated. The World Health Organization has set an objective of making immunization programs available to all children of the world by 1990. This is a laudable objective, worthy of support. Increased efforts will be required to make that objective realizable. A commitment by the United States to see that goal achieved would be a powerful influence. In addition, specific goals should be selected for specific diseases. For example, many countries could sharpen their immunization focus if they would set an objective to reduce infant tetanus deaths and measles deaths, by a given amount, say 50-75%, by a particular date. The goal of eliminating smallpox provided a new focus for multiple countries to discuss a coordination of strategies. Dr. Ciro de Quadros, Regional Advisor for the PAHO/WHO Expanded Program on Immunization, has suggested that the Western Hemisphere commit itself now to eliminating polio. This is exactly the kind of goal needed to provide the force to catalyze the entire immunization program much as a goal of eliminating indigenous measles in the United States has improved this Nation's overall domestic program. The United States could play an important role in supporting such an objective for this hemisphere.

(D) Resource needs must be estimated. Various attempts have been made to predict the cost for global immunization. One estimate, made for a meeting held in Bellagio in 1984, indicated that a program for the 10 countries (excluding China) accounting for two-thirds of the total deaths in the world due to vaccine-preventable diseases, would need to reach approximately 40 million infants per year (at a maximum cost of $15 per infant), and 40 million pregnant women (at a maximum cost of $3.50 per woman) giving a total maximum cost of approximately $745 million a year in 1985 dollars. Even doubling the target to 80 million children a year would allow for the immunization of Third World children for less than $1.5 billion per year. This is less than is spent yearly on advertising tobacco in the United States. The majority of resource requirements must come from within Third World countries, in terms of staff salaries and program support. Therefore, only a portion of that amount would have to be raised from external sources.

Compared to military assistance and arms sales, the United States has the opportunity, at a relatively small cost, to help catalyze a global effort to protect the children of this world. A response, in the spirit of the Marshall Plan, could have a decisive impact on the future of the world, promote medicine as an instrument of peace, and help Americans identify as global citizens.

ATTACHMENT I

Immunization levels of school entrants United States, 1983–1984 school year

Vaccine	Immunization level weighted average
DTP	97%
Polio	97%
Measles	98%
Rubella	98%
Mumps	97%

ATTACHMENT II

REPORTED CASES OF SELECTED DISEASES IN THE UNITED STATES
(Excluding Territories)

YEAR	RUBELLA	MEASLES	DIPHTHERIA	TETANUS	PERTUSSIS	POLIO (total)	MUMPS
1960	na	441,703	918	368	14,809	3,190	na
1961	na	423,919	617	379	11,468	1,312	na
1962	na	481,530	444	322	17,749	910	na
1963	na	385,156	314	325	17,135	449	na
1964	na	458,083	293	289	13,005	122	na
1965	na	261,904	164	300	6,799	72	na
1966	46,975	204,136	209	235	7,717	113	na
1967	46,888	62,705	219	263	9,718	41	na
1968	49,371	22,231	260	178	4,810	53	152,209
1969	57,686	25,826	241	185	3,285	20	90,918
1970	56,552	47,351	435	148	4,249	33	104,953
1971	45,086	75,290	215	116	3,036	21	124,939
1972	25,507	32,275	152	128	3,287	31	74,215
1973	27,804	26,690	228	101	1,759	8	69,612
1974	11,917	22,094	272	101	2,402	7	59,128
1975	16,652	24,374	307	102	1,738	8	59,647
1976	12,491	41,126	128	75	1,010	14	38,492
1977	20,395	57,345	84	87	2,177	18	21,436
1978	18,269	26,871	76	86	2,063	15	16,817
1979	11,795	13,597	59	81	1,623	34	14,225
1980	3,904	13,506	3	95	1,730	9	8,576
1981	2,077	3,124	5	72	1,248	6	4,941
1982	2,325	1,714	2	88	1,895	8	5,270
1983	970	1,497	5	91	2,463	15	3,355
1984	745	2,534	1	64	2,187	4	2,921

ATTACHMENT III

BENEFIT-COST-RATIOS BY VACCINE TYPE

Vaccine	Benefit-Cost-Ratio
Measles-Mumps-Rubella (MMR) (1)	14.4:1
Measles-Rubella (MR) (2)	23.0:1
Polio (3)	10.3:1
Pertussis (4)	11.1:1

(1) Unpublished analysis utilizing 1983 data.

(2) Based on analysis of rubella vaccination policy in the United States 1976.

(3) Fudenberg, HH. Returns of Biomedical Research. Journal of Investigative Dermatology 1973: Vol.61 (321).

(4) Hinman, AR and Koplan, JP. Pertussis and Pertussis Vaccine - Reanalysis of Benefits, Risks, and Costs. JAMA 1984 June: Vol.251 (23) p. 3109-3113.

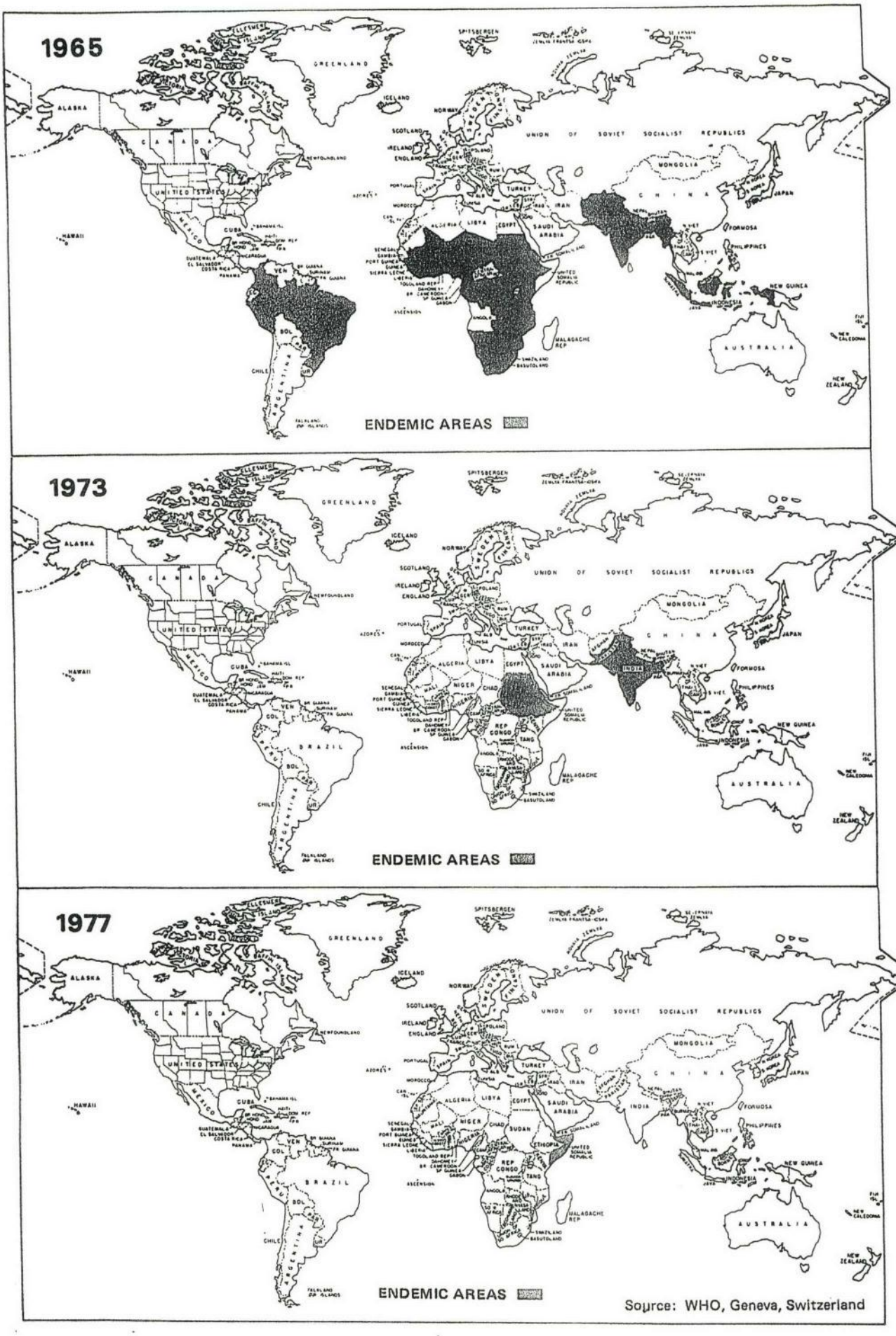
ATTACHMENT IV

DEVELOPING COUNTRIES RANKED BY NUMBER OF DEATHS FROM SELECTED VACCINE PREVENTABLE DISEASES (EXCLUDING CHINA), 1983

Country	Estimated number of annual deaths		
	Neonatal Tetanus (000's)	Measles (000's)	Pertussis (000's)
1. India	288	745	171
2. Pakistan	126	155	53
3. Bangladesh	113	165	55
4. Indonesia	68	208	61
5. Nigeria	61	163	54
6. Mexico	29	54	16
7. Ethopia	15	58	20
8. Zaire	20	43	15
9. Philippines	11	56	14
10. Brazil	26	35	17
11. Burma	19	41	13
12. Thailand	10	53	13
13. Vietnam	11	44	15
14. Kenya	9	35	12
15. Egypt	15	30	10
16. S. Africa	11	33	11
17. Sudan	8	34	12
18. Afghanistan	10	26	9
19. Iran	16	19	8
20. Algeria	10	24	7
21. Morocco	10	20	5
22. Turkey	8	16	5
23. Colombia	9	13	4
24. Tanzania	6	8	6
25. Rep. Korea	5	9	2
TOTAL	**914**	**2,088**	**608**

ATTACHMENT V

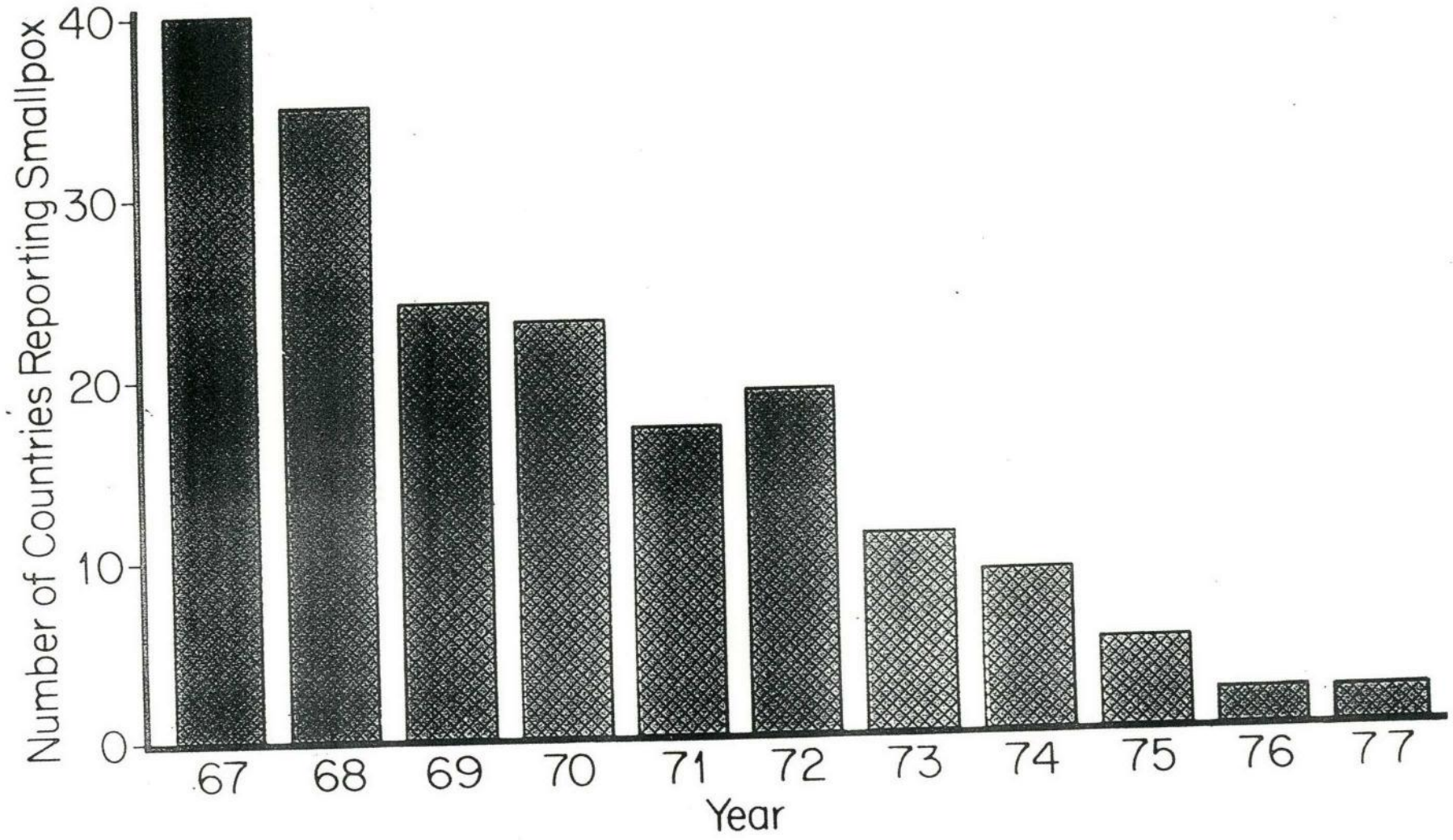
WORLD-WIDE SMALLPOX ENDEMIC AREAS, 1965, 1973, 1977

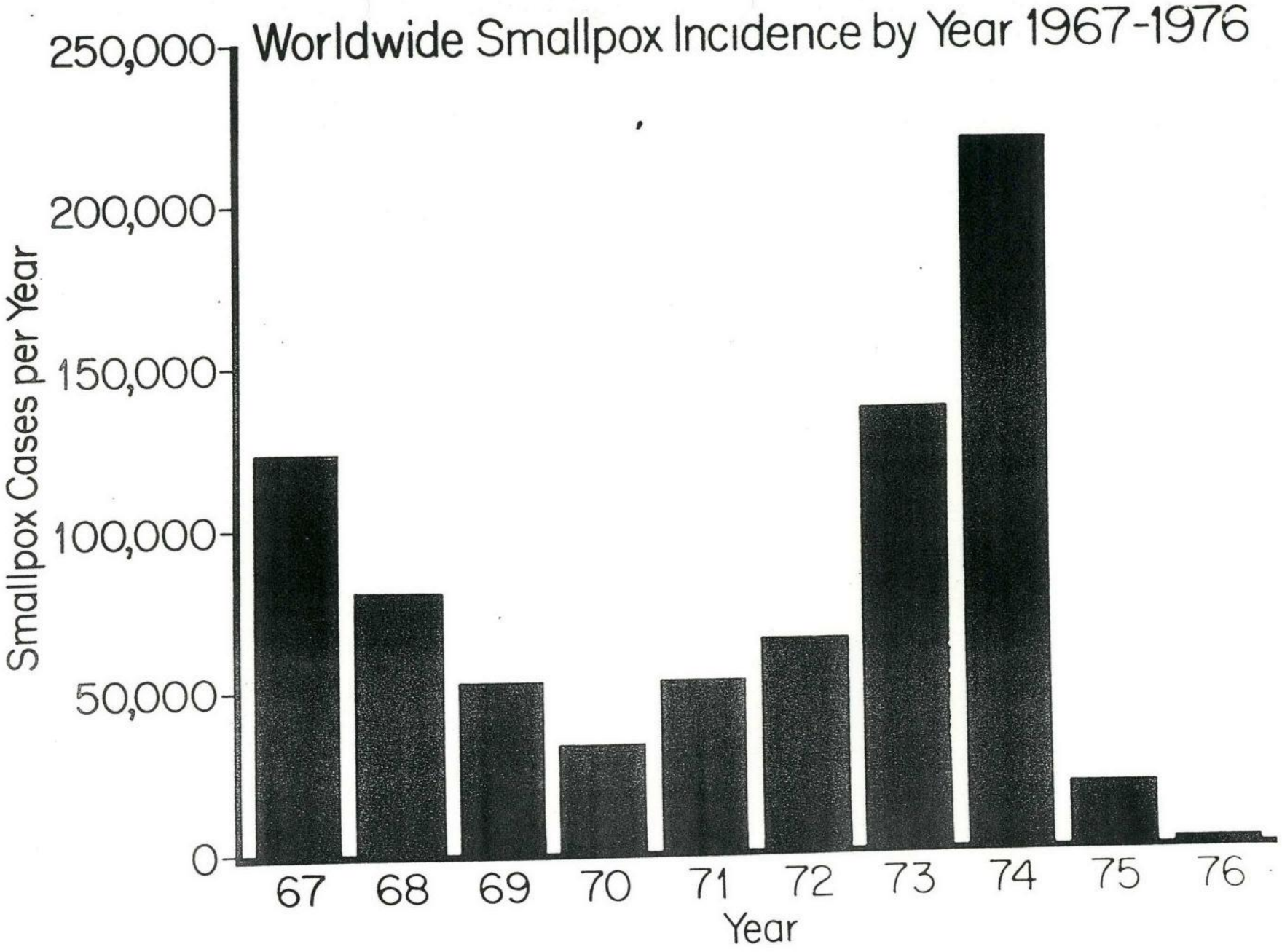


Source: WHO, Geneva, Switzerland

ATTACHMENT VI

Countries Reporting Smallpox 1967-1977




Worldwide Smallpox Incidence by Year 1967-1976
Smallpox Cases per Year
250,000
200,000
150,000
100,000
50,000
0
67
68
69
70
71
72
73
74
75
76
Year

March 27, 1985

To: Tony Measham
From: Karen Hall

Re: Preliminary Comments of the Colombia vaccination campaign evaluation team.

Thanks for sharing this preliminary report. I fully endorse evaluation team's expressed concerns. A couple of points that might be worth noting at your April meeting on subject paper, having not seen "Informe Preliminar" --

(1) With regard to costs of campaign days --
cost per child attended is not very useful since denominator will be large obviously and tend to understate key measure which is actually needed - cost per child fully immunized, immunized meaning not just received full doses, e.g. 3 DPT etc., but per child reached at the right age with effective vaccine. This reflects my continuing concern about whether campaigns at fixed points in time can reach target groups at varying ages with proper timing and spacing of immunizations.
Further, at least on limited scale, consideration should be given to exploring the cost of immunization per death averted, as has been done in referenced studies.

(2) Campaign vs fixed approaches
most striking facts to me are: (a) low coverage in highest risk groups, especially <1s, (though 1-3s too only 70% coverage), particularly in highly urbanized Colombia where exposure to communicable diseases tends to be great at younger ages than rural areas; (b) the apparent dampening of efforts post-jornadas (Table 5) in >1s which fuels my concerns about the fast fix but faster fizzle danger of campaigns, particularly if they become a substitute for, rather than complement to, ongoing immunization programs. If campaigns were perceived as valuable tool for creating constituency, building momentum, it is not clear that they succeeded.

Both these facts argue for caution in endorsing campaign approaches too enthusiastically without better understanding of factors critical to their success, and adequate measures of them, e.g. beyond merely number of children vaccinated.

It would appear useful in full evaluation report for Colombians to delineate actual administrative links and program protocols between the jornadas and regular immunizations activities within MCH programs.

(3) "non-immunized"
in analyzing data from the sample survey on coverage, is it possible to identify key distinguishing characteristics of non-immunized children which might provide clues to guide program designs to reach them? e.g. are they from single mother households, etc.?

Note possible bias introduced by sample survey's design (recorded in Table 2) suggesting overrepresentation of urban population (74% vs. 66% actual) and underrepresentation of ∠ 1s (25% vs. 28% actual), therefore, probably exaggerating actual coverage levels. Urge data be made available, disaggregated by urban/rural residence, to complement existing data disaggregated by discrete age groups, permitting adjustment of coverage levels, as appropriate, thus reflecting true impact of jornadas in difficult to reach, especially remote rural, areas.

(4) efficacy

Though not substitute for laboratory control, tracking of incidence levels of respective diseases is clearly an affordable, acceptable measure of vaccine efficacy. This underscores the importance of instituting immediately planned epidemiologic surveillance system, as team suggested.

If quality control of biologics was and will continue to be an integral part of immunization programs, specific related expenditures should be included in calculations (not evident in existing cost table).

Overall, the evaluation is a very positive step in improving international health community knowledge of the cost-effectiveness of alternative delivery designs and I feel the Bank should fully endorse and support this and follow-on activities through the Bellagio Task-Force.

VACCINES

Kenneth S. Warren, M.D.

The Rockefeller Foundation

Infectious agents must be considered as foreign or alien invaders attacking the vulnerable human and animal body. They can invade through a variety of routes including the skin, the respiratory tract, and the gastrointestinal tract; most of them can multiply into overwhelming numbers and they can spread throughout the body or to certain specific areas. In the process the host may be overwhelmed and killed, or maimed in an almost infinite variety of ways including blindness, destruction of the liver, the heart, the brain, spinal chord, or mutilation through a variety of skin lesions and scarring, and loss of limbs.

The body has an elaborate series of defense mechanisms, some are non-specific, but others are based on the specific recognition of the invader as a foreign object. Two major counter-attack systems are available: chemical warfare through the production of antibodies that will attack only a specific organism and cause relatively little harm to the host. The antibodies can both kill foreign attackers and neutralize their toxic products. An associated line of counter-attack is the mobilization of armies made up of cells which can either approach the foreign invader and release a small amount of highly potent toxic substances in its vicinity or actually engulf and destroy it.

But there is a crucial time lag involved in the recognition of the foreign invader and mobilization of the forces to attack it, an interval that can last for several days or even several weeks. In some cases it may take even longer, and only partial protection may occur. In the meanwhile the host is maimed or destroyed.

The first vaccine came from the cow (Latin vacca), hence its name. In 1778 Edward Jenner wrote, "there is a disease... which is communicated to cows and from cows to the dairy-maids - this disease has obtained the name cow-pox." This is of course the smallpox vaccine. In the two hundred years since then, only about ten vaccines have been developed that are in common use throughout the world. Among the milestone vaccines are those against rabies,

discovered by Pasteur; yellow fever, for which Max Theiler won the Nobel prize; and Salk and Sabin's polio vaccines. The vaccines now available fall into four basic categories: 1) naturally occurring, which includes smallpox, 2) attenuated by multiple passages in laboratory animals or tissues - examples being yellow fever, measles, and the Sabin polio vaccine, 3) killed, which includes whooping cough, rabies, and the Salk polio vaccine, and 4) antitoxins, such as tetanus and diphtheria. These vaccines mobilize the host's defenses so that when invading organisms enter the body both the chemical warfare systems and the troops will be ready and waiting. Even if they do not happen to be available in large quantities, mobilization will occur so rapidly at the time of attack that the invading organisms will be overwhelmed within a relatively short period of time.

We now have vaccines immunizing our children against diphtheria, tetanus, whooping cough, mumps, measles, German measles, and polio, our elderly against influenza and pneumonia, and our travelers against yellow fever, hepatitis B, typhoid and cholera, but many of these vaccines are expensive, require refrigeration, must be given in multiple doses, are relatively ineffective and have unpleasant and at times dangerous side effects. For instance, cholera vaccine is only 40% effective for a period of less than four months and causes fever and aching; whooping cough vaccine may cause brain damage and even death. Furthermore, there are no vaccines for any of the vast protozoan diseases of mankind, such as malaria, amebiasis and African sleeping sickness, or the worm diseases of the developing world, which include hookworm, river blindness and schistosomiasis. In addition, we still remain unprotected against many of the viral and bacterial diseases of both our own country and the rest of the world.

While only ten vaccines were produced in the first two hundred years since Jenner's discovery of the smallpox vaccine, Dr. Richard Krause, former Director of the National Institute of Allergy and Infectious Diseases has recently predicted the development of approximately ten more vaccines in the next decade. My guess is that this is a conservative estimate. The reasons

for this are twofold, the first being the mobilization of the scientific power of the developed world which has heretofore virtually ignored the great diseases of the developing world. Far more important however, is the enormous, new-found power of biotechnology applied to vaccine development and production.

The Role of Biotechnology

The vaccines of the past have either been found by accident, by luck or by good observation and have been largely crude mixtures of whole organisms. Those that are made up of living organisms require careful maintenance, can revert to a disease producing state, and require complex systems to produce. Killed vaccines must be destroyed under exacting conditions so that no infectious materials remain, but they must still be active enough to mobilize the host's defenses. Many of these vaccines are full of extraneous material which may be toxic or lethal. Biotechnology can not only eliminate most of these problems, but can also drastically reduce the time necessary to identify the crucial substances within the infectious organism against which successful attacks can be launched and produce them in large quantities either by genetic engineering or chemistry.

Using genetic engineering techniques investigators have been able to take apart certain viruses and determine exactly which chemical substances are involved in the passage of the organism into the body, its growth and multiplication, its spread to other areas of the body and its lethal effects on the cells of the body. The genetic material (DNA) controlling each one of these substances is also known. Another technique crucial to the development of vaccines is the so-called hybridoma method in which monoclonal antibodies are produced. Using these particularly specific antibodies which home in only on small parts of the large molecules involved in many of the above processes, points of attack can be precisely localized. Some of these monoclonal antibodies will not only pinpoint specific areas on the attacking organisms, but will neutralize those organisms and prevent their infectivity.

Through the use of recombinant DNA, genetic engineering can enable us to produce large amounts of a wide variety of proteins from the infectious organisms in vast bacterial factories. The relevant proteins can be located using both monoclonal antibodies and genetic probes, and can then be produced in large amounts. Thus, instead of whole organisms containing tens to thousands of different extraneous substances, a single protein can be produced in large amounts which may serve as a vaccine.

Going beyond this, once the genetic material is obtained, it can be quite easily analyzed to determine its exact nucleic acid structure. Knowing the genetic code, the structure of the protein for which the gene codes can be determined. This is a simpler and more rapid process than obtaining the protein and attempting to determine its chemical composition directly. Once this is known, the protein can be broken down into small fragments, and the immunizing ability of the fragments can be determined. These small fragments can be easily synthesized chemically in the laboratory in large quantities. Again, this further provides an even more specific system which will further obviate the side effects and toxicities of the standard vaccines.

Another approach which has some unique and very powerful features is to take the genetic material which we know produces the vaccine and inserting it into either bacteria or viruses. In the case of bacteria, when the organisms invade the human body and multiply, their protein composition will be determined by the genetic material and they will be able to immunize the recipient with whatever genetic material has been added.

An example of this is a new typhoid vaccine which is made up of a defective bacterium which gradually commits suicide in the gastrointestinal tract, protecting the individual meanwhile against typhoid fever. To this organism has been added the genetic material from another highly infectious bacterium which causes bacillary dysentery thereby protecting the host against both infectious agents simultaneously.

Even more striking, is the recent use of our old friend the cow-pox virus, which we thought was rendered obsolete by the eradication of smallpox ten years ago. This virus has exceedingly large amounts of genetic material, approximately 25 percent of which is unnecessary for its survival or growth. Thus, bits of relevant genetic material can be taken from other infectious agents and inserted into the gene of the cow-pox virus. When this virus is placed on the skin and scratched into the surface, the host is protected not only against smallpox, but against the other infectious agents as well. Such protection has already been achieved against hepatitis B, influenza, herpes I and herpes II, and malaria. The genetic material is so large that as many as ten different bits of DNA from other organisms can be inserted, all of which would be protective. At present protection has been achieved against three different organisms simultaneously in addition to smallpox.

Thus, biotechnology enables us to 1) identify the precise materials necessary to protect us against infectious agents, 2) produce them in bacterial factories in large quantities, 3) analyze their chemical structure, 4) break them down into smaller fragments which may retain their protective role, and 5) produce these "synthetic vaccines" chemically. Furthermore, we can use living bacteria and viruses to insert the genetic material from several different organisms simultaneously into the host, which will produce its own vaccines.

The outcome will be large numbers of new vaccines, which are non-toxic, cheap and easy to maintain and administer.

Conclusions

Scientists throughout the world are amazed and enthralled by the power of biotechnology. It is not only a moment of intense intellectual stimulation, but a moment which has the potential to drastically enhance the wellbeing of

mankind throughout the world. At a recent meeting entitled "Vaccines 85: Molecular and Chemical Bases of Resistance to Viral, Bacterial and Parasitic Diseases," held at Cold Spring Harbor, one of the great centers of molecular biology, scientists were euphoric at the rapid rate of progress of both the science of vaccines and its possible practical outcomes. Within the last year the Rockefeller Foundation has recognized the great power of these systems for our three science-based areas, health, agriculture and population. To our interest we have learned that the National Institute of Allergy and Infectious Diseases had realized this enormous potential as early as 1980. At that point they suggested a program entitled Accelerated Development of New Vaccines at an annual cost of 25 million dollars. Although the program was framed, it has never received new funding. Furthermore, the level of funds for contracts for vaccine development through NIAID has remained constant for the last 10 years. Pharmaceutical firms are showing relatively little interest because of the well-known litigation problem. They are not interested in the development of vaccines for the third world because they can see little profit.

A bright light in this situation is the new World Health Organization Programme for Vaccine Development which is being set up on the basis of scientific quality alone, and is being supported by two U.S. foundations in its initial phases. Another major development was a meeting in Bellagio, Italy, on March 13-15, 1984, to immunize all the world's children. This meeting was attended by the heads of the World Health Organization, UNICEF, UNDP, and the World Bank, and included the Administrator of the U.S. Agency for International Development and many of the other bilateral aid agencies. A Task Force for Child Survival was organized, led by Dr. William Foege, who until recently was head of the Centers for Disease Control in Atlanta, Georgia. Major programs are now underway in Colombia, Senegal, India, Burkina Faso and Nigeria, not only to immunize all of the children but to develop an infrastructure for continuing immunization. As new and better vaccines appear, it is expected that they will be included in the delivery system. I would like to conclude with the words of a noted vaccinologist, Dr. Geoffrey Edsal, "Never in the history of human progress has a better and cheaper method of preventing illness been developed."

The Task Force for Child Survival
1989 North Williamsburg Drive • Suite I • Decatur, Georgia 30033
(404) 325-2452 • Telex 8107518512
Administratively Affiliated with Emory University

~~JDN~~
~~ARH~~ Pdsmu
See 4/4 agenda –
what about meeting
with Clausen?

March 25, 1985

PARTICIPANTS OF THE TASK FORCE FOR CHILD SURVIVAL MEETING - APRIL 4-5, 1985

Enclosed is the agenda for the April 4-5 meeting in Washington. The agenda for the Pritech meeting has been sent directly from the Pritech staff.

We will look forward to seeing you on the 4th.

With best regards.

Sincerely,

Bill

William H. Foege, M.D.
Executive Director

Enclosure

THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

Date: March 12, 1985

To: Mr. A.W. Clausen (through Mr. Ernest Stern, SVPOP, and Mr. S. Shahid Husain, VPOPS)

From: John D. North, Director, PHND

Extension: 61571

Subject: Request for Meeting with Task Force for Child Survival

This memorandum is to enquire whether you would like to receive Dr. William Foege, Executive Director, Task Force for Child Survival and Dr. Luis Fernando Duque, Coordinator of the Second Meeting on Child Survival ("Bellagio II" - in Colombia), at 4:00 p.m. on Thursday, April 4, 1985. Dr. Foege and Dr. Duque will be in Washington on the day in question for the fifth meeting of the Task Force which will be hosted by the Bank. My memorandum of February 26, 1985 refers.

cc: Dr. Measham ✓

ARMeasham/rmf

The Task Force for Child Survival
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Administratively Affiliated with Emory University

March 1, 1985

Dr. Anthony R. Measham,
The World Bank
Health Advisor
Health, Population and Nutrition
1818 H Street, N.W.
Washington, D.C. 20433

Adm. 3/5/85
Copy to W. Dr
Guzman.
Will discuss with
IDN.

Dear Tony:

Enclosed are the two documents we received from Dr. Steve Jones concerning the evaluation program in Colombia.

I have received permission from Steve and Dr. Ciro de Quadros to make these available to our sponsoring agencies, and plan to include them as part of the package, when we circulate the agenda for our April 4th-5th meeting.

Sincerely,

Bill

William C. Watson
Project Manager

Enclosures

JONES

COMENTARIOS PRELIMINARES DE LA COMISION ASESORA INTERNACIONAL A LA EVALUACION DE LAS JORNADAS NACIONALES DE VACUNACION DE COLOMBIA

Ministerio de Salud
Organización Panamericana de la Salud
UNICEF

Bogotá - Colombia
Febrero 15 de 1985

1. INTRODUCCION

En 1984, Colombia realizó tres Jornadas Nacionales de Vacunación para aumentar la cobertura vacunal en niños menores de cuatro años de edad.

Estas Jornadas se realizaron los sábados 23 de junio, 28 de julio y 25 de agosto de 1984.

Las Jornadas representaron una gran inversión social y financiera de Colombia y de varios Organismos Internacionales. Durante las Jornadas se logró la aplicación de apróximadamente 5'000.000. de dosis de vacuna a través de una gran movilización política y social. Precisamente esta gran movilización de diversos elementos de la Sociedad Colombiana despertó un gran interés de otros países y Organismos Internacionales en la posibilidad de replicar las Jornadas en otros ambientes.

Además, la experiencia de Colombia tiene mayor importancia por el hecho de que fue seleccionado como uno de los tres países (con la India y Senegal) para implementar las recomendaciones de la Conferencia de Bellagio (Italia) de asegurar una mejor supervivencia de los niños a través de actividades de inmunizaciones una de las más efectivas intervenciones existentes en la salud pública.

En Agosto de 1984, durante la tercera Jornada Nacional de Vacunación (J.N.V.), el señor Director de la Organización Panamericana de la Salud (OPS) ofreció al Señor Presidente de la República de Colombia los servicios de una Comisión Asesora Internacional para colaborar en las actividades nacionales de evaluación de estas Jornadas.

Siendo aceptada esta oferta, la Organización Panamericana de la Salud (OPS), organizó y nombró dicha Comisión, conformada por los siguientes Consultores:

T. STEPHEN JONES, M.D.
Director, División de Evaluación y Pesquisa
Oficina de Programa de Salud Internacional del CDC
Atlanta, Georgia, E.U.A.

JACQUES MANCEAU, M.D., M.P.H.
Director, División de Información y Estadística
Fundación de Servicios de Salud Pública
Rio de Janeiro, Brasil

JOAO BAPTISTA RISI JR, M.D.
Secretario Nacional de Acciones Básicas de Salud
Ministerio de Salud
Brasilia, Brasil

La primera visita de la Comisión Asesora Internacional se realizón en Octubre de 1984. En esta ocasión, reunida en Bogotá con funcionarios del Ministerio de Salud, del Instituto Nacional de Salud, de Unicef, de la OPS y de los miembros de los dos grupos Nacionales de Evaluación se han hecho una serie de sugerencias y recomendaciones sobre los protocolos presentados para la evaluación.

Estas sugerencias y recomendaciones hacen parte del "Informe Preliminar de la Comisión Asesora Internacional a la Evaluación de las Jornadas Nacionales de Vacunación en Colombia de octubre de 1984.

Débido a que los documentos presentados por los grupos Nacionales en el Taller de Evaluación realizado del 11 - 15 de febrero de 1985 en Bogotá, no están debidamente concluidos o acabados, la Comisión Asesora Internacional no tiene los elementos suficientes para presentar sus conclusiones finales sobre la evaluación de estas Jornadas.

A pesar de los anterior se presentaron datos que permiten algunos comentarios generales y conclusiones preliminares.

Se espera que estos comentarios y conclusiones preliminares sirvan para ayudar a los grupos Nacionales a completar y afinar aquellos aspectos de la evaluación que requieren revisión y estudios adicionales.

A medida que los informes finales de los grupos Nacionales sean presentados la Comisión Asesora Internacional estará en condiciones de presentar su informe final sobre este importante esfuerzo nacional.

2. COMENTARIOS Y RECOMENDACIONES SOBRE LOS ESTUDIOS PRESENTADOS.

2.1. Cronología y Desempeño Administrativo

El Documento presenta una descripción de la cronología y del Sistema Administrativo "ad hoc" de las Jornadas Nacionales de Vacunación.

La Comisión recomienda un revisión del Documento focalizando prioritariamente los aspectos organizativos y gerenciales en los diferentes niveles del Sistema de Salud, involucrados en el desarrollo de las Jornadas Nacionales de Vacunación "J.N.V" y en los varios componentes evaluativos mencionados y recomendados en el punto 6.3, páginas 12 - 14 del "Informe Preliminar de la Comisión Asesora Internacional a la Evaluación de las Jornadas Nacionales de Vacunación de Colombia", octubre de 1984.

En esta revisión se recomienda la inclusión de:

a. Descripción de la metodología utilizada.

b. Listado de las personas entrevistadas y cuestionarios utilizados.

c. Listado de los documentos consultados.

En especial la Comisión sugiere que se analice los tres puntos recomendados en octubre de 1984.

- Continuidad de las J.N.V. Determinar el grado de apoyo político, técnico y popular para la continuidad de las Jornadas Nacionales de Vacunación.

- Alcance de las J.N.V. en áreas con acceso limitado a los Servicios Seccionales de Salud.

  Descripción de como las Jornadas Nacionales de Vacunación han tratado de llevar servicios de vacunación a las áreas marginadas de las grandes ciudades y en ciertas áreas rurales que no tienen acceso a los Servicios de Salud.

- Menores de 1 año. Porqué las Jornadas no lograron mejor cobertura en este grupo etareo de más alta prioridad.

2.2. " El Costo de las Jornadas ".

Este documento presenta una primera estimación muy razonable de los costos de las Jornadas.

La Comisión recomienda:

a. Tratar de conformar la metodología a la utilizada en otros estudios de costo de programas de Inmunización (ejs: Creese, Shepard, Robertson).

b. Incluir los costos de capital para hacer las estimaciones de costos más reales y más comparables a otros estudios ya publicados.

c. Estimar el costo por niño atendido y por niño completamente vacunado.

2.3. " Encuesta Nacional de Cobertura Vacunal. "

Fueron presentados tablas con resultados preliminares de la encuesta nacional de cobertura vacunal realizada. No hubo documento escrito detallando el análisis realizado.

Entre otros se puede citar los hallazgos preliminares siguientes:

- Coberturas en niños de un año de edad fueron aumentando apróximadamente 50% durante las Jornadas Nacionales de Vacunación como era la meta de las mismas.

- Las coberturas alcanzadas en niños menores de un año sólo están entre 50 y 55% para las diferentes vacunas.

- En niños de 1 - 3 años de edad las coberturas son alrededor de 70% que implican coberturas útiles pero además muestra la existencia de un grupo de niños no alcanzados por ningunas de las estrategias o tácticas de inmunización.

- La existencia de este grupo de niños "inmunizables" es muy preocupante considerando el gran esfuerzo de promoción realizado durante las Jornadas Nacionales de Vacunación

- Que para mayores de un año las actividades de vacunación después de las Jornadas Nacionales de Vacunación J.N.V. (Septiembre a Noviembre) fueron muy pocas.

La Comisión recomienda.

a. Completar el análisis e interpretación de la encuesta nacional.

b. Preparar un documento sobre la metodología, hallazgos e interpretación de la encuesta.

2.4. Estudios Epidemiológicos.

El grupo de estudio epidemiológico se ocupó principalmente con la encuesta nacional de coberturas de vacunación. Por eso, ciertos estudios considerados como claves no se han ~~realizado~~ terminado todavía.

La Comisión considera que los estudios siguientes tienen alta prioridad para la evaluación de las Jornadas Nacionales de Vacunación. Favor de referirse al Informe Preliminar para los detalles de dichos estudios (ver punto 6.2, páginas 10-12 del "Informe Preliminar", Octubre 1984).

a. Población a riesgo. baja cobertura

b. Coberturas alcanzadas durante las Jornadas Nacionales de Vacunación.

c. Impacto indirecto de las Jornadas Nacionales de Vacunación.

   Comparando las actividades de vacunación antes, durante y después de las Jornadas. El enfoque debe ser determinar si había una disminución después de las Jornadas.

d. Impacto de las Jornadas sobre la Canalización.

2.5. Vigilancia Intensificada

En Oct 1984, fue preparado un proyecto de una resolución ministerial para implementar una vigilancia intensificada para las enfermedades inmunoprevenibles la Polio, el Sarampión y el Tétanos Neonatal. Las actividades contempladas incluyen:

- Investigación rápida de todos los casos sospechosos de la Polio, utilizando una ficha nacional. Red Nacional
- Investigación de todos los casos de Tétanos Neonatal utilizando una ficha nacional.
- Creación de puestos centinelas para el Sarampión.
- Recolección oportuna de datos de la mortalidad en menores de 5 años en las capitales departamentales.
- Informe anual de epidemiología de las enfermedades inmunoprevenibles y la marcha del Programa Ampliado de Inmunizaciones "PAI".

Hasta febrero de 1985, el proyecto no está implementado.

La Comisión recomienda la implementación pronta de la vigilancia intensificada.

2.6. Encuesta de Cobertura Vacunal en ~~Areas marginadas de~~ Bogotá.

El Servicio Seccional de Salud de Bogotá ha diseñado una encuesta del estado vacunal de niños viviendo en las áreas marginadas de la capital. La recolección de datos en el campo ha sido llevado a cabo.

La Comisión recomienda la pronta análisis de esta encuestas para la determinación de la cobertura vacunal en las áreas marginadas de Bogotá y la posible identificación de grupos de difícil acceso.

2.7. Estudios del Laboratorio.

Los resultados de pruebas de potencia de las vacunas Antisarampionosa y Antipolio utilizadas durante las Jornadas Nacionales fueron presentados. No hay informe escrito de la investigación.

El hallazgo más llamativo es que cuatro (4) frascos de la Vacuna Antisarampionosa tomados en el Meta tuvieron una potencia inadecuada. Esto representa apróximadamente un 1% del total de muestras estudiadas.

La Comisión recomienda.

a. Los estudios de potencia de vacuna son importantes unicamente dentro del marco de un control nacional de la calidad de biológicos.

b. La manera más práctica de garantizar la calidad de las vacunas es entrenamiento de personal en el manejo de la cadena de frío y una adecuada supervisión.

c. El estudio de seroconversión será dificil a interpretar por la inaxistencia de sueros tomados antes de la vacunación. Este tipo de estudio no es indicado para la evaluación rutinaria de programas de inmunización.

3. CONCLUSIONES

3.1 En razón de los limitantes anteriormente presentados en relación a los estudios de evaluación propuestas durante las reuniones llevadas a cabo en octubre de 1984, las conclusiones que se pueden sacar en este momento son de carácter general y deberán ser profundizadas en el futuro.

3.2 Las Jornadas Nacionales de Vacunación que fueron llevadas ~~en los meses de Junio, Julio y Agosto de 1984~~, han contribuído de manera importante para la movilización de sectores de la sociedad normalmente no involucrados en actividades de salud, que tienden a aumentar la conciencia de la población sobre la necesidad de la vacunación, y a producir también efectos sobre otras acciones en el campo de la salud.

3.3 Entre las actividades que se han programado para evaluación de las Jornadas Nacionales de Vacunación, se destaca la realización de la encuesta nacional de cobertura de vacunación, como de importancia y fundamental para determinar la eficiencia del programa y validación de los datos obtenidos por el método administrativo. Cumple referir que la metodología utilizada, son características de alta confiabilidad, rapidez y bajo costo, y que fué la primera que se ejecutó en América Latina.

3.4 Los datos preliminares indican que las Jornadas Nacionales han contribuído significativamente para el aumento de coberturas de vacunación en niños de uno a tres años de edad, hasta un 75% para las vacunas DPT, antisarampionosa y contra la poliomielitis. No obstante, del mismo modo que otras estrategias ya utilizadas, no se han logrado aparentemente coberturas satisfactorias para niños menores de un año, el grupo prioritario para el PAI.

3.5 A pesar del éxito global alcanzado por el programa, permanecen sin beneficiarse de las actividades de vacunación cerca de 25-30% de los niños menores de 4 años, que se supone constituyen un grupo o grupos de población inaccesible a todas las estrategias de vacunación que se han utilizado.

3.6 Aunque no se disponga de datos definitivos, hay indicaciones que las Jornadas Nacionales de Vacunación tuvieron impacto epidemiológico sobre la incidencia de la poliomielitis.

Teniendo en cuenta que el último pico epidémico de la enfermedad ocurrió en el año 1981 y que en 1984 fué registrado el menor número anual de casos desde el año 1975. Eso se debe posiblemente a la diseminación masiva de virus vacunal en el corto espacio de tres meses.

4. RECOMENDACIONES

4.1 Concluir los estudios iniciados, en particular el referente a la evaluación epidemiológica y elaborar informe final detallando sus metodologías, hallazgos y limitaciones.

4.2 Llevar a cabo los esfuerzos para identificar grupos de población no alcanzados por las distintas estrategias de vacunación y para determinar las causas de ese proceso. En este aspecto, es de fundamental importancia la conclusión de la encuesta iniciada en áreas marginadas de Bogotá, y el seguimiento de los niños no vacunados identificados en la encuesta nacional.

4.3 Implementar el proyecto de Vigilancia Epidemiológica intensificada que se ha elaborado en octubre y que se encuentra todavía pendiente de decisión en el Ministerio de Salud.

4.4 Dar continuidad al esfuerzo nacional coordinado a nivel interinstitucional., con el objetivo de mantener las coberturas de vacunación alcanzadas con las Jornadas y ampliarlas a los menores de un año de edad, así como a otros grupos de difícil acceso a los servicios de salud.

T. Stephen Jones

João Baptista Risi JR

Jacques Manceau

Queremos agradecer la colaboración de las señoritas Flor Alix Umaña y Maria Eugenia Angel por la elaboración del presente Informe.

REPUBLICA DE COLOMBIA

MINISTERIO DE SALUD

JORNADAS NACIONALES DE VACUNACION
RESUMEN DE LA EXPERIENCIA, LOGROS Y PERSPECTIVAS

NATIONAL VACCINATION CRUSADE
A SUMMARY OF THE EXPERIENCE, ACHIEVEMENTS AND PERSPECTIVES

JOURNEES NATIONALES DE VACCINATION
RESUME DE L'EXPERIENCE, REALISATIONS ET PERSPECTIVES

Bogotá, agosto de 1984

DISTRIBUCION DE VIVIENDAS Y NIÑOS MENORES DE CUATRO AÑOS INCLUIDOS EN LA MUESTRA

TABLA No. 1

DATO	No.	%	NIÑOS	No.	%
Viviendas visitadas	13.432	100.0			
Ocupadas	12.543	93.4	Encuestadas	6.801	100.0
Desocupadas	889	6.6			
Ocupadas con respuesta	11.248	88.7	Con información	6.312	92.8
Ocupadas sin respuesta	1.295	10.3	sin información	489	
			Con carnet		93.0
Renuentes	185	1.5			

PRELIMINAR

✓

(2)

RESULTADOS DE LA ENCUESTA

DISTRIBUCION DE LA POBLACION MUESTRAL

SEGUN EDAD Y ZONA DE RESIDENCIA

TABLA No. 2

	ZONA			
Edad	Urbana	Rural	Total No.	%
< 1 año	1090	391	1481	25.0
1 año	1178	389	1567	26.4
2 años	1084	383	1467	24.8
3 años	1025	376	1401	23.6
Ignorada	8	3	11	.2
Total No.	4385(74.0)	1542(26.0)	5927	100.0

24%

Preliminary

'81 69%

RESULTADOS DE LA ENCUESTA

PROPORCION DE VACUNADOS CON Y SIN CARNET POR BIOLOGICO

SEGUN EDAD AL MOMENTO DE LA ENCUESTA

EVALUACION DE LAS JNV- COLOMBIA 1984

≥ 240 d = 396 — BCG

> 98 d =

EDAD	CARNET	POLIO		DPT		Sarampión		BCG		4 Biológicos		3 biológicos	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
0	Si	389	39.7	388	39.6	159	40.2	880	64.7	130	32.8	138	34.8
	No	24	2.4	23	2.3	6	1.5	79	5.8	6	1.5	13	3.3
	Subtotal	413	42.2	411	42.0	165	41.7	959	70.5	136	34.3	151	38.1
1	Si	1084	69.6	1059	68.0	1105	71.0	1172	75.3	503	32.3	531	34.1
	No	62	4.0	60	3.8	74	4.8	90	5.8	29	1.9	33	2.1
	Subtotal	1146	73.6	1119	71.9	1179	75.7	1262	81.0	522	~~33.5~~	564	36.2
2	Si	995	68.7	986	68.1	1030	71.1	1026	70.8	293	20.2	302	20.8
	No	66	4.6	65	4.5	94	6.5	107	7.4	25	1.7	25	1.7
	Subtotal	1061	73.3	1051	72.6	1124	77.6	1133	78.2	318	22.0	327	22.6
3	Si	953	68.8	948	68.4	977	70.5	945	68.2	200	14.4	206	14.9
	No	81	5.8	78	5.6	105	7.6	124	8.9	30	2.2	31	2.2
	Subtotal	1034	74.6	1026	74.0	1082	78.1	1069	77.1	230	16.6	237	17.1
Total con carnet		3421	63.7	3381	63.0	3271	68.3	4023	68.8	1126	23.5	1177	24.6
Total sin carnet		233	4.3	266	4.2	279	5.8	400	6.8	90	1.9	102	2.1
Gran total		3654	68.0	3607	67.2	3550	74.2	4423	75.7	1206	25.2	1279	26.7
Población		5370		5370		4787		5843		4787		4787	

PRELIMINARY

EFECTO DE LAS JORNADAS

COBERTURA PORCENTUAL ACUMULADA DE VACUNACION POR BIOLOGICO SEGUN EDAD *

COLOMBIA 1.984

TABLA No. 5

31 MAYO

EDAD	POLIO			D P T			SARAMPION			B. C. G		
	ANT.	DUR.	DESP.	ANT.	DUR.	DESP.	ANT.	DUR.	DESP.	ANT.	DUR.	DESP.
0	—	25.7	39.4	0.2	25.7	39.6	0.2	12.6	40.1	30.4	49.7	65,9
1	36.4	65.4	69.5	35.3	64.1	68.1	33.5	52.3	70.1 ~~53.8~~	72.8	77.9	80.5
2	52.1	66.4	68.7	51.5	65.9	68.2	55.8	69.6	71.0	71.6	75.8	77.9
3	54.4	66.4	68.6	51.8	63.3	65.4	56.5	69.3	70.0	71.6	74.8	76.7
Todas las edades	38.7	58.8	63.7	38.1	58.0	62.9	45.5	65.6	70.2	61.7	69.7	75.4

* Con carnet (93 %)

PRELIMINARY

(5)

COBERTURA VACUNAL

PORCENTAJE ACUMULADO DE NIÑOS VACUNADOS AL CUMPLIR EL 1º, 2º y 3º ANIVERSARIO RESPECTIVAMENTE POR GRUPO DE EDAD.

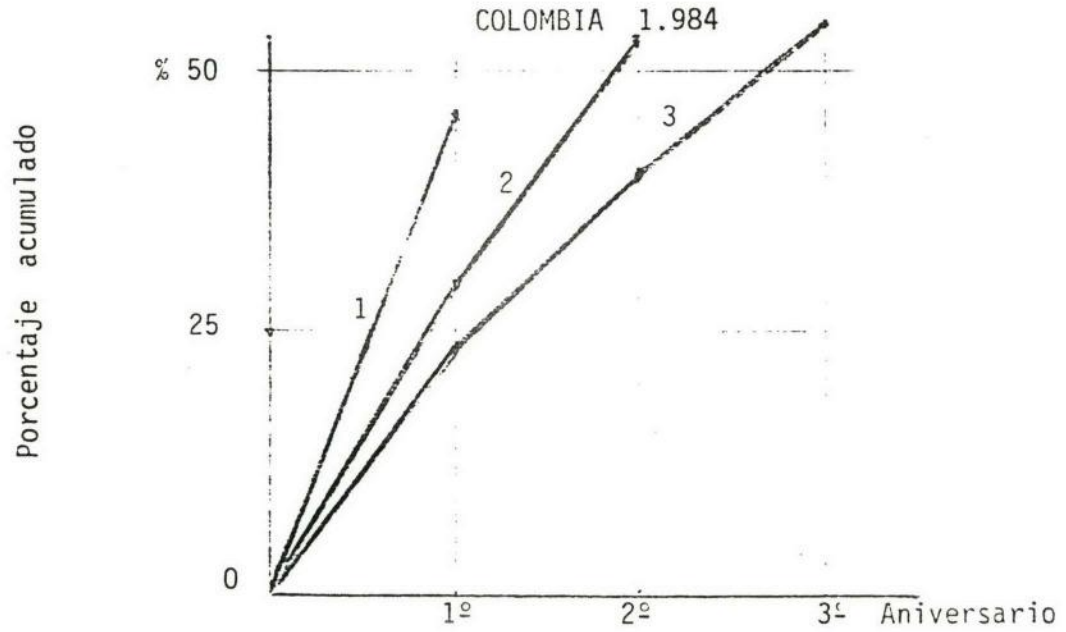
TABLA No. 6

EDAD # niños	3 años (1.386)				2 años (1.448)				1 año (1.557)			
Biol.	Polio	DPT	Sarm.	BCG.	Polio	DPT	Sarm	BCG	Polio	DPT	Sarm.	BCG
1º Aniv.	24.8	24.4	24.6	51.8	29.7	29.7	33.0	57.9	46.8	45.6	49.6	72.1
2º Aniv.	43.5	44.2	50.6	62.1	55.7	56.2	63.9	70.5				
3º Aniv.	57.3	57.7	65.8	70.6								

PRELIMINAR

COBERTURA VACUNAL

PORCENTAJE ACUMULADO DE NIÑOS VACUNADOS AL CUMPLIR EL 1º, 2º y 3º ANIVERSARIO RESPECTIVAMENTE POR GRUPO DE EDAD- POLIO y DPT S/pión



(6)

RESULTADOS DE LA ENCUESTA

PROPORCION DE VACUNADOS CON Y SIN CARNE, POR BIOLOGICO

SEGUN EDAD A 31 DE AGOSTO DE 1984

EVALUACION DE LAS JORNADAS NACIONALES DE VACUNACION

COLOMBIA 1984

EDAD	POBL.	POLIO	DPT	S/PION	BCG
0	916 [a] 490 [b] 1.833 [c]	53.1	51.5	55.1	52.9
1	1.561	74.6	73.0	76.7	81.1
2	1.460	73.9	72.9	78.1	78.9
3	1,313	74.4	74.2	77.6	75.8
< 4					
Población a atender					

a. Para polio y DPT
b. Para Sarampión
c. Para BCG

CUADRO No. 7

COBERTURA NACIONAL DE VACUNACION ALCANZADA EN MENORES DE CUATRO AÑOS SEGUN TIPO BIOLOGICO

COLOMBIA. 1980 - 1983

BIOLOGICO	AÑOS	< 1	1	2	3	TOTAL MENORES DE 4 AÑOS
ANTIPOLIO	1980	16.1	27.2	37.0	41.0	30.5
	1981	25.4	37.6	52.1	63.3	43.4
	1982	27.2	44.5	57.9	75.0	50.3
	1983	43.7	55.2	68.2	84.6	62.2
	1984	61.1	73.1	83.6	100.0	79.8
B. C. G.	1980	47.0	62.5	63.2	71.5	42.6
	1981	61.2	70.0	86.1	88.4	73.3
	1982	66.2	77.5	85.5	100.0	81.7
	1983	79.4	86.4	100.0	100.0	91.1
	1984					
D. P. T.	1980	15.1	27.4	35.8	35.7	28.1
	1981	21.6	35.5	48.6	39.3	34.7
	1982	26.3	41.5	54.2	68.8	46.9
	1983	42.3	53.1	63.8	79.0	58.9
	1984	60.3	71.1	81.2	96.3	76.6
ANTISARAMPION	1980	13.7	32.2	43.1	54.1	35.0
	1981	27.5	50.5	65.9	74.7	52.1
	1982	27.8	55.3	70.1	84.0	58.3
	1983	43.4	62.2	78.1	91.4	68.0
	1984	52.9	79.3	89.5	100.0	79.7

FUENTE: Ministerio de Salud- Subsistema de Información

POLIO 3RD DOSES (X 1000)

APPLIED IN COLOMBIA

CALENDAR 1983, CALENDAR 1984

JORNADAS 1984

AGE GROUPS

	< 1 Year	1 Year	2 Years
1984 Calendar	485 (61%)	236 (30%)	217
1984 Jornadas	191 (24%)	120 (16%)	126
1984 Regular	294 (37%)	116 (14%)	91
1983 Calendar	328 (41%)	193 (25%)	159
Estimated Population	795	771	730

JONES

CUADRO No. 1

JORNADAS NACIONALES DE VACUNACION - RELACION DE COSTOS TOTALES

(miles de pesos)

	CAPITAL					
1.1.	Edificios e instalaciones					
1.2.	Equipos de Oficina					
1.3.	Equipo médico duradero					
1.4.	Cadena fría y refrigeración					
1.5.	Vehículos					
	OPERATIVOS					1'024.024
2.1.	Personal				810.690	
2.1.1.	Remuneración de trabajadores directos			729.871		
2.1.1.1.	Sueldos y prestaciones		622.411			
2.1.1.2.	Voluntarios (imputado)		107.460			
2.1.2.	Viáticos			1.504		
2.1.3.	Prorrata de Administración			79.315		
2.2.	Materiales e Insumos				46.981	
2.2.1.	Elementos médicos			46.375		
2.2.1.1.	Biológicos		24.499			
2.2.1.2.	Jeringas y agujas		20.210			
2.2.1.3.	Alcohol y Algodón		1.474			
2.2.1.4.	Hielo Seco		192			
2.2.2.	Material de Oficina			606		
2.2.2.1.	Papelería y útiles		559			
2.2.2.2.	Implementos varios (grapas tintas...)		47			
2.3.	Transporte				14.071	
2.3.1.	De materiales			2.119		
2.3.2.	De personas			11.952		
2.4.	Gastos de Terreno				8.910	
2.5.	Publicidad y Promoción				139.967	
2.5.1.	Medios			123.346		
2.5.1.1.	Radio		92.051			
2.5.1.1.1.	Caracol - Cuñas previas	27.187				
2.5.1.1.2.	Caracol- días de jornadas	56.657				
2.5.1.1.3.	Caracol - personal ad-hoc	3.000				
2.5.1.1.4.	Otras cadenas y emisoras	5.207				
2.5.1.2.	Televisión		15.804			
2.5.1.2.1.	Producción	4.019				
2.5.1.2.2.	Pautas	11.785				
2.5.1.3.	Prensa escrita		14.100			
2.5.1.4.	Vidrios de cine		1.391			
2.5.2.	Promoción			16.621		
2.6.	Comunicaciones					
2.7.	Gastos Incidentales				3.405	
2.7.1.	Obsequios al público			1.974		
2.7.2.	Espectáculos			1.431		
	COSTOS DEL USUARIO					51.154
3.1.	Transporte				2.894	
3.2.	Tiempo sacrificado				48.260	
T O T A L *						1'075.178

* No incluye capital ni comunicaciones.

9,774,345

THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

Date: February 26, 1985

To: Mr. A.W. Clausen (through Mr. Ernest Stern, SVPOP and Mr. S. Shahid Husain, VPOPS)

From: John D. North, Director, PHND

Extension: 61573

Subject: Report on Activities of the "Task Force for Child Survival"

1. This memorandum provides a brief review of the activities of the Task Force for Child Survival since the Bellagio I meeting which you attended in March 1984.

2. Dr. William Foege, you will recall, was chosen to lead the Bellagio Task Force composed of WHO, UNICEF, UNDP, the Rockefeller Foundation and the Bank. Dr. Foege is devoting half of his time to this effort, with his salary paid by the Centers for Disease Control, where he is a special adviser to the Director, having himself previously served as director for six years. He is assisted by a manager and a small office staff.

3. As planned, the Task Force is devoting most of its attention to catalyzing nationwide immunization efforts in Colombia, Senegal and India. Dr. Foege has spent much of his time in these efforts, plus, more recently, on similar activities in Burkina Faso. In addition, requests for assistance have led to small-scale involvement in Nigeria, El Salvador, and Ethiopia.

4. Colombia. Preliminary indications are that this is the most successful national immunization effort assisted by the Task Force to date. With strong backing from President Betancur and impressive mobilization of the armed forces, police, and voluntary organizations, Colombia staged three immunization campaign jornadas (days) in June, July and August 1984. Over 800,000 children were immunized on each of the three days and over five million doses of vaccine were given. The three campaign days helped to boost immunization coverage to about 60%, up from 43% in 1983 and 27% in 1982. A careful evaluation has been carried out by the Colombian authorities, with technical assistance from the Pan American Health Organization (PAHO) and the Task Force. The evaluation report should soon provide the kind of evidence regarding impact, cost-effectiveness and the applicability elsewhere of lessons learned that will be critical to the long term prospects of the Bellagio effort.

5. Colombia is naturally very proud of its success and eager to go beyond immunization to other aspects of primary health care, again with Task Force assistance. The invitation to hold Bellagio II in Cartagena in October 1985 is a tangible expression of the enthusiasm generated by this successful effort.

6. Senegal. The Task Force considered the original proposal from Senegal, which was presented at Bellagio I, to be infeasible. Accordingly, a short-term consultant sponsored by the Task Force and financed by

UNICEF, assisted the Senegalese authorities to develop a less ambitious and costly proposal, aimed at providing immunization coverage to one quarter of the country's six million population. UNICEF is expected to fund the revised proposal and a two year assignment of the consultant. While UNICEF is likely to finance the first year of the project, years two and three might be funded from savings in the ongoing Bank-financed health project, if this is requested by the Senegalese authorities.

7. India. Less progress is evident so far in India. Task Force efforts to arrange a meeting to discuss India's national program have not yet borne fruit. However, there is a significant Indian interest and Dr. Bisht, Director General of Health, recently visited Atlanta. In addition, UNICEF Executive Director, James Grant has suggested to Prime Minister Rajiv Gandhi that the expanded immunization effort be made a "living memorial" to Mrs. Gandhi. Dr. Foege will coordinate efforts to arrange a meeting in India as soon as possible. One possibility discussed was for the Task Force to see if the Indian authorities would welcome discussions with donors interested in providing assistance in the immunization push (SIDA, Denmark, AID, CIDA and Rotary International have expressed interest). Another option discussed was to hold a future Task Force meeting in Delhi.

8. Burkina Faso. Early returns show that Project "Commando" achieved the following:

Vaccine	No. Vaccinated	% of Target
Measles	1,035,515	79
Yellow Fever	1,804,519	69
Meningitis	2,307,163	89

These figures appear to indicate success in the campaign effort, although more information is needed to corroborate this impression. The Burkina Faso program came about as a result of discussions between James Grant and President Sankara, and was assisted by the Task Force.

9. Task Force Meetings. There have been four one-day meetings so far, including two hosted by the Bank. Attendance has been good and enthusiasm has grown over time as it became apparent that the Task Force was proving to be an important catalyst of increased immunization efforts. Dr. Luis Fernando Duque, director of the Colombian campaign and coordinator of Bellagio II, will attend the next meeting, scheduled for 1-1/2 days at the Bank, April 4-5, 1985. You may wish to meet with Dr. Foege and Dr. Duque at that time.

10. Role of the Bank. Our main role in the Task Force has been to stress the need for careful evaluation of immunization "projects" it sponsors: the coverage achieved compared to targets, the appropriateness of the targets, the health impact, replicability elsewhere, and, above all, the cost-effectiveness of the effort. We have also emphasized the need to make careful comparisons of the relative contributions of

campaigns and regular programs, and the conditions likely to favor one approach over the other in various countries. The extensive evaluation of the Colombian effort resulted, in considerable measure, from our suggestions. We intend to continue to press for rigorous evaluation.

11. Task Force Budget. Operations began with contributions from WHO and UNICEF ($50,000 each) and $35,000 from the Rockefeller Foundation. The budget for the period October 1, 1984 through December 31, 1985 is approximately $345,000, of which the Bank has been asked to contribute $75,000. (It was agreed at Bellagio I that the five members of the Task Force would each contribute to the budget). We are, therefore, processing a grant of $25,000 from the PHN budget for FY 1985, and have requested $50,000 for this purpose in our FY86 budget submission.

12. Progress. The Task Force started relatively slowly, as one would expect given the lead time required to make initial country visits, hire the small staff, and set up an office in Atlanta (Emory University is providing some administrative support there). The effort developed real direction and momentum during the summer of 1984, when the Colombian campaign took place, and has maintained this momentum ever since, as more requests for assistance have come in. The experience so far permits several preliminary generalizations about the utility of the Task Force. First, the Task Force represents a very useful and highly flexible mechanism for donor coordination. This is most evident in the collaboration between the Task Force, WHO and UNICEF. The small size of the group and inclusion of key actors at UNICEF and WHO, have facilitated quicker and arguably more appropriate responses than would be possible working through regular bureaucratic channels. Second, experience to date supports the proposition that major advances in immunization coverage are much more likely when there is a political commitment from the highest level, and that this political commitment is more likely to occur when fostered by a group like the Task Force, working within a small network of key contacts in donor organizations, the scientific community, and developing countries.

13. A third preliminary conclusion is that immunization campaigns, complete with banners, hoopla and heavy media coverage, may deserve a larger role in the scheme of things than most technical people were inclined to believe. Campaigns lend themselves to a vivid demonstration of political commitment and have the potential of adding a major impetus to regular activities. When used as a complement to, and not a substitute for, regular programs, they may be a cost-effective strategy. Fourth, the Colombian experience provides support for the notion, debated in relation to Bellagio I, that immunization is an excellent entry point for other selected health interventions. Colombia, flushed with the success of its immunization effort, now wants to expand other areas of primary health care. Within the Task Force there is an emerging consensus that immunization, diarrheal disease control and family planning represent a critical triad of interventions on which to base the effort to reduce illness and death, and lower fertility.

14. A final preliminary conclusion based on Task Force experience to

date is that the contribution of the Bellagio effort may lie less in mobilizing additional donor resources, than in catalyzing political commitment and reallocation of resources at country level. It is clearly too early to foreclose on the options for consideration at Bellagio II and beyond. But it is possible that Bellagio II should focus on expanding the current role of the Task Force - in fostering political commitment, ensuring rapid donor response, and demonstrating impact and cost-effectiveness - rather than in attempting to mobilize additional donor resources or adding to the existing international bureaucracy. The Task Force appears to perform a valuable set of functions from within the interstices of existing organizations. The challenge now is to find a way to extend this role effectively to a larger number of beneficiary countries.

cc: Mr. van der Tak
Dr. Measham
Dr. Sai
Mr. Berg
Dr. Liese
Mr. Hodgkinson
Ms. Birdsall/Ms Hall
Mr. Schebeck
Ms. Husain
Mr. Denning

ARMeasham/rmf

THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

file

DATE: February 11, 1985

TO: Mr. A. W. Clausen, President
Through: Mr. A. David Knox, Acting SVPOP
Mr. S. Shahid Husain, OPSVP
FROM: John D. North, Director, PHN

EXTENSION: 61571

SUBJECT: Invitations for "Bellagio II" Conference, October 1985

1. Attached for your signature are two letters prepared by the Task Force for Child Survival, of which the World Bank is a member, inviting participation in the planned "Bellagio II" conference, to be held in Cartagena, Colombia, October 14-17, 1985. This conference, for which President Betancur of Colombia will serve as official host, hopes to secure participation of both those international organizations represented at the initial 1984 conference (Letter 1), and a select group of research foundations and Ministries of Health, as listed at the end of Letter 2.

2. Please return both letters to us after signing, unfolded, for forwarding to the Task Force. They plan to combine all signatures from the five heads of Agencies, and disseminate the letter by early next week.

Attachments

cc: Mr. van der Tak, OPSVP

KHall:lhs