The Regional Vaccine Implementation Plan (RVIP) 2022–2026 was developed to support the implementation of the Strategic Framework for South-East Asia Regional Vaccine Action Plan 2022–2030, which was endorsed by the Seventy-fourth Session of the WHO Regional Committee for South-East Asia in 2021. The Strategic Framework for South-East Asia Regional Vaccine Action Plan 2022–2030 is the regional adaptation of the Immunization Agenda 2030.

This Regional Vaccine Implementation Plan 2022–2026 is a seamless transition from the Regional Vaccine Action Plan (RVAP) 2016–2020 and builds on the effective models of collaboration and oversight established under RVAP, with a stronger emphasis on creating continuous quality improvement cycles that strengthen the performance of national immunization programmes and provide the essential foundation for achieving regional disease control and elimination goals.
Regional Vaccine Implementation Plan
2022–2026
WHO South-East Asia Region
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Foreword

The WHO South-East Asia Region is committed to ensuring that everyone, everywhere, at every age, fully benefits from vaccines to improve health and well-being. In support of this objective, since 2016 the WHO South-East Asia Regional Vaccine Action Plan 2016–2021 has provided strategic guidance to national immunization programmes and national and international partners to strengthen routine immunization; reach national, Regional and global immunization targets; and contribute to achieving universal health coverage.

Since then, the Region has sustained elimination of maternal and neonatal tetanus and remains polio-free. Five countries have eliminated measles, of which four have also eliminated rubella. Four countries have controlled hepatitis B through immunization. By 2019, coverage of the third dose of diphtheria-tetanus-pertussis vaccine had increased to 91%, the highest ever. Despite significant disruptions caused by the COVID-19 crisis, by 2022, routine immunization coverage in the Region had returned to pre-pandemic levels.

In 2021, amid the COVID-19 response, the Seventy-fourth Session of the Regional Committee adopted the South-East Asia Regional Strategic Framework for the Regional Vaccine Action Plan 2022–2030, which is aligned with the Immunization Agenda 2030, endorsed by the World Health Assembly in 2020. In support of these and other developments, this Regional Vaccine Implementation Plan 2022–2026 provides details on how national immunization programmes and national and international partners can effectively implement the Regional Strategic Framework at both the country and Regional level.

For this, the Implementation Plan focuses specifically on increasing equitable access to routine immunization, including by strengthening primary health care; on expanding the use of new and underutilized vaccines; and on achieving and/or sustaining key Regional targets such as elimination of measles and rubella. It also contains guidance on reducing overall mortality and morbidity from vaccine-preventable diseases across the life-cycle. In these and other areas, it highlights the need for coordinated planning, ownership, accountability, communication and advocacy, and contains within it a framework for monitoring and evaluation for year-on-year improvement.

I urge all national immunization programmes and national and international partners in the Region to effectively leverage this Plan to ensure that all people fully benefit from vaccines to improve health and well-being, leaving no one behind.

Dr Poonam Khetrapal Singh
Regional Director
WHO South-East Asia Region
## Acronyms and abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AFP</td>
<td>acute flaccid paralysis</td>
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<tr>
<td>CRS</td>
<td>congenital rubella syndrome</td>
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<tr>
<td>cMYP</td>
<td>comprehensive multiyear plan</td>
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<tr>
<td>cVDPV1</td>
<td>circulating vaccine-derived polioviruses type 1</td>
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<tr>
<td>DTP</td>
<td>diphtheria-tetanus-pertussis</td>
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<tr>
<td>HepB-BD</td>
<td>hepatitis B birth dose</td>
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<tr>
<td>EVM</td>
<td>effective vaccine management</td>
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<td>Gavi</td>
<td>Global alliance for vaccine and immunization</td>
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<td>HPV</td>
<td>human papillomavirus vaccine</td>
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<td>IA 2030</td>
<td>Immunization Agenda 2030</td>
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<tr>
<td>ICC</td>
<td>interagency coordination committee</td>
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<td>ITAG</td>
<td>Immunization Technical Advisory Group</td>
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<td>JE</td>
<td>Japanese encephalitis</td>
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<tr>
<td>MCV1</td>
<td>first dose of measles-containing vaccine</td>
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<tr>
<td>MCV2</td>
<td>second dose of measles-containing vaccine</td>
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<tr>
<td>MNT</td>
<td>maternal and neonatal tetanus</td>
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<td>MR</td>
<td>measles and rubella</td>
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<td>NIS</td>
<td>National Immunization strategy</td>
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<td>NRA</td>
<td>National Regulatory Authority</td>
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<td>NCL</td>
<td>National Control Laboratory</td>
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<td>NDVP</td>
<td>National Deployment and Vaccination Plan</td>
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<td>NITAG</td>
<td>National Immunization Technical Advisory Group</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>NVC</td>
<td>National Verification Committee</td>
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<td>OPV</td>
<td>oral polio vaccine</td>
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<td>PCV</td>
<td>pneumococcal conjugate vaccine</td>
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<tr>
<td>PIE</td>
<td>post-introduction evaluation</td>
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<tr>
<td>RCCPE</td>
<td>Regional Certification Commission on Polio Eradication</td>
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<tr>
<td>RCV</td>
<td>rubella-containing vaccine</td>
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<td>RVAP</td>
<td>Regional Vaccine Action Plan</td>
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<td>RVIP</td>
<td>Regional Vaccine Implementation Plan</td>
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<tr>
<td>RWG</td>
<td>Regional Working Group</td>
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<tr>
<td>SDG</td>
<td>Sustainable Development Goal</td>
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<tr>
<td>SE Asia</td>
<td>South-East Asia</td>
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<tr>
<td>SEAR-ITAG</td>
<td>South-East Asia Regional Immunization Technical Advisory Group</td>
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<tr>
<td>SEA-RVC</td>
<td>South-East Asia Regional Verification Commission</td>
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<tr>
<td>TTCV</td>
<td>tetanus toxoid-containing vaccine</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>WHO-SEARO</td>
<td>(WHO) Regional Office for South-East Asia</td>
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<tr>
<td>VPD</td>
<td>Vaccine-preventable disease</td>
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Executive summary

The World Health Assembly in 2020 endorsed the Immunization Agenda 2030 (IA2030) that sets out a global immunization strategy for up to 2030. The WHO Regional Committee for South-East Asia in 2021 endorsed the “Strategic Framework for South-East Asia Regional Vaccine Action Plan 2022–2030” (Regional Strategic Framework). The plan was developed collaboratively with countries and immunization stakeholders; it adapts the global IA 2030 strategy according to regional context and lays out the specific impact goals of the Region. This Regional Vaccine Implementation Plan (RVIP) 2022–2026 complements these documents, providing details on how the Regional Strategic Framework will be implemented within countries and at the regional level.

Primary responsibility for implementation lies with individual countries. Using the RVIP framework, countries can identify where their national immunization programmes need to be strengthened in order to achieve regional goals and targets. For key indicators, countries will establish their own targets – challenging but achievable – which will act as steppingstones to the regional “gold standard” targets.

Partners will work with countries to identify development needs and collaborate and coordinate their activities in order to deliver tailored packages of support that meet individual country needs. Technical support will draw upon globally collated resources plus regional expertise and peer support among countries.

National Immunization Technical Advisory Groups (NITAGs) will offer technical advice to national immunization programmes. They will also provide an oversight mechanism for monitoring progress towards targets. At the regional level, the South-East Asia Regional Immunization Technical Advisory Group (SEAR ITAG) will provide an overarching oversight mechanism and offer countries individualized advice and support.

Implementation in countries will be based on national health policies, national immunization strategies and comprehensive multi-year plans (cMYPs), which will be updated over time to reflect the IA2030 Strategic Priorities. Annual workplans will be developed outlining the specific activities that need to be undertaken to achieve national targets and identifying who has responsibility for ensuring that they are carried out.

Annual reports will summarize activities undertaken and progress towards national targets. Annual reports will identify areas requiring further attention, creating continuous quality improvement cycles that drive ever-improving programme performance.

Annual workplans and annual reports will be put together by national immunization programmes in collaboration with partners. Annual workplans will include the specific contributions to be made by countries and partners. Annual reports will guide the development of tailored packages of support.
focused on priority areas. NITAGs will also feed into the development of annual workplans and comment on annual reports. Similarly, SEAR ITAG will review annual workplans and reports, and offer advice to enhance performance.

The monitoring and evaluation framework of the Region will underpin these continuous quality improvement cycles. The framework will include regional versions of global impact goals as well as indicators corresponding to global Strategic Priority Objectives (SPOs). A further set of indicators is being established covering regional priority key areas of focus. Scorecards/dashboards will be developed to provide a visual representation of the progress towards both regional “gold standard” and national targets.

For large countries and those with devolved health systems, similar mechanisms will be established at the subnational level. These will include subnational target-setting within the context of national planning, with inputs from subnational-level technical experts and partners. The principle of continuous quality improvement, underpinned by data collection and analysis, will be promoted at all levels of national immunization programmes.

The WHO Regional Office for South-East Asia, together with partners, will develop analogous regional annual workplans and annual reports, providing an overview of the performance of all countries of the Region as well as a summary of the activities undertaken at the regional level. These processes will also be undertaken in collaboration with partners to ensure continuing coordination and alignment.

The first RVIP will run until 2026. Initially, activities will have a strong focus on the rollout of COVID-19 vaccination and recovery following the damage caused to immunization services and vaccine-preventable disease (VPD) surveillance by the COVID-19 pandemic. A more comprehensive mid-term review will be carried out in 2026 and will be used for the development of a revised RVIP for 2027–2030.

The Regional Strategic Framework and the Regional Vaccine Implementation Plan (RVIP) 2022–2026 provide a seamless transition from the Regional Vaccine Action Plan (RVAP) 2016–2020. They build on the effective models of collaboration and oversight established under RVAP, but with a stronger emphasis on creating continuous quality improvement cycles that strengthen national immunization programme performance and provide the essential foundation for achieving regional disease elimination and control goals.
1. Introduction

Control of VPDs through vaccination will make a critical contribution to achieving Sustainable Development Goal 3 (SDG3), ensuring healthy lives and promoting well-being for all at all ages. Furthermore, by ensuring the health of populations, it will be a cornerstone of progress towards all other SDGs. Vaccination remains one of the most cost-effective public health interventions, saving millions of lives every year.

In recent decades, countries of the SE Asia Region have demonstrated a commitment to universal immunization coverage and achieving vaccine-preventable disease control, elimination and eradication goals. Since 2016, the South-East Asia Regional Vaccine Action Plan (RVAP) 2016–2020 has provided the strategic framework for these regional immunization goals and great progress has been made.

The Region has maintained its polio-free status since 2014 and elimination of maternal and neonatal tetanus since 2016. Measles elimination has been achieved and maintained in five countries while two of these countries have also achieved rubella elimination. Four countries have been verified as having achieved hepatitis B control through immunization in 2019. All countries of the Region have introduced between two and eight new or underutilized vaccines since 2011.

The coverage of immunization with the third dose of diphtheria–tetanus–pertussis (DTP3) vaccine increased to 91% in 2019, compared with 83% in 2010. This is the highest-ever immunization coverage achieved in the Region. Ten countries of the Region achieved DTP3 coverage of 90% or more in 2019: Bangladesh, Bhutan, the Democratic People’s Republic of Korea, India, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste. The total number of unvaccinated or partially vaccinated children declined to three million in 2019, compared with 8.2 million in 2009.

However, the COVID-19 pandemic severely disrupted essential immunization services in 2020 and DTP3 coverage was reduced to 85% in 2020 and 82% in 2021. There is an urgent need to recover and regain the momentum achieved in the previous decade, and to continue reducing the number of infants, young people and adults, who are missing out on potentially life-saving vaccines. Meanwhile countries of the Region optimally utilized available COVID 19 vaccines and by 31 December 2022, 67% of the population in the Region have received the primary series of vaccination and 20% received a booster dose. Five countries have provided primary series of vaccines to more than 70% of the population and another five countries have provided primary series for more than 40% of the population.
Building on advances made during the Decade of Vaccines (2011–2020), a new global vaccination strategy, **Immunization Agenda 2030 (IA2030)**, has been developed through a global collaborative process. Approved by the Seventy-third Session of the World Health Assembly (WHA) in 2020, the IA2030 provides an overarching vision and a set of Strategic Priorities for the period 2021–2030. The **IA2030 Framework for Action**, reviewed by the World Health Assembly in 2021, adds further detail in areas such as coordinated operational planning, ownership and accountability, monitoring and evaluation, and communications and advocacy.

The IA2030 has a strong focus on countries, recognizing that global progress will be achieved through the collective achievements of individual countries. It also recognizes that countries are at different stages on their journeys towards full immunization coverage for all at all ages, with immunization programmes at different levels of maturity. While all countries have the goal of universal coverage, the speed of progress towards this goal will inevitably vary between countries, which is recognized in the IA2030’s flexible approach to monitoring and evaluation.

Immunization strategies for the next decade cannot exist in isolation. Activities must reflect the wider drive towards universal health coverage and strengthening of primary health care systems, of which immunization programmes are a key element. Integration of services and delivery of person-centred care will therefore be important priorities over the next decade. An effective response to COVID-19 is not only critical to halt the pandemic but also offers opportunities to strengthen immunization and primary health care platforms across the life-course.

Multiple other challenges need to be addressed. Inequities in access to vaccination must be tackled to ensure that disadvantaged populations in rural and urban settings are fully vaccinated. If there is any emerging vaccine hesitancy, it needs to be better understood and addressed. Infectious disease surveillance systems also need to be strengthened to ensure that prompt responses can be launched, and outbreaks controlled before they become major public health emergencies. Again, restoring the damage caused to surveillance systems by COVID-19 is an immediate priority.

During 2020, WHO-SEARO, in consultation with national immunization programmes and partners, developed a **Strategic Framework for the South-East Asia Regional Vaccine Action Plan (RVAP) 2022–2030**, adapting the global IA2030 strategy to the regional context. This Regional Strategic Framework is intended to provide a seamless transition from the RVAP 2016–2020 (extended to 2021) by maintaining a focus on key regional priorities while introducing new elements that reflect emerging challenges and opportunities. In September 2021, the Seventy-fourth Session of the Regional Committee for South-East Asia endorsed the RVAP 2022–2030 and expressed commitment to and full support for developing its implementation plan covering the period 2022–2026 to meet the global, regional and national targets.

The Regional Strategic Framework provides a coherent approach to embed country ownership of the IA2030 strategy and to guide the coordinated and collaborative activities of countries, partners and other immunization stakeholders in the Region. This **Regional Vaccine Implementation Plan** provides details of how countries will implement the IA2030 strategy, how activities will be coordinated and how they will be shaped according to the needs of individual countries. It will be

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a living document under the umbrella of the Strategic Framework for the South-East Asia Regional Vaccine Action Plan (RVAP) 2022–2030.

The Regional Vaccine Implementation Plan identifies the mechanisms that will ensure coordination and alignment across national and regional levels, and how roles and responsibilities will be established. It summarizes the monitoring and evaluation activities that will provide the data to drive action through continuous quality improvement cycles, and details how stakeholders will be engaged to ensure their commitment to the Regional Vaccine Implementation Plan.
2. Current status

The 11 countries of the SE Asia Region are home to more than 1.8 billion people, with a combined annual birth cohort of nearly 37 million. All countries of the Region accord high importance to their national immunization programmes. Over the past few decades, immunization has prevented millions of deaths and disabilities. The RVAP 2016–2020 has served as the framework for implementation of all immunization activities within the Region.

Improving national immunization programme performance continues to be a priority of national health plans of all countries of the Region. Strong partnerships for immunization and VPD control have been established at country and regional levels.

In 2019, for the first time, overall DTP3 coverage reached 91%, with 10 countries having achieved DTP3 coverage of more than 90%. The Region has interrupted the transmission of wild poliovirus, eliminated maternal and neonatal tetanus (MNT), eliminated indigenous transmission of measles in five out of 11 countries, eliminated rubella in two countries, and controlled hepatitis B in four countries. Since 2011, each country has introduced between two and eight new and underutilized vaccines.

All countries of the Region have been significantly affected by COVID-19. The pandemic has disrupted health service delivery, with many staff getting redeployed to work on COVID-19 responses and has also impacted health care-seeking behaviour. As a result, routine immunization services had a negative impact and vaccination coverage rates fell in 2020 and 2021 from the historically high levels achieved in 2019. Although in 2021 and 2022 countries had accorded priority to revitalize routine immunization through various innovative strategies, some countries were able to continue with planned new vaccination introductions; immunity gaps caused by the COVID-19 pandemic need to be closed.

Staff redeployment and travel restrictions also led to significant disruption in VPD surveillance activities. In some countries, delayed deliveries of consumables impacted the activities of national and reference laboratories.

The following sections highlight the achievements through implementing the Regional Vaccine Action Plan 2016–2021.4

A. Immunization systems strengthening

**Goal:** All countries will have 90% national coverage and 80% coverage in all districts or equivalent areas for all vaccines

- DTP3 coverage: 91% (2019), an increase from 83% in 2010; 85% (2020), 82% (2021)
- Countries achieving 80% or more DTP3 coverage in all districts: 4/11 (2019) and 4/11 (2020), 4/11 (2021)

**National policies and plans**

All countries have national immunization policies embedded within national health policies. Bhutan, India, Maldives and Thailand fully fund vaccines and operational costs of national immunization programmes. National expenditure of vaccines has increased in all countries. Bangladesh, Bhutan, India, Indonesia, Myanmar, Nepal, Sri Lanka and Timor-Leste have transitioned to national funding on time when Gavi, The Vaccine Alliance support for a new vaccine has ceased.

Each country has established a **National Immunization Technical Advisory Group (NITAG).** NITAGs provide guidance to national programmes on policies and strategies relating to vaccination and introduction of new vaccines and technologies, and also monitor overall vaccination performance. According to an external evaluation conducted in 2019/2020, all NITAGs achieved overall functionality scores between 77% and 92%. However, the levels of evolution, competency, operations and governance mechanisms of NITAGs vary across the Region.

**Interagency coordination committees (ICCs)** coordinate partner support for immunization and ensure that all stakeholders are involved in planning, implementation and monitoring of national immunization programmes.

**Vaccine-preventable disease surveillance**

Countries are closely monitoring surveillance indicators for polio eradication and measles and rubella elimination. Ten countries are collecting case-based data for diphtheria and pertussis. All six countries that have introduced Japanese encephalitis vaccine collect case-based surveillance data.

Completeness and timeliness of reporting of VPD surveillance data is commendable. Each week, countries share polio and measles case-based surveillance data with WHO-SEARO, using a standardized format, while aggregate data of other VPDs are shared with the Regional Office every month.

**Cold chain capacity**

The COVID 19 vaccination rollout helped all countries to expand the cold chain capacity at national and subnational levels. Six countries have completed at least one Effective Vaccine Management (EVM) assessment and developed improvement plans. Continuous capacity-building will be required to optimize supply chain, digitalize immunization supply chain information, including temperature monitoring.

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5 https://cdn.who.int/media/docs/default-source/searo/evaluation-reports/evaluation-of-national-immunization-technical-advisory-groups-(nitag)-in-south-east-asia-region.pdf?sfvrsn=4bd8990e_5
capacity of cold chain handlers, repair and maintenance, inventory management, and management of dry space for optimal cold chain management.

**Monitoring and evaluation**

Data quality assessments have been carried out in Indonesia, Myanmar and Timor-Leste in the past five years; data quality improvement plans have been developed and recommendations followed. In addition to monitoring administrative data, countries have been periodically conducting coverage evaluation surveys.

Periodic reviews of national immunization programmes and vaccine-preventable disease surveillance systems continue to be conducted, with follow-up on recommendations made during these reviews. When feasible, the reviews are combined with other programme assessments, such as post-introduction evaluations (PIEs), Gavi joint appraisals (JAs), EVM assessments and MNT post-validation assessments.

**Diphtheria**

Diphtheria continues to be endemic in some countries of the South-East Asia Region. Bhutan and Sri Lanka have been providing three doses of diphtheria toxoid-containing vaccine during infancy and two and three booster doses respectively and reported no diphtheria cases. DPR Korea and Maldives also reported zero diphtheria cases, having achieved high coverage in diphtheria toxoid-containing vaccines, administered during infancy, and a booster dose.

India, Indonesia, Myanmar, Nepal and Thailand continue to report diphtheria cases and outbreaks. This is likely due to persistent immunity gaps as well as policy barriers preventing provision of an adequate number of booster doses.

**Challenges**

**Zero-dose<sup>6</sup> and partially vaccinated children:** Two million children in the South-East Asia Region did not receive the first dose of DTP containing vaccine in 2019 and this increased to 3.9 million in 2021 and 4.6 million to 2021. In addition, one million children were partially vaccinated with DTP containing vaccine in 2019, 0.7 million in 2020 and 1.3 million in 2021. Pockets of unreached children remain in countries, including in those with high overall coverage.

**Mobile populations:** Migrating and displaced populations are at high risk of low immunization coverage, potentially leading to outbreaks of vaccine-preventable diseases.

**Data quality:** The variable quality of data at subnational levels and the challenges to ascertaining the denominator for coverage estimates make it difficult to determine true coverage in districts.

**Gavi transition:** Some low middle-income countries in the Region are transitioning out of Gavi support but have suboptimal immunization coverage.

**Surveillance:** For some vaccine-preventable diseases, surveillance systems – especially laboratory support – remain suboptimal in some countries. Countries need to use VPD outbreak data to identify vaccine-preventable disease and conduct catch-up immunization activities in those areas.

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<sup>6</sup> Number of children not vaccinated with DPT1 according to WHO/UNICEF estimates 2021 and UN population estimates.
B. Measles and rubella elimination

**Goal:** Elimination of measles and rubella in the South-East Asia Region by 2023.

- Countries achieving measles elimination: 5/11
- Countries achieving rubella elimination: 2/11
- Regional MCV1 coverage: 94% (2019), 88% (2020), 86% (2021)
- Regional MCV2 coverage: 83% (2019), 80% (2020), 78% (2021)

Measles and rubella elimination by 2023 is one of the Region’s Flagship Programmes. A costed Strategic Plan for Measles and Rubella Elimination in the WHO South-East Asia Region 2020–2024 has been developed and endorsed by Member States. The WHO South-East Asia Regional Verification Commission (SEA-RVC) for measles and rubella elimination annually reviews the progress made by countries. Between 2000 and 2019, mortality due to measles in the Region has been reduced by an estimated 80%.

**Immunization**

All 11 countries of the Region are administering two doses of measles-containing vaccine (MCV) and at least one dose of rubella-containing vaccine (RCV) through national immunization programmes. Following increasing regional coverage of MCV1, MCV2 and RCV from 2000 to 2019, coverage dropped in 2020 and 2021 due to the COVID-19 pandemic.

Across age groups and particularly among the youngest children, cases are typically seen in those who have received zero or one dose of MCV, indicating a significant immunity gap in the Region and the need for intensified efforts to vaccinate every child.

**Surveillance**

Laboratory-supported case-based surveillance for measles and rubella has been initiated in all countries according to regional guidelines. Congenital rubella syndrome surveillance (CRS) is conducted in all countries either as part of the case-based surveillance system or as sentinel surveillance.

The number of reported cases of suspected measles decreased significantly in 2020, likely due to COVID-19-related infection prevention and control measures and/or under-reporting. Surveillance performance indicators also showed a steep decline in 2020. The key surveillance performance indicator – non-measles non-rubella discard rate – declined in all countries except in Maldives.

All countries of the Region now have at least one proficient national laboratory to support measles and rubella case-based surveillance. While the number of samples reaching laboratories significantly declined in 2020, laboratory performance indicators remained at high levels.

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Challenges

Suboptimal implementation of strategies reflects variation in the commitment at national and subnational levels for MR elimination.

Recovering from the COVID-19 pandemic: Disruption in routine immunization services has affected coverage while surveillance activities have been disrupted. Mass vaccination campaigns for measles and rubella have been delayed.

Procuring diagnostics kits: Procurement of diagnostic kits for measles and rubella is a challenge in some countries.

Funding: Additional funding of US$ 0.19 per capita per year is required to optimally implement strategies to achieve the measles and rubella elimination goal by 2023.

C. Polio-free status sustained

Goal: Sustaining polio-free status in the South-East Asia Region

- Countries maintaining polio free status: 11/11
- Regional OPV3 coverage: 90% (2019), 85% (2020), 82% (2021)
- Regional IPV coverage: 85% (2019), 77% (2020), 79% (2021)

The South-East Asia Region has maintained its polio-free status since 2014. It has sustained high overall population immunity against polio, certification-standard acute flaccid paralysis (AFP) surveillance, and good outbreak response preparedness. However, several polio activities were affected by the COVID-19 pandemic in 2020, leading to gaps in polio immunization coverage and surveillance. Together with population movements (migrants, refugees), this may lead to delayed detection of polio cases.

Circulating vaccine-derived polioviruses type 1 (cVDPV1) were detected in pockets of low coverage in Indonesia and Myanmar in February and July 2019 respectively. Responses were swiftly launched, and outbreaks declared closed in May 2020 (Indonesia) and October 2020 (Myanmar), following virtual outbreak response assessments.

Overall surveillance indicators were maintained above global certification standards in 2020 despite COVID-19-related challenges. The Regional Polio Laboratory Network, comprising 16 laboratories, continues to perform to a satisfactory standard, with quality assurance mechanisms in place. Environmental surveillance is conducted at 87 sites in 29 states/provinces of six countries.

A regional risk assessment is conducted annually and presented to all countries at the meeting of the Regional Certification Commission on Polio Eradication (RCCPE). All countries of the Region have polio outbreak response plans in place. The SEA-RCCPE and national certification committees for polio eradication in all 11 countries are functional and provide oversight and guidance for polio eradication activities.
Containment activities, as per the WHO Global Action Plan, to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of routine OPV (GAP III) are steadily progressing.

The five polio priority countries of the Region (Bangladesh, India, Indonesia, Myanmar, and Nepal) have developed national transition plans. The Transition Independent Monitoring Board, established by the Global Polio Eradication Initiative, has recognized that the South-East Asia Region is the most advanced Region in terms of polio transition planning, with strong commitment from the highest levels of WHO and ministries of health. The main concerns of the board centre on financial sustainability and longer-term planning.

**Challenges**

**Recovering from impact of the COVID-19 pandemic:** Polio immunization coverage, AFP reporting and collection of environmental surveillance samples remain below pre-COVID-19 levels in several countries.

**Response capacity:** All countries of the Region need to strengthen outbreak response capacity for wild poliovirus or cVDPV outbreaks.

**Polio transitions:** Integrated surveillance and immunization infrastructure and capacities must continue to support essential polio functions and strengthen health systems.

**D. Maternal and neonatal tetanus elimination sustained**

**Goal:** Sustaining maternal and neonatal tetanus elimination

- Countries achieving MNT elimination: 11/11
- Infant immunization (DTP/pentavalent3) coverage: 91% (2019), 85% (2020), 82% (2021)

The South-East Asia Region achieved maternal and neonatal tetanus elimination (MNTE) in 2016. Sustaining MNTE requires a continuous and comprehensive multipronged approach, spanning multiple age groups, requiring strong coordination between different health programmes:

- immunization of pregnant women and routine vaccination of all children/adolescents to receive three primary infant doses and three booster doses of tetanus toxoid-containing vaccine (TTCV) before adolescence for expanded protection and a life-course approach;
- antenatal screening of pregnant women to verify tetanus vaccination status (to ensure tetanus protection at birth) and vaccination, if required;
- access to skilled health personnel at birth and clean birth/cord care practices; and
- strong tetanus/neonatal tetanus surveillance and regular review of data to identify districts at risk of re-emergence of MNT and needing corrective action.
Coverage of infant immunization against tetanus (DTP and pentavalent vaccines) in the Region remained around 90% from 2016 to 2019 but declined to 85% in 2020 and 82% in 2021. Eight countries provide booster doses in early childhood or have integrated TTCV vaccination into school health programmes; coverage varies between countries and doses. Five countries provide six TTCV doses in their national schedule.

In 2020, ≥90% coverage of two or more doses of TT2+ in pregnant women was achieved in four countries and three countries in 2021. TTCV for pregnant women is now offered in all countries as tetanus and diphtheria toxoid (Td) to sustain protection against diphtheria in light of waning immunity following vaccination in infancy/childhood.

**Challenges**

**Recovering from impact of COVID-19 pandemic:** While no country reported neonatal tetanus cases above the elimination threshold of ≥1 per 1000 live births at the district level, it is likely that surveillance was negatively impacted by the COVID-19 pandemic.

**Subnational coverage:** Subnational data suggest significant differences at the district level, even when the national coverage is high; however, only administrative data are available.

**COVID-19 impact on health system:** Shortages of skilled health workers and increased reluctance of women to use the health system could have led to lower coverage of antenatal and postnatal care as well as fewer health facility deliveries during the COVID-19 pandemic.

**Under-reporting:** Even during non-emergency times, it is likely that not all neonatal tetanus cases are reported, especially those in disadvantaged communities.

**E. Hepatitis B control**

**Goal: Achieve hepatitis B control through vaccination**

- Countries verified for hepatitis B control: 8/11
- Regional HepB3 coverage: 91% (2019), 85% (2020), 82% (2021)
- Regional HepB-Birth Dose coverage: 54% (2019), 51% (2020), 51% (2021)

All countries in the Region have introduced hepatitis B vaccine. Eight out of 11 countries have introduced a hepatitis B birth dose (HepB-BD).

The regional hepatitis B control goal has a target of achieving ≤1% hepatitis B surface antigen (HBsAg) seroprevalence by 2020 among children aged at least five years old, in line with the WHO Global Health Sector Strategy on Viral Hepatitis 2016–2021.

A SEA Regional Expert Panel (SEA REP) on hepatitis B has been established to verify country achievement of hepatitis B control. The SEA REP established two essential criteria for verification of achievement of hepatitis B control:

8 Countries verified to have achieved the target of ≤1% hepatitis B surface antigen (HBsAg) among children under 5 years
- nationally representative seroprevalence survey showing HBsAg <1% among children aged at least 5 years born after the nationwide implementation of universal hepatitis B infant immunization; and
- coverage of HepB-BD (where applicable) and HepB3 ≥90% at national and ≥80% at subnational levels for the past five years.

In 2019, four countries – Bangladesh, Bhutan, Nepal and Thailand – were verified by the SEA REP as having achieved the regional hepatitis B control target. With sustained national HepB3 coverage of ≥90% and all districts achieving HepB3 ≥80%, DPR Korea, Maldives and Sri Lanka need to conduct serosurveys to determine if they have reached the control target.

Challenges

Recovering from the impact of COVID-19 pandemic: The COVID-19 pandemic has negatively impacted HepB3 coverage, which dropped below 90% in four countries (India, Myanmar, Nepal and Timor-Leste) while coverage in Indonesia fell from 85% in 2019 to 77% in 2020.

Low coverage of HepB-BD: Birth dose coverage is less than 80% in four countries that have introduced the birth dose.

Seroprevalence surveys: The COVID-19 pandemic led to the postponement of planned national seroprevalence surveys in three countries (DPR Korea, Maldives and Sri Lanka).

F. Introduction of new and underutilized vaccines

- Countries introduced three or more new and underutilized vaccines since 2011: 11/11
- Countries introduced four or more: 9/11

Priority vaccines that have been introduced are hepatitis B vaccine, *Haemophilus influenzae* type b vaccine (Hib), pneumococcal conjugate vaccine (PCV), human papillomavirus (HPV) vaccine, Japanese encephalitis (JE) vaccine, rotavirus vaccine, inactivated polio vaccine (IPV), measles/rubella- or rubella-containing vaccine and mumps-containing vaccine. Some countries have also introduced mumps vaccine, typhoid conjugate vaccine (TCV) and seasonal influenza vaccine for special populations. New vaccines have been well accepted and generally, when a new vaccine is introduced in a country, within 1–2 years, the coverage reaches the level equivalent to that of other vaccines administered at the same age.

India, Myanmar, Nepal, Sri Lanka and Thailand achieved more than 80% vaccination coverage with JE vaccine in 2019 and 2020; Sri Lanka and Thailand have maintained more than 90% coverage since 2015. India has seen a gradual increase in rotavirus vaccine coverage, reaching more than 80% in 2020 after national introduction was completed in 2019.

Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal, Thailand, and Timor-Leste are conducting surveillance for rotavirus through sentinel sites and have established national laboratories. Similarly, surveillance for invasive bacterial diseases is conducted in Bangladesh, India, Nepal and Sri Lanka. Nationwide or sentinel surveillance for Japanese encephalitis is conducted in all 10 endemic countries.
Table 1. Introduction of new or underutilized vaccines in the South-East Asia Region, as of December 2022

<table>
<thead>
<tr>
<th>Country</th>
<th>Hep B</th>
<th>Hib</th>
<th>IPV</th>
<th>Rubella/</th>
<th>JEV</th>
<th>HPV</th>
<th>PCV</th>
<th>RVV</th>
<th>TCV</th>
<th>SIV</th>
<th>Number of new or underutilized vaccines introduced since 2011</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MR</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>National</td>
</tr>
<tr>
<td>DPR Korea</td>
<td>2003</td>
<td>2012</td>
<td>2015</td>
<td>2019</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>3</td>
</tr>
</tbody>
</table>

Bangladesh # demonstration project in one district, India + in six states, @ in one state (Sikkim) * Navi Mumbai
Indonesia *In one province, “ in six provinces including Jakarta province, Yogyakarta province, East Java province, South Sulawesi province, North Sulawesi, and Central Java, ” in 21 districts
Thailand: *pilot in Mahasakham province since September 2021
Nepal # demonstration project in one district
NE: Non-endemic

Challenges

Delayed submission of applications and introductions: Due to the COVID-19 pandemic, preparation and/or submission of new vaccine applications to Gavi and introductions experienced some delays.

Slow expansion: Despite progress, opportunities remain for new vaccine introductions and/or extension to additional geographical areas.

COVID-19 disruption: Deliveries of laboratory supplies to countries and sample shipment from country sites to regional reference laboratories have been delayed due to travel restrictions.

Surveillance issues: Challenges include inconsistent procedures for laboratory confirmation, as seen with JE/acute encephalitis syndrome (AES) surveillance and incomplete reporting while several countries conduct invasive bacterial disease or rotavirus surveillance; all of them do not report data to global surveillance networks currently.

Limited field assessments: Redeployment of staff, a focus on COVID-19 vaccine rollout and movement restrictions for international assessors have made it difficult to conduct field assessments.
G. Access to high-quality vaccines

Providing affordable vaccines of assured quality is a priority in all countries. Vaccine development and production capacity in the Region is growing and playing an increasingly important role at both regional and global levels. More than a billion doses of vaccine are administered annually in the Region through national immunization programmes, with the introduction of new vaccines and use of combinations of antigens. India, Indonesia and Thailand are WHO-prequalified vaccine-producing nations. The National Regulatory Authority (NRA) and the National Control Laboratory (NCL) in each of these countries have reached Maturity Level 3 in the WHO global functionality benchmarking.

All countries of the Region reported to WHO’s Vaccine Product, Price and Procurement (V3P) web-based platform through the WHO/UNICEF Joint Reporting Form. Vaccine procurement policy in the Region is based on self-procurement in three out of 11 countries; group procurement through UNICEF in six countries; and mixed procurement in two countries.

In 2019, no supply shortages were reported in primary vaccine series in any country in the Region. However, middle-income countries have cited price as a major barrier to the introduction of rotavirus vaccine, human papillomavirus vaccine, pneumococcal conjugate vaccine and measles, mumps and rubella vaccine. In 2020 and 2021, the COVID-19 pandemic led to vaccine shortages at national and subnational levels in some countries.

Vaccine safety surveillance is a priority in all countries. All countries have a national reporting system for adverse events following immunization (AEFI). National AEFI committees of all countries regularly hold meetings to conduct causality assessments of serious AEFI.

Challenges

NRAs need adequate staffing, training, infrastructure and resources to undertake the nine NRA functions for vaccine-manufacturing countries and the relevant NRA functions for other countries.

COVID-19 vaccine deployment has shown the gaps in the adverse events following immunization reporting and the challenges to conducting causality assessment of serious adverse events. Primary health care workers and clinicians need to be aware of the importance of timely reporting of adverse events and conducting causality assessments of serious adverse events.

H. COVID-19 vaccine deployment

- Number of countries using COVID-19 vaccine: 10/11
- Vaccine coverage (completed primary series): 67%: range: 41% to 90% (9 countries above 60% coverage)
- Vaccine coverage (booster dose): 20%; range 0% to 84% (7 countries above 25% coverage)

All 10 countries that provide COVID 19 vaccine have identified vaccination of health workers, front-line workers and elderly populations as priorities. Currently, all countries in the Region have

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9 As of 31 December 2022
expanded the scope of vaccination to cover all above 12 years. Two countries are vaccinating 5–11-year children and one country is vaccinating 6–11 years children. Eight countries are providing booster doses to all adults and other two are providing them to selected priority groups. Three countries are providing further dose. Availability of vaccines in 2021 has been the major cause of variation in coverage between countries. Currently, adequate amounts of vaccines are available in all countries. Eleven presentations of vaccines have been used in the Region.

A Regional Operational Framework for COVID-19 vaccine preparedness, deployment and use was circulated in October 2020. Countries used this framework to initiate their planning for COVID-19 vaccines, together with the global WHO guidance released in November 2020.

All countries have established high-level national coordination committees for COVID-19 vaccine deployment with subcommittees for key functions. By February 2021, all countries had developed National Deployment and Vaccination Plans (NDVPs). In February 2021, a multistakeholder Regional Review Committee (RRC) was created to review the NDVPs and determine if countries were sufficiently prepared to be included in the COVAX vaccine allocation rounds. All countries were approved for allocation of COVID-19 vaccines in the first round to cover 3% of the population and all but two were approved for the allocation to cover 20% of the population.

WHO-SEARO organized several meetings and workshops to support countries in the Region with their COVID-19 vaccine deployment. It has also provided oversight and monitoring of vaccine deployment. A subgroup of the Regional Working Group (RWG) has held monthly coordination meetings and follow-up meetings with countries.

Countries rapidly sourced funds to vaccinate their population, primarily domestic resources together with support from COVAX, the Asian Development Bank (ADB) and the World Bank. COVAX has provided funding to support technical assistance in 10 countries (all countries except Thailand are receiving support from the COVAX facility). Countries and partners have worked closely with the COVAX facility to obtain vaccines, cold chain equipment and financial support.

All countries rapidly registered COVID-19 vaccines through emergency use authorization (EUA), building on prior experience. The number of vaccines receiving EUA in countries has varied from three to eight.

As of 31 December 2022, 84% of vaccine doses have been directly procured by governments from manufacturers, 13% have been supplied through COVAX and 3% have been donations.

A Regional Vaccine Effectiveness (VE) Working Group has been established and several countries have expressed interest in conducting VE evaluations. Bhutan, India, Indonesia, Maldives, Nepal, Sri Lanka and Thailand conducted post-implementation evaluation (PIE) and several other countries have shown interest in conducting a PIE.

High-level commitment of national governments and immunization programmes, engagement of partners and stakeholders at all levels as well as availability of timely global and regional technical recommendations resulted in rapid rollout of vaccination, guided by country context.

10 Astra Zenica, Covaxin, Janssen, Moderna, Sinopharm, Sinovac, SputnikV, Sputnik Light, Pfizer, Covovax, Corbevax
Challenges

Ensuring that NDVPs were developed, improved and implemented to reach priority target groups: Not all countries were able to ensure that priority adult populations were reached.

Speed of the rollout: Rapid rollout gave countries limited time to adapt and/or strengthen their systems in preparation.

Use of multiple vaccines and vaccines originating from different sources: Different vaccines target different age groups and have different storage and handling requirements and expiry dates. Some countries have faced challenges to reporting data by vaccine type or by priority target group.

Monitoring coverage, effectiveness and safety: Countries have had to develop new systems to monitor multiple types of vaccines in multiple target populations while differentiating between first and second dose coverage. AEFI monitoring and management systems needed to be adapted as well.

Managing information flows: Information has been changing rapidly and sometimes, there have been delays in information reaching WHO-SEARO.

Incorporating vaccination status in COVID-19 surveillance systems: To ascertain the impact of vaccination on changing epidemiology, including variants of concern, robust disease surveillance with information on vaccination status of death and serious complication due to COVID-19 will be required. High-quality, timely surveillance data that demonstrate the link between COVID-19 vaccination and subsequent reductions in hospitalization and deaths may be useful for overcoming vaccine hesitancy among health-care providers and the public.

Current slow utilization of vaccines: Despite the heavy demand for COVID-19 vaccine initially and when variants of concern occurred, the current demand for booster doses is low. Even in countries with high coverage, there are districts with suboptimum coverage for primary series vaccination. This will require analysis of national- and subnational-level coverage and enhance demand generation activities and explore possibilities integrating COVID-19 vaccination with routine immunization.
3. Regional Strategic Framework

The Strategic Framework for the South-East Asia Regional Vaccine Action Plan 2022–2030 (Regional Strategic Framework)\(^{11}\) outlines the regional immunization goals and the principles guiding implementation of the global IA2030 strategy. It provides an overarching framework that embeds country ownership and facilitates alignment and coordination of activities of regional immunization partners to ensure effective delivery of support tailored to country needs.

A. Vision, mission and goals

The Regional Strategic Framework adopts the vision of the global IA2030 strategy:

**Vision:** A Region where everyone, everywhere and at every age fully benefits from vaccines for good health and well-being.

To this, it adds a mission statement that captures in more detail how this vision will be achieved in the Region:

**Mission:** To ensure and sustain the highest level of political and programmatic commitment and community acceptability for immunization in South-East Asia Region to enable countries achieve national and regional immunization goals and targets, with the highest-quality technical assistance from regional and country implementing partners.

The Regional Strategic Framework also incorporates the three IA2030 impact goals, adapted according to the regional context:

1. leaving no one behind by increasing equitable access and use of new and existing vaccines;
2. pursuing vaccine-preventable disease elimination and control goals, regional priorities:
   (i) achieving measles and rubella elimination
   (ii) sustaining polio-free status
   (iii) maintaining MNT elimination
   (iv) achieving hepatitis B control; and
3. reducing overall mortality and morbidity from vaccine-preventable diseases for all across the life-course.

\(^{11}\) https://apps.who.int/iris/bitstream/handle/10665/343756/sear rc74-8infDoc1-eng.pdf?sequence=5&isAllowed=y
Four **core principles** are intended to guide how the Regional Strategic Framework is implemented:

- **People-centred**: The design, management and delivery of immunization services should be shaped by and responsive to the needs of individuals and communities, including addressing barriers to access to immunization services due to age, location, social and cultural norms, and gender-related factors.

- **Country-owned**: Countries should establish targets that represent the local context and should be held accountable for achieving them.

- **Partnership-based**: Immunization partners should align and coordinate their actions to increase efficiency, build on complementarity and involve sectors beyond immunization for mutual benefit.

- **Data-driven**: High-quality, “fit-for-purpose” data will be used to track progress, improve programme performance and form the basis of decision-making at all levels.

**B. Strategic priorities (SPs)**

The Region will pursue the seven **Strategic Priorities** outlined in the global IA2030 strategy:

- **SP1. Immunization for PHC/UHC**: Effective, efficient and resilient immunization services are accessible to all people as an essential part of primary health care, and thereby contribute to universal health coverage.

- **SP2. Commitment and demand**: Immunization is valued and actively sought by all people, and health authorities commit to ensuring that immunization is available as a key contributor to the enjoyment of the highest attainable standard of health as a fundamental right.

- **SP3. Coverage and equity**: Full protection of immunization is realized by everyone, regardless of location, age, sex, socioeconomic status, ethnicity and gender-related barriers.

- **SP4. Life-course and integration**: All people benefit from recommended immunizations throughout the life-course, effectively integrated with other essential health services.
| SP5. **Outbreaks and emergencies**: Immunization programmes can (1) anticipate, prepare for, detect, and rapidly respond to vaccine-preventable and emerging disease outbreaks, and (2) ensure immunization service delivery during acute emergencies and among communities affected by conflict, disaster and humanitarian crisis.

| SP6. **Supply and sustainability**: All countries have a reliable supply of appropriate and affordable vaccines of assured quality, and sustainable financing for immunization programmes.

| SP7. **Research and innovation**: Innovations for increasing the immunization programme reach and impact are rapidly made available to all countries and communities. |
C. Objectives and key areas of focus

Each Strategic Priority includes several Strategic Priority Objectives (SPOs) and multiple key areas of focus (KAFs). In total, there are 20 SPOs and 34 KAFs.

SP1. Immunization for primary health care/universal health coverage

Objectives

SPO1.1: Reinforce and sustain strong leadership, management and coordination of immunization programmes at all levels.

SPO1.2: Ensure the availability of an adequate, effective, sustainable health workforce.

SPO1.3: Build and strengthen comprehensive vaccine-preventable disease surveillance as a component of the national public health surveillance system, supported by strong, reliable laboratory networks.

SPO1.4: Secure high-quality supply chains for vaccines and related commodities and effective vaccine management, within the primary health care supply system.

SPO1.5: Strengthen immunization information within a robust health information system and promote use of high-quality, “fit-for-purpose” data for action at all levels.

SPO1.6: Establish and maintain a well-functioning vaccine safety system involving all stakeholders.

Key areas of focus

KAF1.1: Immunization in primary health care: Ensure that sustainable immunization programmes are an integral part of the national primary health care strategies and operations, and of national strategies for universal health coverage.

KAF1.2: Leadership, governance and management: Create an environment for effective coordination, financial management and performance monitoring at every level of the immunization programme.

KAF1.3: Health workforce: Ensure the availability and appropriate distribution of health workers, who are motivated, skilled, knowledgeable and appropriately resourced to plan, manage, implement and monitor the performance of immunization programmes at all levels and locations, as part of primary health care.
KAF1.4: Supply chain and logistics: Strengthen supply chains to ensure that high-quality vaccines are always available in the right quantity and form at the right time, in the right place, and stored and distributed under the right conditions. Promote integration with other supply chains for more effective delivery of primary health care. Invest in systems and infrastructure to safely manage, treat and dispose of vaccine waste to help reduce their environmental footprint.

KAF1.5: Vaccine-preventable disease surveillance: Increase the efficiency, responsiveness and comprehensiveness of disease surveillance (including epidemiology and laboratory capacity) in order to: encourage the introduction of vaccines; optimize immunization programmes; measure the impact of vaccines; monitor disease control, elimination and eradication; and detect, investigate and respond to outbreaks. These activities should be based on existing surveillance infrastructure, such as that for polio and measles.

KAF1.6: Health information systems: Ensure that health information systems allow health workers and decision-makers to generate and use high-quality, “fit-for-purpose” data to implement and manage immunization programmes effectively at all levels and that the data are also integrated into national health information systems.

KAF1.7: Monitoring vaccine safety: Ensure that national immunization programmes can detect and respond to any concern about vaccine safety by continuous monitoring, coordination and communication among relevant stakeholders.
SP2. Commitment and demand

Objectives

SPO2.1: Build and sustain strong political and financial commitment for immunization at all levels.

SPO2.2: Ensure that all people and communities value, actively support and seek out immunization services

Key areas of focus

KAF2.1: Commitment: Ensure that key groups, champions and stakeholders advocate for greater commitment to and ownership of immunization programmes and for sustained national and subnational financing. Encourage leaders to prioritize immunization in strategic and operational planning and in policy, fiscal and legislative instruments. Strengthen evidence-based decision-making, with technical input from bodies, such as national immunization technical advisory groups (NITAGs).

KAF2.2: Subnational support: Build support for immunization and capacity for national and subnational leadership, management, and coordination, especially in large countries and in those with decentralized health systems. Establish mechanisms for stakeholder coordination and participation in planning, implementation and monitoring.

KAF2.3: Accountability: Establish accountability frameworks for all stakeholders, with platforms for engagement and dialogue. Ensure that communities and civil society organizations are equipped to hold national and subnational authorities accountable for equitable delivery and for the quality of immunization services. Ensure access to data and information and develop frameworks for joint monitoring.

KAF2.4: Public trust and confidence: Establish an ongoing understanding of all the behavioural and social drivers to vaccination (including social processes, gender-related barriers, practical factors and social media) to engage communities and encourage greater use of immunization services.

KAF2.5: Public knowledge and understanding: Include the topic of immunization in educational curricula, formulate public education tools (including to meet the needs of vulnerable and marginalized groups), provide educational opportunities for the health workforce and prepare information resources for advocacy groups.
Objectives

**SPO3.1**: Extend immunization services to regularly reach “zero-dose” and under-immunized children and communities.

**SPO3.2**: Advance and sustain high and equitable immunization coverage nationally and in all districts.

Key areas of focus

**KAF3.1**: Disadvantaged populations: Identify and address low coverage throughout the life-course of the poorest and most disadvantaged individuals and communities.

**KAF3.2**: Barriers to vaccination: Identify barriers to uptake of vaccination services due to age, location, social and cultural and gender-related factors, and use evidence-based approaches to overcome these barriers to achieving high, equitable coverage.

**KAF3.3**: Measles as a tracer: Use measles cases and outbreaks as a tracer to identify weaknesses in immunization programmes, and to guide programmatic planning on identifying and addressing these weaknesses.

**KAF3.4**: Learning from disease-specific initiatives: Use the experience of disease eradication and elimination initiatives in reaching the most marginalized populations and integrate successful strategies for delivery and accountability into immunization programmes, with the full integration of disease control perspectives into primary health care.

**KAF3.5**: Context-specific interventions: Develop, evaluate and scale up innovative, locally tailored, evidence-based, people-centred approaches to reach poorly served populations.

**KAF3.6**: Subnational support and capacity: Build support for immunization and capacity for subnational management and coordination, especially in large countries and in those with decentralized health systems. Establish mechanisms for stakeholder coordination and participation in planning, implementation and monitoring.
SP4. Life-course and integration

Objectives

SPO4.1: Strengthen immunization policies and service delivery throughout the life-course, including for appropriate catch-up vaccinations and booster doses.

SPO4.2: Establish integrated delivery points of contact between immunization and other public health interventions for different target age groups.

SPO4.3: Accelerate new vaccine introductions to protect more people from more diseases in all countries

Key areas of focus

KAF4.1: Mobilizing support: Raise awareness of the benefits of vaccination beyond early childhood, through adolescence and in priority adult groups, such as pregnant women, health workers and older adults.

KAF4.2: Evidence-based delivery practices: Identify and evaluate new delivery strategies for increasing coverage of recommended vaccines throughout the life-course.

KAF4.3: Missed opportunities: Implement proven approaches to reduce the number of missed opportunities by integrating immunization into other primary health care planning, health registers and other record-keeping systems, and streamline use of all encounters with the health system to verify and provide missed vaccines and other essential health interventions.

KAF4.4: Cross-sector collaboration: Form collaborations to integrate age-appropriate and catch-up vaccination into public and private health services, emphasizing the reciprocal benefits of receiving vaccines with other health interventions. Establish collaboration beyond the health-care sector to ensure integration of immunization into context-specific programmes, such as those for education, nutrition, water and sanitation, care of older people and women’s empowerment.
SP5. Outbreaks and emergencies

Objectives

**SPO5.1:** Ensure preparation for, detection of and rapid, high-quality response to vaccine-preventable disease outbreaks.

**SPO5.2:** Establish timely and appropriate immunization services during emergencies, and in communities affected by conflict, disaster and humanitarian crisis.

Key areas of focus

**KAF5.1: Coordination and integration:** Strengthen coordination of implementation of vaccination and outbreak preparedness, detection and activities in the overall humanitarian response and in conformity with the International Health Regulations (2005) and health systems development programming, with the participation of all relevant stakeholders, including civil society, national and international organizations, humanitarian and development partners, and the private sector. Since conflicts, disasters and other humanitarian crises disrupt immunization programmes, it is important to plan for them in anticipation of disruptions based on locations, past history and vulnerable populations.

**KAF5.2: Local capacity:** Invest in and sustain local capacity and health systems to ensure timely detection of and response to vaccine-preventable disease outbreaks; identify and address the underlying causes of outbreaks; ensure that communities affected by outbreaks, other emergencies and humanitarian crises have continual access to a package of health services that includes immunization; and ensure that immunization recovery is embedded into outbreak and emergency response plans.

**KAF5.3: Comprehensive health response:** Ensure that global, regional, national and subnational coordination and governance mechanisms effectively support equitable, transparent, timely decision-making on the allocation of essential supplies and vaccines and mobilization of trained human resources.

**KAF5.4: Community engagement:** Plan and rehearse risk communication strategies for outbreaks and emergencies. Prioritize two-way communication and engagement with communities and health workers during outbreaks and in settings of humanitarian aid to inform communities and enable participation in decision-making; ensure access to and use of services and identify and fill unmet health needs based on robust evidence.
SP6. Supply and sustainability

Objectives

SPO6.1: Build and maintain healthy global markets across all vaccine antigens.
SPO6.2: Ensure sufficient financial resources for immunization programmes in all countries.
SPO6.3: Increase immunization expenditure from domestic resources in aid-dependent countries, and when transitioning away from aid, secure government funding to achieve and sustain high coverage for all vaccines.

Key areas of focus

KAF6.1: Innovation and affordability: Ensure that the supply of and access to new vaccines meet country needs and that vaccines are introduced in a timely manner, regardless of a country’s wealth, and at a price that is affordable to ensure the supply.

KAF6.2: Vaccine forecasting, procurement and supply: Improve national and global forecasting, planning and procurement capability to safeguard affordable, sustainable supplies, and strengthen relations with manufacturers to ensure that vaccine production and supply meet national needs in all countries.

KAF6.3: Sources of assured quality vaccines: Strengthen regulatory capacity in all countries to improve timely access to vaccines of assured quality and to allow diversification of manufacturing sources.

KAF6.4: Sufficient, predictable resources: Ensure that funding from all sources is sufficient to procure and deliver recommended vaccines universally.

KAF6.5: Immunization financing: Ensure good governance, stewardship and accountability of financing for immunization programmes for optimal performance and best value for money.

KAF6.6: Partner alignment: Streamline and align partnerships for immunization, primary health care or integrated financing, and ensure effective global collaboration in which the roles, responsibilities and accountability of all partners are clearly defined, transparent and monitored.
Objectives

SPO7.1: Establish and strengthen capacity at all levels to identify priorities for innovation and to create and manage innovation.

SPO7.1: Evaluate promising innovations and scale up innovations, as appropriate, on the basis of the best available evidence.

Key area of focus

KAF7.1: Needs-based innovation: Strengthen mechanisms to identify vaccine-related research and priorities for innovation according to community needs, particularly for underserved populations, and ensure that the priorities inform innovations in immunization products, services and practices.

KAF7.2: Evidence for implementation: Shorten the path to maximum vaccine impact by implementation and operational research and through evidence-informed decisions on policy and implementation, based on sound evidence of needs, benefits and risks.
D. Regional priorities

To ensure a country-centric approach to regional strategy development and to identify priority areas for immunization for countries in the Region, the following two activities were undertaken:

- a document analysis of existing strategic plans, comprehensive multi-year plans (cMYPs) and reviews of immunization systems; and
- an online stakeholder survey to identify priority areas in immunization.

These activities identified the key areas of focus seen as most important in the Region:

- **KAF1.1**: Immunization integrated into PHC
- **KAF1.2**: Leadership, governance and management
- **KAF1.3**: Health workforce
- **KAF1.4**: Supply chain and logistics
- **KAF1.5**: Vaccine-preventable disease surveillance
- **KAF1.6**: Health information systems
- **KAF1.7**: Vaccine safety monitoring
- **KAF2.1**: Political commitment and ownership
- **KAF3.1**: Addressing low coverage among disadvantaged populations
- **KAF3.2**: Recognizing and addressing barriers to immunization
- **KAF3.5**: Context-specific interventions
- **KAF3.6**: Subnational support and capacity
- **KAF6.2**: Vaccine forecasting, procurement and supply

These priorities will form the basis of the coordinated support provided by partners to countries.
Principles

- Participative
- Open and honest spirit
- Space for experience sharing and mutual learning
- Analysis of systems and processes
- Oriented towards the identification of solutions
- Mobilization of participation in actions
4. Regional Vaccine Implementation Plan 2022–2026

The Regional Strategic Framework 2022–2030 will be implemented in two phases through associated regional vaccine implementation plans. The Regional Vaccine Implementation Plan (RVIP) 2022–2026 will be a living document drawing on the lessons learnt during the implementation of previous Regional Vaccine Action Plans (RVAPs) and the comprehensive multi-year plans of countries.

The Regional Strategic Framework 2022–2030, in conjunction with the RVIP 2022–2026, is focused on key regional and country priorities while introducing new elements that reflect emerging challenges and opportunities. Overall, the focus will be on sustaining past achievements as well as accelerating progress towards regional goals by applying what is already known to be effective and by developing innovative new approaches where required.

RVIP 2022–2026 focuses, in particular, on ownership and accountability mechanisms, coordinated planning processes, a regional monitoring and evaluation framework, and communication and advocacy strategies. It will have a strong initial focus on addressing the damage caused to immunization programmes during the COVID-19 pandemic and COVID-19 vaccination. It emphasizes the need to focus on subnational levels to provide essential immunization services to all communities. It also recognizes the need to align and synergize RVIP approaches and activities with the immunization agendas of all stakeholders, including Gavi 5.0. The regional framework for feedback and accountability is illustrated in Fig 1.

Fig 1. Regional framework for ownership and coordination
Following a mid-term review, a revised Regional Vaccine Implementation Plan will be developed for the period 2027–2030.

A. Coordinated operational planning

Achieving the goals of the Regional Strategic Framework will require concerted actions at a country level – regional achievements will represent the sum of national progress. To achieve this progress, it is essential that all stakeholders shown in Fig. 1 need to work together towards common goals at country and regional levels. The Regional Working Group for immunization will provide a platform for this.

The Regional Vaccine Implementation Plan 2022–2026 draws on the following principles from the IA2030 Framework for Action to guide implementation:

- **instilling broad ownership to achieve the regional vision** among all immunization and non-immunization stakeholders, including those involved in health system strengthening and disease-specific initiatives;

- **leveraging and strengthening existing mechanisms** for coordination, accountability, planning, M&E and advocacy at country, regional and global levels;

- **promoting continuous quality improvement cycles** using timely, reliable and fit-for-purpose data;

- **building and strengthening** stakeholder accountability and technical alignment to address country needs;

- **aligning and harmonizing** with existing regional and national plans and global strategies, including the Sustainable Development Goals (SDGs), universal health coverage (UHC) and Gavi 5.0; and

- **tailoring country support** according to the state of maturity of each country’s immunization system.

These principles will underpin implementation activities within the Region:

**Instilling broad ownership**

Country ownership is key to achieving RVIP goals and objectives, as the most important actions will be the responsibility of individual countries. High-level political commitment has been demonstrated by the endorsement of the Regional Strategic Framework 2022–2030 by the WHO Regional Committee for South-East Asia in September 2021. Countries will then commit themselves to achieving national immunization and VPD control targets in national health plans, national immunization strategies and multi-year immunization plans, which will act as steppingstones to regionally defined “gold standard” targets and regional impact goals.

Through collaborative development of RVIP 2022–2026, partners and other stakeholders have embraced regional immunization goals, and committed to aligning and coordinating their support activities. At regional and country levels, they will specify the contributions they will make to enable countries of the Region to achieve their goals.
At regional and country levels, stakeholders involved in areas, such as health systems strengthening, primary health care development and universal health coverage as well as disease-specific initiatives, will be engaged in strategy development and planning. The aim will be to build wider commitment to RVIP goals and objectives, and to identify opportunities for alignment of activities to mutual benefit.

For large countries and those with devolved health systems, subnational health authorities will have primary responsibility for strengthening the performance of immunization systems. Subnational ownership will be strengthened, alongside the building of stronger collaborations across subnational partners.

**Leveraging and strengthening existing mechanisms**

**National health policy and plans, national immunization strategic plans** and **comprehensive multi-year plans (cMYPs)** remain the key instruments through which the Regional Strategic Framework will be translated into action at the country level. Current plans of the countries are ending at various years. Over time, when countries develop new plans, they will be updated and adapted to align where necessary with the Regional Strategic Framework and its associated strategic priorities and objectives.

National coordination of support activities will continue to be managed through existing **Interagency Coordination Committees (ICCs)**. ICCs will, therefore, have critical input into cMYPs and annual workplans. **National Immunization Technical Advisory Groups (NITAGs)** will continue to provide evidence-based technical guidance to national immunization programmes and monitor implementation of national plans.

Coordination of activities across regional partners will continue to be principally through the **Regional Working Group** for Immunization. The regional **Immunization Technical Advisory Group (ITAG)** will continue to provide technical guidance based on the evidence generated at global, regional and country levels, in particular interpreting recommendations from the global Strategic Advisory Group of Experts (SAGE) on immunization. It will also monitor progress towards the achievement of regional goals and strategic priority objectives across all countries in the Region.

Guidance from key regional disease-specific advisory bodies, such as the Regional Certification Commission on Polio Eradication (RCCPE), the WHO South-East Asia Regional Verification Commission (SEA-RVC) for measles and rubella elimination, and the South-East Asia Regional Expert Panel (SEA REP) on hepatitis B, will ensure that disease-specific control plans are developed in unison with overall immunization and VPD surveillance plan. Where necessary, disease specific immunization plans will be part of overall regional plans, i.e., COVID 19 control, hepatitis control and cervical cancer control.

**Promoting continuous quality improvement cycles**

As shown in Fig. 2, continuous collection and use of data to monitor progress and to drive corrective action, when required, is essential for effective development of immunization services. On the basis of baseline assessments and in line with their cMYPs, countries will develop **annual workplans (AWPs)** that identify the specific activities required over the following year to ensure progress towards identified targets.
**Annual reports** (ARs) will be used to assess whether planned activities have been carried out and to track progress against targets. In consultation with all stakeholders, these annual reports will identify corrective actions required, guiding the development of the annual workplan of the following year (Fig. 2). NITAGs will be involved in the development of annual workplans and annual reports, providing both technical guidance and a key oversight mechanism for national immunization programmes.

**Fig. 2. Coordinated planning based on continuous national quality improvement cycles**

Regional annual workplans and annual reports will also be developed to provide a mechanism for coordinated regional planning and to monitor activities carried out at a regional level.

Country and regional annual workplans and annual reports will be reviewed by the regional ITAG, which will monitor country and regional progress, provide feedback, and offer advice on future priority activities. The recommendations of ITAG will be reported to the Regional Committee for South-East Asia.

**Building and strengthening stakeholder accountability and technical alignment**

Within countries, key stakeholders will be involved in the development of workplans and annual reports to ensure that support activities are driven by national needs, are aligned and are accompanied by robust assignment of roles and responsibilities to ensure accountability. Stakeholders will include immunization partners, key civil society organizations (CSOs) supporting national immunization programmes, and potentially community-based and private sector stakeholders.

At the regional level, similar mechanisms will ensure that regional annual workplans and annual reports include clear statements of roles and responsibilities to promote alignment and accountability.
Aligning and harmonizing with existing regional and national plans and global strategies

Immunization operates within a wider health system. Operational planning will need to take into account other global, regional and national health and development strategies to ensure close alignment and integration, wherever possible. These will include overall national health policies, national strategies and plans related to universal health coverage, development of primary health care services, COVID-19 responses, emergency responses and specific disease-control initiatives.

Coordinated planning will ensure that immunization systems both gain from and contribute to wider national health-care development, delivering higher-quality and more people-centred care.

Similarly, regional planning activities will need to coordinate with regional structures and organizations with interests in areas, such as sustainable development, universal health coverage, health systems strengthening and emergency responses.

Tailoring country support according to the requirements of immunization system of each country

Different countries have different development needs. Baseline assessments of the state of maturity of national immunization programmes, based on the regional monitoring and evaluation framework, will provide the foundation for tailored packages of support coordinated across partners and other stakeholders. The details of these packages of support will be included in annual workplans and progress in their implementation tracked in annual reports.

B. Recovery of immunization system following the COVID-19 pandemic

The COVID-19 pandemic years of 2020 and 2021 marked the worst backsliding in regional immunization coverage. Since 2020, there have been ongoing efforts in all countries to reverse the impact of pandemic on immunization systems, including identifying strategies to vaccinate missed children and monitoring the immunization coverage at national and subnational levels. Countries have variable levels of coverage recovery. However, the accumulated number of zero-dose and partially immunized children has resulted in VPD outbreaks (including for measles, diphtheria, pertussis and circulating vaccine-derived poliovirus).

The Essential Immunization Recovery Plan has a three-pronged approach:

- catch-up on vaccination of children missed since 2019 through catch-up immunization campaigns or through routine immunization services;
- restore immunization services – closing the gap between current and 2019 pre-pandemic coverage; and
- strengthen immunization and primary health care (PHC) systems – ensuring that countries get back on track to reach the IA2030 targets.

Supporting these approaches are six levers: (1) political leadership, (2) advocacy and partnerships, (3) resource mobilization, (4) tailored country response planning and implementation, (5) responsive, intensified technical assistance, and (6) monitoring and learning.
All countries have identified the next steps to conduct catch up, restore and strengthen immunization under key components. Developing the national plan for recovery in line with the RVIP 2022–2026 will enhance this process.

The critical considerations for catch-up, restoration and strengthening of routine immunization are:

- Implement and update short-term plans developed for catch-up and restoration of immunization according to the country context. In this endeavor, it is necessary to consider children who missed immunization during and before the pandemic (i.e., the last five years) for catch-up vaccination.
- Incorporate requirements for partner support.
- Ensure subnational focus on planning, implementation and monitoring.
- Conduct microplanning and defaulter tracking to ensure children and communities are not missed.
- Report data timely to the next level.
- Use reported VPD outbreaks for catching up with all missed vaccines in affected communities.
- Build the capacity of mid-level managers, immunization staff and their supervisors.
- Use evidence-based demand generation to reach missed children.

C. Planning and implementation of COVID-19 vaccination

COVID-19 vaccination will be an important priority in the initial years of RVIP 2022–2026. Countries in the Region can build on the experience of rapid vaccine deployment in 2020 and 2021 for efficient and equitable distribution of first-generation COVID-19 vaccines to all parts of the countries.

The WHO SAGE roadmap for prioritizing the use of COVID-19 vaccines\(^{12}\) has presented an approach, considering the sufficient availability of COVID-19 vaccines and the high population-level seroprevalence, currently estimated at above 90% in most countries due to increasing vaccine coverage rates and infection-induced immunity. It further addresses evolving public health needs as the Omicron variant and its sublineages continue to circulate and provides updates for COVID-19 vaccination in relation to new priority use groups, specific recommendations for primary series and boosters according to priority-use groups, need and frequency for boosters beyond the first booster dose, and vaccination during pregnancy.

The roadmap will be further adapted should new variants of concern that do not have characteristics of Omicron emerge, in the event of significant changes in the COVID-19 disease epidemiology or changes in vaccine attributes that are relevant to the roadmap.

According to the roadmap, population is divided into three groups: high priority use groups, medium priority use groups and low priority use groups. The composition of these groups and details about primary and booster doses for them are included in the document mentioned in the footnote below.

(1) **High priority** use groups are groups for whom COVID-19 vaccines are of greatest importance to reduce death and severe disease. They will require primary series, first booster and additional booster doses.

(2) For **medium priority** use groups, WHO recommends vaccination with primary series and first booster. Additional boosters are not routinely recommended at this time. Countries that already have a policy in place for additional boosters should assess the evolving need, based on the national disease burden, cost-effectiveness and opportunity costs.

(3) Healthy children and adolescents, aged between six months and 17 years, are in the **low priority** use group.

Recognizing the impact of the COVID-19 pandemic on routine immunization systems and coverage and the extensive involvement of national immunization programmes, including mid-Level managers and vaccinators in COVID-19 vaccine deployment in 2021, efforts need to be made to synergize routine immunization activities and COVID-19 vaccination to the extent possible. It is necessary to consider the longer-term need for a COVID-19 vaccination integrated with existing infrastructure and immunization services of a country, able to deliver primary courses and booster vaccination.

Comprehensive COVID-19 surveillance, integrated with global monitoring systems, will be essential due to the changing epidemiology, including variants of concern. This will require national and regional capacity-building in COVID-19 detection and characterization, such as genotyping and sequencing.

To ensure integration of COVID-19-related and other immunization activities, COVID-19-related actions should be planned within the context of the Regional Strategic Framework, national immunization strategies and multi-year plans for immunization. Nearly all Strategic Priority Objectives are of relevance to COVID-19. Considering COVID-19 responses within this framework will help to ensure that they are not siloed and that synergies can be identified whereby COVID-19-related actions strengthen core immunization programmes (and vice versa). If necessary, COVID-19-related actions can be extracted from overall immunization planning to create a COVID-19-specific action plan. However, by first considering these actions within the context of the Regional Strategic Framework, these should be better integrated into all other immunization activities. Country experiences in polio eradication, measles and rubella elimination and new vaccine introduction can guide the accelerated deployment of COVID-19 vaccines, whenever necessary.

As has been the case in the initial stages of COVID-19 vaccine rollout in the Region, activities should continue to be coordinated across partners, drawing on existing Regional Working Group mechanisms.

In summary, countries need to consider future COVID-19 vaccination strategies, including identifying use groups in consultation with NITAGs; identify the resources necessary; and optimally use the vaccines and operational costs available from Gavi for 2023 and 2024. Meanwhile, reasons for vaccine hesitancy should be identified and addressed.
D. Ownership and accountability

An emphasis on ownership is intended to underscore the importance of countries, partners and other stakeholders committing to RVIP goals, priorities and core principles, and then following up on these commitments with real action. Accountability mechanisms provide a way to track the responses of all stakeholders against the commitments they have made.

Ultimately, countries own the plans developed to implement the global IA2030 strategy. It is, therefore, important that countries recognize their accountability for achieving national and global targets. Similar principles of ownership and accountability apply to all immunization stakeholders across global, regional and national levels.

The following mechanisms will be used to ensure ownership and accountability in the Region:

**Endorsement of the Regional Strategic Framework:** By endorsing the Regional Strategic Framework, countries, partners and other stakeholders will commit to achieving regional goals, focusing on regional priorities, and adhering to IA2030 principles and ways of working.

**Joint development of Regional Vaccine Implementation Plans for 2022–2026 and 2027–2030:** By contributing to RVIPs, countries, partners and other stakeholders will commit to setting of targets aligned with regional goals, to comprehensive monitoring and to adaptive planning, based on the progress achieved.

**Participatory development of annual workplans and annual reports:** Although owned by the national immunization programmes, annual workplans will be developed through collaborative consultation processes with a wide range of stakeholders and include the specific contributions to be made by all parties.

**Joint review of annual reports:** Produced by countries, annual reports will incorporate details of the contributions made by all stakeholders, mapped against their original commitments.

**Periodic national reviews:** The existing practice of joint national and international reviews of national immunization programmes and VPD disease surveillance as well as post-introduction evaluations will provide an opportunity for national programmes and partners to jointly evaluate progress at national and subnational levels and contribute to the workplan for the following year.

**Country annual workplans** will include the specific actions required to address priority issues and identify who has responsibility for carrying them out and who else is contributing to their delivery.

The monitoring and evaluation framework (see below) of the Region will play a key role in tracking progress against targets and in identifying priority areas for action. Scorecards and dashboards at the regional office and in each country will provide an intuitive overview of country and regional progress, enabling all stakeholders to see how their activities have contributed to progress and where further coordinated efforts are required. Through broad ownership, successes can be jointly shared and celebrated, and collaborative plans developed to address any area of underperformance.
Target setting will be central to monitoring and evaluation as well as a critical aspect of ownership and accountability. Countries will set challenging but achievable targets, bearing in mind the ultimate aim of achieving regional “gold standard” targets. Countries and partners will need to work together to establish targets and jointly draw up and commit to plans to ensure that targets are achieved.

Accountability will be reinforced by ongoing scrutiny, for example, by NITAGs at a national level and by ITAG regionally.

E. Monitoring and evaluation

Comprehensive and timely monitoring and evaluation (M&E) is critical to the creation of continuous quality improvement cycles. M&E will generate the data through which multiple aspects of immunization programme performance can be assessed, enabling areas requiring more attention to be identified. This will be vital for the countries to build on the achievement gained through implementing the Regional Vaccine Implementation Plan 2016–2021 and reach more challenging targets.

In addition, tracking progress towards the agreed targets will make an important contribution to ensuring stakeholder accountability. The M&E framework will also ensure that the attention of decision-makers remains focused on priority areas, including high-level goals, such as measles elimination, and reducing coverage inequalities. Finally, comprehensive monitoring will maintain the spotlight on immunization goals, helping to sustain the achievements put at risk by the COVID-19 pandemic.

Continuous quality improvement

M&E cycles encourage immunization programme stakeholders to continuously ask the questions:

How are we doing? (Monitor)

How can we do it better? (Evaluate)

Who is responsible for doing what to make improvements? (Act)

The country-level M&E framework incorporates a core set of indicators that will enable priority issues to be tracked and data to be acted upon. This M&E framework will be embedded within the national immunization strategy and cMYPs, annual workplans and annual reports, providing the basis for tracking progress and identifying what new activities are required (Fig. 3).

The M&E cycle will be based on:

coordinated planning, led by national immunization programmes with input from NITAG and partners;

coordinated implementation, led by national immunization programmes with input from all stakeholders;

embedded monitoring, using routinely collected data, wherever possible; and

supportive review, oversight intended to encourage self-reflection, identify opportunities, and suggest mechanisms to improve performance in a supportive and constructive manner.
A core set of indicators have been included to ensure consistency in M&E practice across countries. The key selection criteria for region-specific indicators include:

**Global reporting**: Some indicators are mandated by the IA2030 Framework for Action.

**Feasibility**: Indicators should be feasible to measure reliably and ideally based on routinely collected data.

**Applicability**: Indicators should provide meaningful insights, driving action.

**Priority**: Indicators should align with regional priority areas.

**Country relevance**: Wherever possible, regional indicators should map to those used at a country level.
An indicator hierarchy

To provide coherence across different levels of the M&E framework, a three-level hierarchy has been established:

- **Base layers:** Key performance indicators (KPIs).
- **Strategic Priority Objective (SPO) indicators:** These may be either (1) the most relevant KPI for an SPO or, more usefully, (2) an averaging of all KPI indicators for an SPO.
- **Strategic Priorities:** An averaging of all KPI indicators for a Strategic Priority or an indicator for a key KPI.
- **Impact goals:** High-level indicators that track the overall impact of improving performance.

For each SPO, multiple KPIs may be monitored to provide data on relevant aspects of national immunization programme function. Countries are encouraged to use additional indicators to monitor performance at a more granular level, but these will not be a part of the RVIP M&E reporting process.

The indicator hierarchy is based on the organizing principles – the seven Strategic Priorities and their associated objectives – that are at the heart of the global IA2030 strategy and the Regional Strategic Framework. Progress in these areas will contribute to the development of high-performing, sustainable and well-supported national immunization programmes, which will be essential for delivering the high-level regional impact goals.

**Indicators and targets for impact goals**

For impact goals, seven global indicators and targets have been set. These have been adapted according to the regional context. Definition of each indicator, along with definition, method of measurement and operational considerations, regional base line, regional target for 2030, data source and frequency of reporting of these indicators, is included in Annex 1. Summary of the information is in Table 2.

**Strategic Priorities and key areas of focus**

Each of the seven IA2030 Strategic Priorities has multiple SPOs associated with it (20 in total). For 15 of these SPOs, SPO indicators have been proposed at the global level. In addition, each Strategic Priority includes multiple key areas of focus (KAFs). In some cases, SPOs and KAFs are closely aligned. However, some KAFs have no corresponding SPOs. To monitor the regional progress, four more indicators have been included. The regional monitoring and evaluation framework for SPOs and KAFs is included in Annex 2. Based on that, countries can develop country-specific monitoring and evaluation frameworks for SPOs and KAFs.
<table>
<thead>
<tr>
<th>Impact goal</th>
<th>Objective</th>
<th>Global indicator</th>
<th>Regional specifics</th>
<th>2026 regional target</th>
<th>2030 regional target</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Leaving no one behind by increasing equitable access and use of new and existing vaccines</td>
<td>Leave no one behind.</td>
<td>1.1: Number of zero-dose children</td>
<td>2 009 165 (2019)</td>
<td>1 379 333</td>
<td>1 019 429¹</td>
</tr>
<tr>
<td></td>
<td>Provide access to all vaccines.</td>
<td>1.2: Introduction of new or under-utilized vaccines in low- and middle-income countries⁴</td>
<td>91 (2019)</td>
<td>32</td>
<td>51</td>
</tr>
<tr>
<td></td>
<td>Deliver across the life-course.</td>
<td>1.3: Vaccination coverage across the life-course (DTP3, MCV2, PCV3, HPV)</td>
<td>3.1.1 DTP3: 91% (2019)</td>
<td>94%</td>
<td>94%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3.1.2 MCV2: 83% (2019)</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3.1.3 PCV3: 23% (2019)</td>
<td>58%</td>
<td>91%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3.1.4 HPV: 3% (2019)</td>
<td>48%</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td>Contribute to PHC/UHC.</td>
<td>1.4: UHC Index of Service Coverage</td>
<td>61%</td>
<td>Improve</td>
<td>Improve</td>
</tr>
<tr>
<td>2. Pursuing vaccine-preventable disease elimination and control goals</td>
<td>Control, eliminate and eradicate VPDs.</td>
<td>2.1 Number and % of countries achieving endorsed regional or global VPD control, elimination and eradication targets</td>
<td>2.1.1 Number of countries sustaining polio eradication: 11 (2021)</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2.1.2 Number of countries achieving measles and rubella elimination: 5 (Measles), 2 (Rubella) (2021)</td>
<td>11 (measles) 11 (Rubella)</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2.1.3 Number of countries achieving MNTE 11 (2021)</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2.1.4 Number of countries achieving hepatitis B control 4 (2021)</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>3. Reducing overall mortality and morbidity from vaccine-preventable diseases for all across the life-course</td>
<td>Save lives.</td>
<td>3.1: Number of future deaths averted through immunization¹</td>
<td>919 556¹¹ (2019)</td>
<td>1 123 026 (2030) 10 495 760¹² (2021–2030)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reduce VPD outbreaks.</td>
<td>3.2: Number of large or disruptive VPD outbreaks²</td>
<td>Measles: 1.66 (mean number from 2018–2020) 1 (Declining trend)</td>
<td>0 (declining trend)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Vaccine-derived polio myelitis: 0.66 (mean number from 2018–2020) 0 (declining trend)</td>
<td>0 (declining trend)</td>
<td></td>
</tr>
</tbody>
</table>

¹ Vaccine antigens included: HepB, Hib, HPV, JE, measles, MenA, Streptococcus pneumoniae, rotavirus, rubella, yellow fever, diphtheria, tetanus, pertussis, BCG. Measured relative to zero coverage levels (absence of vaccination); target includes deaths averted over the lifetime of the birth cohort by vaccines given during 2021–2030 (according to the methodology to be calculated globally).
² Large or disruptive outbreaks of measles, polio including vaccine-derived polio, meningococcus, yellow fever, cholera and Ebola will be defined based on the criteria for each disease.
³ Reduce by 50% in comparison to 2019, maintain 99% coverage of DTP1 in countries where it has been achieved.
⁴ Vaccines included: HepB birth dose, Hib, HPV, IPV2, MCV2, PCV, rotavirus, rubella, DTP booster, COVID-19, JE, YF, MenA, multivalent meningitis, typhoid, cholera, dengue, rabies, HepA, influenza, varicella and mumps. Malaria and other relevant vaccines will potentially be included when recommended.


¹² Regional contribution to global target of 50 million deaths averted from 2021–2030
For each SPO indicator, a regional “gold standard” will be established for 2030. These represent aspirational targets that all countries should be aiming to achieve over the long term. Countries may establish ambitious but feasible targets for 2026 and 2030, according to their baseline situation in 2021. These represent steppingstones on the pathway to the regional “gold standards”. Fig. 4 illustrates the process for each country to map out trajectories, according to the maturity of the immunization programme. To monitor the progress, countries can set annual targets in their comprehensive multiyear plan (cMYPs) or National Immunization Strategy (NIS)s.

Fig. 4. Setting targets for SPO indicators for 2026 and 2030

Baseline assessments

Each country in the Region will undertake a baseline assessment of the national immunization programme performance and capacity, based on the core set of indicators in the regional M&E framework. These assessments will be used to identify priority areas for capacity-building and to shape annual workplans. They will also be used to inform the design of tailored packages of support according to country needs.

Scorecards/dashboards

To support effective communication of indicator data, scores for each indicator will be converted into a five-point scale and colour-coded according to the degree to which they are in line with regional and country targets. This system will track:

- absolute performance (in relation to regional “gold standard” targets); and
- performance in relation to national targets.
This will ensure that countries are aware of (1) how their performance compares with that of peers (absolute performance) and (2) how well they are performing with respect to the targets they have set themselves.

Scorecards will be developed for different levels of the RVIP framework, including key performance indicators (KPIs), Strategic Priority Objectives (SPOs) and Strategic Priorities (see Fig. 3 above).

It is envisaged that high-level scorecards will be used primarily to provide political leaders and other key stakeholders with an overall picture of the immunization programme performance and the extent of the progress towards national and regional targets. More granular scorecards or dashboards will enable programme managers and partners to continually monitor and improve different elements of programme performance, as part of continuous quality improvement cycles. Scorecards and dashboards will form a part of annual reports.

**Regional monitoring and evaluation**

There are two aspects to regional M&E:

- monitoring of national performance; and
- monitoring of activities carried out at a region-wide level.

For monitoring of national performance, WHO-SEARO will collate national data, generating regional performance figures for:

- average regional performance (e.g., average coverage);
- proportion of countries achieving regional targets; and
- proportion of countries achieving national targets.

Regional M&E is based on the core set of indicators used across all countries in the Region, including those mandated by the global M&E framework. WHO-SEARO will also monitor progress towards regional impact goals. Regional scorecards will be developed to track country progress based on the above three criteria.

Country-level and region-level scorecards will be reviewed by ITAG as part of its oversight function.

**F. Communications and advocacy**

Immunization is unequivocally one of the most cost-effective public health interventions. This RVIP 2022–2026 will adopt “people-centred design” that uses existing motivations, daily realities, habits and limitations to generate tailored solutions and is country-owned. The RVIP communications and advocacy activities have two objectives. These are to:

- raise awareness of the Regional Strategic Framework and the RVIP among stakeholders and encourage commitment to its goals and principles; and
- build awareness and support for immunization in general.
The thematic areas that will be undertaken are as follows:

- advocacy to create incentives by securing policies and partnerships, making universal access to childhood immunizations a national priority;
- advocacy to enable increased allocation, and effective use, of resources to deliver vaccines in zero-dose communities; and
- advocacy to secure commitment and action for accountability frameworks at country and subnational levels.

At the national level, communications and advocacy will form a part of activities linked to Strategic Priority 2 (commitment and demand). National and regional activities will also draw on the messaging and plans developed at the global level.

To support communication and advocacy strategies, it is vital for countries to understand how people think, feel and act in relation to a vaccine, when developing strategies to generate acceptance and uptake for the vaccine. Gathering and using quality data on the behavioural and social drivers of vaccination will enable programmes to design, target and evaluate interventions to achieve greater impact with more efficiency, and to examine and understand comparable trends over time. The behavioural and social drivers of vaccination (BeSD) guidebook provide tools and practical guidance for achieving high uptake.15

The surveys measure four domains that play a major role in shaping uptake: what people think and feel about vaccines; social processes that drive or inhibit vaccination; individual motivations (or hesitancy) to seek vaccination; and practical issues that shape the experience of seeking and receiving vaccination. Assessing all domains will enable more comprehensive planning and evaluation. Routinely gathering and using such data will offer insights into how to continually improve implementation strategies and tailor communication approaches. This data will be particularly important for programme managers and health workers, given their critical role in relation to vaccination.

Regional communications and advocacy activities will be planned following discussions with partners and with the global IA2030 Working Group on Communications and Advocacy.

G. Regional implementation

Regional activities will be identified and detailed in the regional annual workplans developed by WHO-SEARO in conjunction with the Regional Working Group (RWG) for Immunization and other stakeholders and in consultation with national immunization programmes. They will outline the specific activities slated to take place over the following year and summarize the roles and responsibilities of individual stakeholders.

Activities will be organized in the following categories:

Partner coordination

Activities undertaken to ensure the participation of all relevant stakeholder organizations and coordination/alignment of activities.

15 https://apps.who.int/iris/bitstream/handle/10665/354458/WER9720-eng-fre.pdf (WER position paper)
20 MAY 2022, 97th YEAR / 20 MAI 2022, 97e ANNÉE No 20, 2022, 97, 209–224 http://www.who.int/wer
Ownership and accountability

Activities undertaken to ensure that countries and partners remain committed to RVIP goals, objectives and core principles, and that accountability mechanisms are fit for purpose.

Country-support activities

Planned activities to support capacity-building and provide necessary technical assistance to countries.

Regional activities

Activities related to regional development of guidelines and tools and regional cooperation (e.g., surveillance, data systems, coordinating peer support).

Laboratory networks

Activities to ensure existing regional laboratory networks for polio, measles, Japanese encephalitis, rotavirus and invasive bacterial disease.

Communications and advocacy

Coordinated region-level activities (1) to build commitment to RVIP 2022–2026 and (2) to promote immunization in the countries and (3) to engage policy-makers and stakeholders.

IA2030 reporting

Activities undertaken to ensure timely and comprehensive reporting from countries and partners to WHO-SEARO, and from the Regional Office to the global level.

For monitoring of regional performance, the Regional Office will monitor a smaller set of indicators related to these region-wide activities. Progress against activities identified in regional annual workplans will be summarized in regional annual reports, which will also provide a synthesis of national-level performance for the preceding year.

Coordination of regional support to countries

Partners will develop coordinated regional packages of support in priority areas. These will draw upon a range of “accelerators” that have the potential to build national immunization programme capacity and enhance performance:

**IA2030 technical annexes and Working Group outputs**: A set of detailed annexes have been developed covering the IA2030 Strategic Priorities and other key issues related to immunization. These include practical guidance and detail of the global resources available. Technical Working Groups have been established at the global level for each Strategic Priority and will generate outputs that will feed into regional and national activities.

**Regional expertise**: Multiple partners, CSOs, private sector bodies and community-based organizations can provide expertise and experience to strengthen immunization systems.

**Peer support**: Countries have specific strengths in particular aspects of immunization system functions, providing opportunities to learn from each other. RWG partners will facilitate sharing of these information.
**Leveraging disease-control infrastructure**: Systems and resources developed for, among others, polio and COVID-19 have the potential to be redeployed or used to advance progress towards the RVIP 2022–2026 goals.

**Subnational capacity-building**: This involves using Gavi and other resources to build subnational capabilities, where applicable.

Initially baseline assessments and then annual reports will identify key areas where further strengthening of national immunization systems is required. This will enable support packages to be tailored to individual country needs.

As a first step, a landscaping exercise will be undertaken to identify:

- global and regional resources and financial and technical assistance that are available in regional priority areas; and
- currently under-utilized resources with the potential to be applied in the Region.

Partners will use the results of this exercise to identify areas, where resource gaps need to be filled, and to inform the design of the tailored packages of support.

Input will also be obtained from disease-specific programmes, which have identified development needs related to their specific disease control goals. These insights need to be integrated into the RVIP strategic priority framework to ensure close alignment with the national immunization programme development.

A detailed **mid-term review** will be undertaken in 2026 to take stock of progress towards regional impact goals and targets. At this point, regional priorities and targets will be revisited and revised, if necessary.

### H. Country-level implementation

National immunization programmes will take the lead in implementation, supported by WHO-SEARO and partners.

**National immunization strategies** and **comprehensive multi-year plans (cMYPs)** will continue to be at the heart of immunization planning in countries. As strategies and cMYPs are updated, they will incorporate elements from the Regional Strategic Framework. New global guidance has been developed to support the development of national immunization strategies aligned with IA2030.¹⁶

Annual activities will be shaped by **annual workplans** organized around the RVIP structure. These will be put together in collaboration with partners, taking advantage of structures, such as ICCs, and will identify the respective roles and responsibilities of national stakeholders. NITAGs will provide technical input and review draft annual workplans.

Consultations should also be held with national structures responsible for the development of primary health care services and advancement of universal health coverage as well as with other relevant sectors (such as education for school-based vaccination).

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¹⁶ https://www.who.int/teams/immunization-vaccines-and-biologicals/vaccine-access/planning-and-financing/nis
Annual workplans should include **annual targets for all key performance indicators (KPIs)**, identify the specific actions required to achieve those targets, adequately resourced, and specify who is principally responsible for ensuring that such actions are carried out. Managerial staff at all levels of the national immunization programme should have the opportunity to contribute to annual workplans and be aware of what their expected contributions will be. Staff at all levels should be encouraged to use data to track performance, to set local targets consistent with national target setting, and to investigate possible root causes of missed targets.

Although achieving targets is important, emphasis should be placed on accurate and comprehensive reporting and on the development of improvement plans. National immunization programmes will have the primary responsibility of compiling annual reports that track the activities that have been completed and identify the progress made on the national targets. Scorecards/dashboards will provide insights into areas requiring greater attention.

Wherever possible, indicators should be based on routinely collected data. The principles of “monitor–evaluate–act” and continuous improvement cycles should be embedded at all levels of national immunization programmes. The planning, M&E and reporting systems, outlined for the national level, should be implemented at all levels and adapted, as necessary, according to the local context. Local planning activities should be undertaken in partnership with local communities.

For countries with highly devolved health systems, processes for **subnational implementation** will be a high priority. Subnational planning and implementation will follow all principles identified for national planning and implementation, including the focus on partnerships and the emphasis on continuous quality improvement cycles.

Subnational M&E frameworks that align with national frameworks should be established. Subnational target-setting should also be undertaken, again ensuring consistency with national targets. Where they exist, subnational technical advisory groups can provide inputs into annual workplans and review annual reports.
5. Conclusion

The Strategic Framework for the Regional Vaccine Action Plan 2022–2030 presents an opportunity to maintain the momentum generated through the Decade of Vaccines and the RVAP 2016–2020 and further extend the reach and breadth of vaccination services in the Region. The Regional Vaccine Implementation Plan 2022–2026 provides a foundation for translating this strategy into action on the ground.

The RVIP 2022–2026 provides a framework for coordinating and aligning the work of the many stakeholders involved in the planning and delivery of vaccination services at regional and national levels, led at the country level by national immunization programmes. It integrates the key principles identified in the global IA2030 Framework for Action, particularly the concept of continuous quality improvement cycles, underpinned by a monitoring and evaluation framework that generates the data to drive action and an ownership and accountability model in which roles and responsibilities are clear from the outset and commitments monitored and tracked.

Through coordinated partnerships, geared to country needs, the RVIP 2022–2026 will ensure rebuilding of immunization systems, required due to the COVID-19 pandemic. COVID-19 has presented an unprecedented challenge to health systems but has also highlighted the critical value of strong primary health care systems and of vaccination.

Learning the lessons from COVID-19 will mean strengthening health systems so that countries are better able to detect and respond to emerging infectious disease threats and to minimize their impact on the health of the population. As the COVID-19 pandemic has illustrated, effective prevention is beneficial not only for the health of populations but also for the economic well-being of a country. Optimum utilization of available resources and sustained commitment from all stakeholders will be the key pillars of this endeavour.
### Annex 1

Monitoring of Impact goal indicators

<table>
<thead>
<tr>
<th>Indicator 1.1: Number of zero-dose children</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition</strong></td>
</tr>
<tr>
<td><strong>Calculation</strong></td>
</tr>
<tr>
<td><strong>Method of measurement and operational considerations</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Countries</th>
<th>Regional Baseline 2019</th>
<th>Regional Target 2026</th>
<th>Regional Target 2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEA Region</td>
<td>2 million</td>
<td>1.3 million</td>
<td>1 million</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>28 405</td>
<td>26 329</td>
<td>25 143</td>
</tr>
<tr>
<td>Bhutan</td>
<td>127</td>
<td>115</td>
<td>108</td>
</tr>
<tr>
<td>DPR Korea</td>
<td>7015</td>
<td>4 783</td>
<td>3 508</td>
</tr>
<tr>
<td>India</td>
<td>1 403 384</td>
<td>956 853</td>
<td>701 692</td>
</tr>
<tr>
<td>Indonesia</td>
<td>471 515</td>
<td>321 495</td>
<td>235 763</td>
</tr>
<tr>
<td>Maldives</td>
<td>69</td>
<td>59</td>
<td>53</td>
</tr>
<tr>
<td>Myanmar</td>
<td>63 487</td>
<td>43 287</td>
<td>31 744</td>
</tr>
<tr>
<td>Nepal</td>
<td>21 918</td>
<td>14 944</td>
<td>10 959</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>3 289</td>
<td>3 084</td>
<td>2 967</td>
</tr>
<tr>
<td>Thailand</td>
<td>7,022</td>
<td>6,391</td>
<td>6,030</td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>2 924</td>
<td>1 994</td>
<td>1 462</td>
</tr>
</tbody>
</table>

**Data source**
WUENIC, UNPD population estimates; HMIS, Coverage evaluation survey

**Frequency of reporting**
Annual at global level and monthly at country and regional level
Indicator 1.2: Introduction of new or under-utilized vaccines in low- and middle-income countries

<table>
<thead>
<tr>
<th>Definition</th>
<th>Introduction(^1) of new or under-utilized vaccines(^2) in low- and middle-income countries.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calculation</td>
<td>Count of the number of country vaccine introductions for WHO recommended vaccines reported from 2021–2030.</td>
</tr>
<tr>
<td>Method of measurement and operational considerations</td>
<td>Vaccines included in this indicator that are recommended by WHO for use in national immunization schedules in all countries: HepB birth dose, Hib, HPV, IPV2, MCV2, PCV, rotavirus, rubella, DTP booster, and COVID-19 (interim recommendation). Other relevant vaccines (e.g., malaria) will be included when recommended. Low- and middle-income countries are defined according to the World Bank’s income classifications.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Countries</th>
<th>Regional Baseline 2019</th>
<th>Regional Target 2021–2026 (In addition to 2019)</th>
<th>Regional Target 2030 (In addition to 2019)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEA Region</td>
<td>91</td>
<td>32</td>
<td>51</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>6</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Bhutan</td>
<td>9</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>DPR Korea</td>
<td>6</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>India</td>
<td>10</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Indonesia</td>
<td>10</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Maldives</td>
<td>9</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Myanmar</td>
<td>8</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Nepal</td>
<td>7</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>8</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Thailand</td>
<td>10</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>8</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>

Data source: JRF, PIE and other introduction reports

Frequency of reporting: Annual

---

1 Addition of a vaccine to the national immunization schedule and use of the vaccine for a sustained period of at least 12 months (excludes vaccines used only in the private sector that are not in national immunization schedule; includes vaccines in national immunization schedules that are used in at risk populations, e.g., seasonal influenza).

2 New or underutilized vaccines are vaccines that have not yet been introduced into national immunization schedules in all countries, where recommended by WHO.
**Indicator 1.3. SDG 3.b.1 - Coverage of vaccines included in national immunization schedules (DTP3, MCV2, PCV3, and HPVc)**

**Definition**
Immunization coverage for DTPc3, MCV-2, PCV3 and HPVc.

**Calculation**
Denominator is estimated population of target group of children that should receive DTPc3, MCV-2, PCV3 and HPVc. Numerator consists of target population who have received DTPc3, MCV-2, PCV3 and HPVc. Target population of children and their appropriate age for last dose is determined by national immunization schedule.

**Method of measurement and operational considerations**
Immunization coverage for a certain year is defined as the proportion of the targeted population that received the relevant vaccine and dose in that year. Analysis and interpretation: Level and trend, disaggregated by geography and other dimensions (socio-economic, language group, ethnicity) as available.

<table>
<thead>
<tr>
<th>Antigens</th>
<th>Regional Baseline 2019 (%)</th>
<th>Regional Target 2026 (%)</th>
<th>Regional Target 2030 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DTP3</td>
<td>MCV2</td>
<td>PCV3</td>
</tr>
<tr>
<td>SE Asia Region</td>
<td>91</td>
<td>83</td>
<td>23</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>98</td>
<td>93</td>
<td>99</td>
</tr>
<tr>
<td>Bhutan</td>
<td>97</td>
<td>92</td>
<td>26</td>
</tr>
<tr>
<td>DPR Korea</td>
<td>97</td>
<td>98</td>
<td>0</td>
</tr>
<tr>
<td>India</td>
<td>91</td>
<td>84</td>
<td>15</td>
</tr>
<tr>
<td>Indonesia</td>
<td>85</td>
<td>71</td>
<td>3</td>
</tr>
<tr>
<td>Maldives</td>
<td>98</td>
<td>96</td>
<td>0</td>
</tr>
<tr>
<td>Myanmar</td>
<td>90</td>
<td>80</td>
<td>90</td>
</tr>
<tr>
<td>Nepal</td>
<td>93</td>
<td>76</td>
<td>83</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>99</td>
<td>99</td>
<td>0</td>
</tr>
<tr>
<td>Thailand</td>
<td>97</td>
<td>87</td>
<td>0</td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>83</td>
<td>80</td>
<td>0</td>
</tr>
</tbody>
</table>

**Data source**
WHO and UNICEF estimates of national immunization coverage (WUENIC); CES and HMIS

**Frequency of reporting**
Annual
**Indicator** | **1.4 UHC Index of service coverage**
---|---
**Definition** | The indicator will measure coverage of essential health care services. Coverage of essential health services is defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, noncommunicable diseases and service capacity and access, among the general and the most disadvantaged population.

**Calculation** | UHC SCI will be reported at the country level. Regional and global means will be calculated.

**Method of measurement and operational considerations** | The UHC SCI is constructed from 14 tracer indicators selected based on epidemiological and statistical criteria. The index is reported on a unitless scale of 0 to 100, with 100 being the optimal value.

<table>
<thead>
<tr>
<th></th>
<th><strong>Regional Baseline 2019</strong></th>
<th><strong>Regional Target 2021–2026</strong></th>
<th><strong>Regional Target 2030</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>SE Asia Region</td>
<td>61</td>
<td>Improve over baseline</td>
<td>Improve over 2026</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>51</td>
<td>Improve over baseline</td>
<td>Improve over 2026</td>
</tr>
<tr>
<td>Bhutan</td>
<td>62</td>
<td>Improve over baseline</td>
<td>Improve over 2026</td>
</tr>
<tr>
<td>DPR Korea</td>
<td>68</td>
<td>Improve over baseline</td>
<td>Improve over 2026</td>
</tr>
<tr>
<td>India</td>
<td>61</td>
<td>Improve over baseline</td>
<td>Improve over 2026</td>
</tr>
<tr>
<td>Indonesia</td>
<td>59</td>
<td>Improve over baseline</td>
<td>Improve over 2026</td>
</tr>
<tr>
<td>Maldives</td>
<td>69</td>
<td>Improve over baseline</td>
<td>Improve over 2026</td>
</tr>
<tr>
<td>Myanmar</td>
<td>61</td>
<td>Improve over baseline</td>
<td>Improve over 2026</td>
</tr>
<tr>
<td>Nepal</td>
<td>53</td>
<td>Improve over baseline</td>
<td>Improve over 2026</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>67</td>
<td>Improve over baseline</td>
<td>Improve over 2026</td>
</tr>
<tr>
<td>Thailand</td>
<td>83</td>
<td>Improve over baseline</td>
<td>Improve over 2026</td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>53</td>
<td>Improve over baseline</td>
<td>Improve over 2026</td>
</tr>
</tbody>
</table>

**Data source** | UHC SCI

**Frequency of reporting** | Every second year
**Indicator 2.1 Number and proportion of countries that have achieved regional or global VPD control, elimination and eradication targets**

<table>
<thead>
<tr>
<th>Definition</th>
<th>Achievement of all VPD control, elimination and eradication targets; endorsed by a global or regional body of WHO Member States, with target dates between 2021 and 2030, and that are based on incidence or prevalence measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calculation</td>
<td>Numerator is the number of countries that met the VPD target, and the denominator is the number of countries with an endorsed VPD target based on incidence or prevalence measures.</td>
</tr>
</tbody>
</table>

**Method of measurement and operational considerations**

- 1.2.1 Number of countries sustaining polio eradication
- 1.2.2 Number of countries achieving and sustaining measles and rubella elimination
- 1.2.3 Number of countries achieving MNTE
- 1.2.4 Number of countries achieving Hepatitis B control through immunization

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Regional Baseline 2020</th>
<th>Regional Target 2026</th>
<th>Regional Target 2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1.1 Number of countries sustaining polio eradication</td>
<td>11 countries</td>
<td>11 countries</td>
<td>11 countries</td>
</tr>
</tbody>
</table>
| 2.1.2 Number of countries achieving and sustaining measles and rubella elimination | • Five countries for measles elimination: Bhutan, DPR Korea, Maldives, Sri Lanka, Timor-Leste
  • Two countries for rubella elimination: Maldives, Sri Lanka | 11 countries for measles and rubella elimination | 11 countries for measles and rubella elimination |
| 2.1.3 Number of countries achieving MNTE | 11 countries | 11 countries | 11 countries |
| 2.1.4 Number of countries achieving Hepatitis B control through immunization | Four countries (Bangladesh, Bhutan, Nepal, Thailand) | Seven countries (Bangladesh, Bhutan, DPR Korea, Maldives, Nepal, Sri Lanka, Thailand) | 11 countries |

**Data source**

Verification, certification and disease-specific committee reports

**Frequency of reporting**

Annual
## Indicator 3.1 Number of future deaths averted through immunization

<table>
<thead>
<tr>
<th>Definition</th>
<th>Total number of future deaths averted from 2021–2030, based on the IA2030 coverage scenario.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calculation</td>
<td>Observed and averted deaths, collected from multiple data sources, are converted into a single measure of country-, age-, and vaccine-specific relative risk of death conditional upon coverage levels. The relative-risk model is used to predict deaths averted in all locations and diseases.</td>
</tr>
<tr>
<td>Method of measurement and operational considerations</td>
<td>A modelling approach is used to project the number of deaths averted at the global and regional levels by achieving aspirational coverage targets for IA2030. The initial scope focuses on 14 pathogens, which will be expanded to update the estimates at the midpoint of IA2030. 2021–2030: Hepatitis B, Hib, HPV, JE, measles, Streptococcus pneumoniae, rotavirus, rubella, yellow fever, diphtheria, tetanus, pertussis, TB (BCG) By 2025: Polio, typhoid, influenza, cholera, multivalent meningitis, COVID-19, varicella, dengue, mumps, rabies, hepatitis A, hepatitis E, and other new vaccines.</td>
</tr>
<tr>
<td>Zero dose children</td>
<td><strong>Regional Baseline 2019</strong></td>
</tr>
<tr>
<td></td>
<td>9 195 563</td>
</tr>
<tr>
<td>Data source</td>
<td>WHO-UNICEF immunization coverage estimates, estimates of deaths averted from the Vaccine Impact Modelling Consortium (VIMC), Global Burden of Disease Study, and other model inputs from published literature.</td>
</tr>
<tr>
<td>Frequency of reporting</td>
<td>Twice (midpoint and endpoint of IA2030) for monitoring and reporting. The midpoint evaluation will focus on 14 pathogens only, based on the models used for the starting point. The endpoint evaluation will focus on the expanded scope of pathogens based on the updated models from the midpoint. WHO/HQ will do the country and regional estimates.</td>
</tr>
</tbody>
</table>

---


4 Regional contribution to global target of 50 million deaths averted from 2021–2030
**Indicator 3.2: Number of large or disruptive vaccine-preventable disease outbreaks**

**Definition**
A VPD outbreak meeting size criteria for large or disruptive outbreaks aligned with global vaccine-preventable disease strategies and at least one criterion from Annex 2 of the International Health Regulations (2005) https://www.who.int/ihr/annex_2/en/

**Calculation**
Baseline: The mean number of large or disruptive VPD outbreaks calculated over three years, 2018–2020.
Target: All (100%) of measles, polio, meningococcus, yellow fever, cholera, and Ebola separately show a declining trend in the global annual number of large outbreaks by end of decade.
Number of outbreaks will be reported separately for each disease.

**Method of measurement and operational considerations**
Large or disruptive VPD outbreaks are identified using data from specific VPD control programmes and from WHO World Health Emergencies surveillance systems. Different criteria were applied for each disease. For multicountry outbreaks, each country’s portion of the outbreak was assessed separately. The overall indicator will function as a composite combining data across the different diseases.

<table>
<thead>
<tr>
<th>Outbreaks</th>
<th>Measles outbreaks</th>
<th>Vaccine derived polio outbreaks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline (Mean 2018–2020)</td>
<td>Target 2026</td>
</tr>
<tr>
<td>SEA Region</td>
<td>1.66</td>
<td>1</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>0.33</td>
<td>0</td>
</tr>
<tr>
<td>Bhutan</td>
<td>0.33</td>
<td>0</td>
</tr>
<tr>
<td>DPR Korea</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>India</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Indonesia</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Myanmar</td>
<td>0.33</td>
<td>0</td>
</tr>
<tr>
<td>Maldives</td>
<td>0.33</td>
<td>0</td>
</tr>
<tr>
<td>Nepal</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Thailand</td>
<td>0.33</td>
<td>0</td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Data source**
VPD surveillance data

**Frequency of reporting**
Annual

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5 including measles, wild poliovirus, circulating vaccine derived poliovirus, and cholera, the list could be revised, especially as additional diseases become vaccine preventable
### Annex 2

**Regional monitoring and evaluation framework for Strategic Priority Objectives and key areas of focus**

Notes: This is a dynamic framework and includes all SPOs and regional priority key areas of focus (KAF). This framework provides a regional core set of indicators; countries could choose additional indicators as deemed necessary.

**Strategic Priority 1: IMMUNIZATION PROGRAMMES FOR PHC/UHC**

<table>
<thead>
<tr>
<th>Regional Indicator</th>
<th>Regional gold standard</th>
<th>Criteria</th>
<th>Data source</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPO1 Reinforce and sustain strong leadership, management and coordination of immunization programmes at all levels.</td>
<td>Functional NITAGs in all countries</td>
<td>“Functional” is defined as meeting the following criteria: 1. Technical advisory group has a formal written terms of reference; 2. There is a legislative or administrative basis for the advisory group; 3. The following areas of expertise are represented in the group as core membership: paediatrics; public health; infectious diseases; epidemiology; immunology; 4. Members of the technical advisory group are required to disclose conflict of interest; 5. Committee meets at least once a year on a regular basis; and 6. Agenda and background documents distributed to technical advisory group members at least 1 week ahead of meetings</td>
<td>JRF/NITAG Evaluations</td>
</tr>
<tr>
<td>Proportion of countries with evidence of adopted mechanism for monitoring and evaluation, and action at national and subnational levels</td>
<td>M&amp;E and action (ME&amp;A) cycle in all countries</td>
<td>Monitoring, evaluation, and action cycles are in place for data-driven decision-making as evident by: (1) presence of an operational document describing the ME&amp;A process; (2) evidence of actions taken using the process; (3) involvement of the following stakeholder in the process as appropriate, namely, NITAG, the government, partners, CSOs</td>
<td>JRF/NIP&amp;NITAG reporting form</td>
</tr>
<tr>
<td>Feedback loop from national to subnational level and from subnational level to national level in all countries</td>
<td>Feedback loop is in place to communicate assessments of progress, and recommendation actions from subnational to national and from national to subnational level. The indicator envisions the presence of well-defined mechanism to communicate evaluation of immunization indicator results from national to subnational levels and vice versa</td>
<td>JRF</td>
<td></td>
</tr>
<tr>
<td>Regional Indicator</td>
<td>Regional gold standard</td>
<td>Criteria</td>
<td>Data source</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>SPO1.2 Ensure the availability of an adequate, effective, sustainable health workforce</strong></td>
<td></td>
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</tr>
<tr>
<td>Density of physicians, nurses and midwives per 10 000 population (Global Indicator)</td>
<td>Number of physicians, nurses, and midwives per 10 000 population improves regularly</td>
<td>Number of physicians, nurses and midwives per 10 000 population improves regularly</td>
<td>Numerator: WHO National Health Workforce Accounts (NHWA) or national and subnational human resource information system Denominator: UN Population Division's World Population Prospects NIP/NITAG reporting form to ITAG</td>
</tr>
<tr>
<td>Density of vaccinators per 10 000 population</td>
<td>Density of vaccinators per 10 000 population on increasing trend</td>
<td>Number of vaccinators per 10 000 population improves regularly</td>
<td></td>
</tr>
<tr>
<td><strong>SPO1.3 Build and strengthen comprehensive vaccine-preventable disease surveillance as a component of the national public health surveillance system, supported by strong, reliable laboratory networks</strong></td>
<td></td>
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<tr>
<td>Proportion of countries with at least 90% on-time reporting from 90% districts for suspected cases for all priority VPDs under nationwide surveillance, including reporting of zero cases</td>
<td>90% timeliness and 90% completeness of reporting for suspected cases of acute flaccid paralysis; suspected measles/ suspected diphtheria/acute encephalitis syndrome from all countries</td>
<td>90% timeliness and 90% completeness of reporting for suspected cases of acute flaccid paralysis; suspected measles/ suspected diphtheria/Acute Encephalitis syndrome for JE</td>
<td>JRF/monthly report</td>
</tr>
<tr>
<td>Proportion of countries meeting key surveillance performance indicators for polio</td>
<td>Non-polio acute flaccid paralysis rate of &gt;2/100 000 among &lt;15 years population in a 12-month period</td>
<td>Non-polio acute flaccid paralysis rate of &gt;2/100 000 among &lt;15 years population in a 12-month period</td>
<td>JRF/weekly reports</td>
</tr>
<tr>
<td>Proportion of countries meeting key surveillance performance indicators for measles</td>
<td>More than 90% of the subnational administrative units achieving non-measles/non-rubella discard rate of ≥2/100 000 population in all countries</td>
<td>More than 90% of the subnational administrative units achieving non-measles/non-rubella discard rate of ≥2/100 000 population in all countries</td>
<td>JRF/monthly reports</td>
</tr>
</tbody>
</table>
### SPO1.4 Secure high-quality supply chains for vaccines and related commodities and effective vaccine management, within the primary health care supply system.

<table>
<thead>
<tr>
<th>Regional Indicator</th>
<th>Regional gold standard</th>
<th>Criteria</th>
<th>Data source</th>
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<tbody>
<tr>
<td>Proportion of time with full availability of DTPcv and MCV at service delivery level</td>
<td>No stock out of DTPcv at national and subnational level</td>
<td>The country has a system in place to measure vaccine availability at the service delivery level, all health facilities report no stock-outs for the full year for DTPcv and MCV. In the context of this indicator, this means for each month, every health facility was able to meet all vaccine needs and reported no stock-outs for the full year for both vaccines</td>
<td>JRF/Annual NIP/NITAG reporting form to ITAG</td>
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<thead>
<tr>
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<tbody>
<tr>
<td>No stockout of MCV at national and subnational level MCV</td>
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### SPO1.6 Establish and maintain a well-functioning vaccine safety system involving all stakeholders

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<tr>
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<tbody>
<tr>
<td>Proportion of countries with at least 1 documented (with reporting form) individual serious AEFI case per million total population</td>
<td>More than 1 serious AEFI case reported per one million population form all countries</td>
<td>A mechanism to report AEFI is in place and an AEFI data repository exists. Individual serious AEFI case investigation reports are available</td>
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<tr>
<td></td>
<td></td>
<td>Numerator: Vigi base/National AEFI data base Denominator: UN Population Division’s World Population Prospects</td>
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### Strategic Priority 2: COMMITMENT & DEMAND

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<tbody>
<tr>
<td>SPO2.1 Build and sustain strong political and financial commitment for immunization at all levels.</td>
<td>All countries have a legislation supporting immunization</td>
<td>The existence of a legislative basis underlying the commitment to provide government-funded immunization to the population. A ‘vaccination law or other legislation’ could include written laws (Acts, statutes) or regulations, orders or decrees established by public authority and enforceable by law. Legislation may be specialized for immunization or be contained in other general public health legislation and, among other things, must consider securing financing for all components of the Immunization Programme at all levels, including the purchase and timely availability of vaccines in accordance with national planning, training, supervision, outreach activities, information systems, and others</td>
<td>NIP/NITAG reporting form to ITAG</td>
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<thead>
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<tbody>
<tr>
<td>2.1 Proportion of countries with legislation in place that is supportive of immunization as a public good</td>
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### Strategic Priority 3: COVERAGE AND EQUITY

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<tbody>
<tr>
<td><strong>SPO 3.2: Advance and sustain high and equitable immunization coverage nationally and in all districts.</strong></td>
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<tr>
<td>3.2: DTP3, MCV1, and MCV2 coverage in 20% of districts with the lowest coverage (mean across countries) enhanced</td>
<td>Average DPT3 coverage in 20% lowest-performing districts improve to 80% and above (Baseline 69% in 2020)</td>
<td>Average coverage in the lowest-performing quintile for each country that reports district-level coverage. The group of lowest-performing districts may change from year to year</td>
<td>SEAR annual EPI reporting form</td>
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<td>Average MCV1 coverage in 20% lowest-performing districts improve to 95% and above (Baseline 70% in 2020)</td>
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<td></td>
<td>Average MCV2 coverage in 20% lowest-performing districts improve to 95% and above (Baseline 61% in 2020)</td>
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### KAF3.3: Measles as a tracer

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<tbody>
<tr>
<td>Annual Incidence of confirmed measles</td>
<td>&lt;1 confirmed case of measles reported per million population</td>
<td>Numerator is the reported number of confirmed measles cases and denominator is the total population. Incidence weighted in the context of well performing surveillance system and data adjusted based on sensitivity of surveillance system as measured by non-measles non rubella discard rate.</td>
<td>Monthly reporting data/JRF</td>
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### STRATEGIC PRIORITY 4: LIFE COURSE AND INTEGRATION

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<tr>
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<tbody>
<tr>
<td>4.1: Strengthen immunization policies and service delivery throughout the life-course, including for appropriate catch-up vaccinations and booster doses</td>
<td>Breadth of protection defined as mean coverage for primary series for following vaccines/antigens for the following diseases: Diphtheria, tetanus, pertussis, hepatitis B, Hib, measles, pneumococcus pneumonia, polio, IPV, rubella, rotavirus, HPV. The antigens/diseases to be included will be regularly revised based on newer developments. Every country will do a country specific calculation on the average breadth of protection for the above-mentioned diseases which will add to the regional average</td>
<td>Analysis of WUENIC</td>
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### STRATEGIC PRIORITY 5: OUTBREAKS AND EMERGENCIES

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<thead>
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<tbody>
<tr>
<td>SPO5.1: Ensure preparation for, detection of and rapid, high-quality response to vaccine-preventable disease outbreaks</td>
<td>Polio outbreaks (100%)</td>
<td>Time from onset of outbreak to implementation of vaccination campaign should be determined for each polio, measles, and cholera outbreak for which there is an outbreak response vaccination campaign&lt;sup&gt;6&lt;/sup&gt;</td>
<td>ICG, MRI, GPEI, WHO, national immunization and disease surveillance programmes&lt;sup&gt;7&lt;/sup&gt;</td>
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<tr>
<td></td>
<td>Measles outbreaks (100%)</td>
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<td>Cholera outbreaks (100%)</td>
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#### Strategic Priority 6: SUPPLY AND SUSTAINABILITY

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<tbody>
<tr>
<td>SPO6.1: Build and maintain healthy global markets across all vaccine antigens</td>
<td>No regional gold standard for this global indicator</td>
<td>The following attribute will be measured at global/regional level: Global supply exceeds global demand by more than X and by no more than y-x and y defined by the Mi4A vaccine-specific market studies: <a href="https://www.who.int/immunization/programmes_systems/procurement/mi4a/platform/module2/en/">https://www.who.int/immunization/programmes_systems/procurement/mi4a/platform/module2/en/</a>, by antigen</td>
<td>(This indicator is calculated at global level only)</td>
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<sup>6</sup> Maximum time for the period from onset of outbreak to implementation of vaccination campaign to be considered timely will be defined for each vaccine. Criteria for determining onset of outbreak and timeliness of outbreak detection and response to be consistent with WHO surveillance standards and disease eradication, elimination or control strategies.

<sup>7</sup> Information will be systematically collected from national immunization and disease surveillance programs to provide data for regional and global level data.
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<tbody>
<tr>
<td>SPO6.2: Ensure sufficient financial resources for immunization programmes in all countries</td>
<td>Proportion of countries whose current government expenditure level (from domestic and donor funding) on primary health care (PHC) per capita in US$ (constant prices) increased or remained stable since the pre-2020 levels</td>
<td>Current government expenditure level (from domestic and donor funding) on primary health care (PHC) per capita in US$ (constant prices) increased or remained stable since pre-2020 level in all countries</td>
<td>Per capita constant US$ PHC expenditure data is calculated using PHC expenditure, divided by population and measured in constant US$ price (converted in 2020 NCU price and then converted into 2020 US$ prices) The trend calculation will be defined subsequently, leveraging methodologies used for WHO GHED and GHER (Global Health Expenditure Report)</td>
</tr>
<tr>
<td>SPO6.3: Increase immunization expenditure from domestic resources in aid-dependent countries, and when transitioning away from aid, secure government funding to achieve and sustain high coverage for all vaccines</td>
<td>Number of countries whose share of current expenditure on vaccines (in the national immunization schedule) that is financed with domestic government funds increased since pre-2020 level</td>
<td>Share of current expenditure on vaccines (in the national immunization schedule) that is financed with domestic government funds increased since pre-2020 level in all countries.</td>
<td>The share is calculated from domestic government spending on vaccine as a % of total expenditure on routine immunization vaccines. Domestic public resources spent on all vaccines used in conformity with the national immunization programme, including routine doses of vaccines, and following each country’s vaccination schedule. Includes the international market price, as well as transport and handling expenditures. Vaccines used in Child Health Days are included in routine vaccine expenditures, but expenditures related to doses of vaccine given through supplemental immunization activities (SIAs) are excluded</td>
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8 https://apps.who.int/nha/database/Select/Indicators/en
Strategic Priority 7: RESEARCH AND INNOVATIONS

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<tbody>
<tr>
<td>SPO7.1: Establish and strengthen capacity at all levels to identify priorities for innovation, and to create and manage innovation.</td>
<td>Proportion of countries with national agenda for research on immunization</td>
<td>All countries have national agenda for research on immunization. Availability of supporting document like national immunization strategy, national health plan, etc. that can provide evidence of the national agenda for research on immunization. The national agenda has identified priority research areas that increase the likelihood that the country will achieve its IA2030 targets.</td>
<td>JRF NIP/NITAG reporting form to ITAG</td>
</tr>
<tr>
<td>SPO7.2: Develop new vaccines and technologies, and improve existing products and services for immunization programmes</td>
<td>Progress towards global research and development</td>
<td>No Regional gold standard for this global indicator</td>
<td>Indicator will be measured globally</td>
</tr>
<tr>
<td></td>
<td></td>
<td>WHO HQ and regional offices together with key partners/stakeholders will mutually define targets and monitor and evaluate progress at the global and regional level. The process will require a prioritization framework to align on priorities, targets, and a mechanism for monitoring and evaluation. The suggested short list should be presented no later than SAGE Oct 2022</td>
<td></td>
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</tbody>
</table>
The Regional Vaccine Implementation Plan (RVIP) 2022–2026 was developed to support the implementation of the Strategic Framework for South-East Asia Regional Vaccine Action Plan 2022–2030, which was endorsed by the Seventy-fourth Session of the WHO Regional Committee for South-East Asia in 2021. The Strategic Framework for South-East Asia Regional Vaccine Action Plan 2022–2030 is the regional adaptation of the Immunization Agenda 2030.

This Regional Vaccine Implementation Plan 2022–2026 is a seamless transition from the Regional Vaccine Action Plan (RVAP) 2016–2020 and builds on the effective models of collaboration and oversight established under RVAP, with a stronger emphasis on creating continuous quality improvement cycles that strengthen the performance of national immunization programmes and provide the essential foundation for achieving regional disease control and elimination goals.