Report on South-East Asia Regional Working Group on Immunization

22 March 2022
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1. Introduction

The Regional Working Group (RWG) on immunization systems strengthening (ISS), which also covers introduction of new and underutilized vaccines (NUV) and the impact on health system strengthening (HSS), is an interagency body that was set up in the WHO South-East Asia Region in 2007–2008. It liaises with global and other regional immunization initiatives and acts as the primary regional forum for partner and programme coordination, consensus-building and monitoring of the implementation of resources, including that of Gavi, the Vaccine Alliance, and also provides country support.

The membership of the RWG meeting comprises Bill and Melinda Gates Foundation (BMGF), US Centers for Disease Control and Prevention (US CDC), Gavi, the Vaccine Alliance, United States Agency for International Development (USAID), United Nations Children’s Fund (UNICEF), the World Bank and the World Health Organization (WHO).

The virtual RWG meeting was conducted on 22 March 2022 with the general objective to harmonize and coordinate partner support to countries in the Region in order to revitalize routine immunization coverage, following the COVID-19 pandemic, and operationalize the strategic framework for the South-East Asia Regional Vaccine Action Plan 2022–2030, which is aligned with the Immunization Agenda 2030. The specific objectives were to:

➢ support countries to plan actions for improving the routine immunization coverage to the pre-pandemic level and conduct catch-up immunization activities for children, who missed routine vaccines;
➢ support countries in integrating COVID-19 vaccination and routine immunization activities to the greatest extent possible;
➢ discuss and facilitate introduction of new vaccines that are planned in the current biennium or were planned in 2020 and 2021 but had to be deferred due to the COVID-19 pandemic;
➢ discuss the Regional Vaccine Implementation Plan 2022–2026; and
➢ discuss operationalizing Gavi 5.0 strategy in the Region.

The agenda of the meeting is attached herewith as Annex 1 and the list of participants is added as Annex 2.1.

2. Opening session

Dr Sunil Bahl, Coordinator (COVAX, IVD), WHO SEARO, welcomed the participants and presented the objectives of the meeting. He appreciated the robust collaboration among RWG partners to support countries for maintaining and revitalizing the routine immunization and vaccine preventable disease surveillance, following the COVID-19 pandemic, and rolling out COVID-19 vaccination.

Mr Basil Rodriques, Regional Health Adviser with the East Asia and Pacific Regional Office of UNICEF, mentioned that the RWG meeting was timely because there is a need to refocus again on routine immunization and get countries back on track. He stressed the meeting would be a good platform to discuss the challenges observed and the ways in which those challenges could be addressed together. Harmonization and coordination of partner support to countries are important since a team is stronger than individuals.
Dr Günter Boussery, Senior Health Specialist with the Regional Office for South Asia of UNICEF, highlighted that multiple waves of COVID-19 circulation severely affected immunization services in countries in the WHO South-East Asia Region. The slowing down of COVID-19 transmission has provided an opportunity to discuss the country experiences and how the experiences from COVID-19 can be used to leverage RI services to increase coverage of both COVID-19 and routine immunization.

Ms Colette Selman, Regional Head, Asia-Pacific Region, Gavi, the Vaccine Alliance, appreciated the efforts of WHO and UNICEF country offices in supporting the countries over the past two years in a complex and challenging pandemic environment. The Gavi 5.0 Strategy was launched a year ago and aligned with the UNICEF and WHO strategies for reaching zero-dose children and leaving no one behind, thus identifying communities that had been systematically missing routine vaccinations. There are new applications for Gavi support, a new platform for reaching zero-dose children and funding opportunities for countries. The RWG meeting provides learning opportunities between countries and help address issues thereby creating the momentum to move forward.

2.1 Regional status of immunization and vaccine preventable disease (VPD) control and Regional Vaccine Implementation Plan 2022–2026

Dr Sunil Bahl presented an update on the status of immunization and VPD elimination/control in the South-East Asia Region and the South-East Asia Regional Vaccine Implementation Plan 2022–2026.

The key points from the presentation were:

- Routine immunization coverage (3 doses of diphtheria-tetanus-pertussis vaccine / DTP3) in the South-East Asia Region increased steadily to reach 91% in 2019, but dropped from 91% to 85% in 2020.
- The number of unvaccinated or under-vaccinated children increased from 3 million to 4.9 million.
- Six countries maintained immunization coverage (DTP3) above 90% in 2020, although subnational variability was seen in 2019 and 2020.
- Despite delays, new vaccine introduction and surveillance were progressing well in the Region with a number of countries introducing new vaccines during 2020–2021.
- However, surveillance activities encountered multiple challenges due to the COVID-19 pandemic.

The main achievements of the Region include maintaining the polio-free status (certified in 2014), maintaining the maternal and neonatal tetanus elimination status of the Region (achieved in 2016), making progress towards the Reginal Flagship Programme on – “measles and rubella elimination by 2023”, elimination of measles in five countries (achieved between 2017 and 2019) and elimination of rubella in two countries (achieved in 2020). Hepatitis B was controlled through immunization in four countries (achieved in 2019). These achievements are at a risk because of the reduction in the routine immunization coverage.
The Region has progressed well in COVID-19 vaccination and 10 out of 11 countries are offering vaccines – all have reached the first target of 40% fully vaccinated coverage. Two countries (Bhutan and Thailand) have reached the next target of 70% full vaccination. The first-dose coverage in the Region is 68% and the primary series coverage is 56%.

The Strategic Framework for Regional Vaccine Action Plan 2022–2030 has been developed; it was endorsed by the Regional Committee in September 2021. Work on the Regional Vaccine Implementation Plan 2022–2026 is being carried out, for which regional partners are developing the monitoring framework with identification of baseline targets, national targets and score cards.

The main challenges now are renewing political and organizational commitment for immunization despite the COVID-19 pandemic, identifying new ways of working, supporting subnational levels, ensuring consensus of all stakeholders, demand generation and addressing vaccine hesitancy, supporting some countries for data quality improvement, and conducting frequent analyses to take corrective actions.

The next steps are the following:

- Reach consensus on modalities of RWG support to countries to improve immunization coverage and equity.
- Take all opportunities to vaccinate children and women, who missed routine immunization.
- Identify opportunities for combining COVID-19 vaccination with routine immunization.
- The regional office will consolidate feedback and develop a revised Regional Vaccine Implementation Plan 2022–2026.
- Synergize partner support to the countries.
- Enhance focus on the subnational level for continuous quality improvement.
3. Session: Improving coverage and equity of routine immunization amid responding to the COVID-19 pandemic

3.1 Revitalizing routine immunization services

3.1.1 Bangladesh’s experience of revitalization of routine immunization after the initial lockdown period in 2020

On behalf of the country offices of WHO and UNICEF in Bangladesh, Dr Balwinder Singh, Medical Officer, WHO Country Office of Bangladesh presented the impact of the COVID-19 outbreak on routine immunization from 2020 to 2021.

Following the COVID-19 outbreak in 2020, routine immunization sessions were affected from March to May 2020, leading to a coverage decline (3 doses pentavalent vaccine/Penta 3 coverage by 22% in March, 68% in April and 53% in May). The programme undertook infection prevention and control (IPC) training of health workers in small batches to build their capacity on IPC during immunization sessions and boost their confidence for continuing vaccination despite the COVID-19 pandemic, following which the routine immunization coverage picked up rapidly. However, a nationwide protest of health workers in November 2020 again led to a decline in coverage.

After the protest was resolved, a nationwide measles-rubella campaign was undertaken in January 2021 during which 35.3 million children were vaccinated. Bangladesh undertook routine immunization catch-up during the World Immunization Week in April 2021 and vaccinated 60,000 zero-dose children. The second wave of COVID-19 in June 2021 also led to some reduction in routine immunization coverage. Nevertheless, the third wave of COVID-19 in January 2022 did not affect routine immunization coverage.

A comparative analysis of coverage between 2019 and 2020 showed that all divisions had similar trends in routine immunization throughout the COVID-19 pandemic. It was found that 20% (24,400) routine immunization sessions were not held in April 2020 and 28% (36,600) in May 2020. Hence, in 2020, compared with 2019, Penta 3 coverage declined by 22% in March, 68% in April and 53% in May. The urban areas were more affected than the rural ones due to lockdowns. For example, the Penta 3 coverage in urban areas was 27% as compared with 50% in rural areas in April 2020.

The following factors contributed to the revitalization of routine immunization in Bangladesh:

There was a high level of political commitment with regular messages from the Prime Minister to revitalize routine immunization.

➢ The periodic assessment of COVID-19 impact on routine immunization was carried out through development of tools to identify functionality of health facilities and their staff affected by the pandemic and the effect on routine immunization coverage and VPD surveillance, including outbreak detection, storage and shipment of VPD samples.

➢ Routine immunization and VPD review were undertaken in priority districts and city corporations jointly by the partners and the government. This deep dive was conducted to assess the quality of the generated data at all levels and the findings were shared at all operational levels for corrective actions.
- Reviewed and strategized microplanning for routine immunization was carried out in all areas, including Cox’s Bazar.
- Health management information system (HMIS) data was monitored on a monthly basis, using DHIS2, and virtual meetings were conducted by EPI with underperforming districts.
- Routine immunization services were resumed following in-person IPC training for 26,000 vaccinators and development of guidelines for vaccination. The training boosted the confidence of the vaccinators and dispelled their fears.
- Community engagement remains instrumental and the health workers, including vaccinators, are trusted and accepted as most of them reside in the same community.
- Access to vaccination session sites was facilitated even during lockdowns and access to outreach vaccination sessions was facilitated by the government through presentation of EPI cards at the security checks. Messages in media informed parents about this arrangement.
- Tracking of supplies: Despite lockdowns, vaccine supply was ensured, based on vaccine alerts, and no major vaccine and logistic stock-out reported. UNICEF supported vaccine distribution through special shipment and distribution from national to subnational levels. The WHO Surveillance and Immunization Medical Officer (SIMO) network also supported transportations from district to upazila levels.
- The SIMO network and UNICEF field staff members were available for local-level advocacy, planning and on-the-spot support.
- Institutions such as the Islamic Foundation played a big role in reaching out to communities for acceptance of vaccines. The engagement of religious leaders played an important role since they disseminated messages on continuing vaccination of children to parents through public service announcement (PSA), media interviews, posters and leaflets. Announcements from mosques during the time of prayers played a key role in community mobilization at the local and grassroots level. Media platforms, including social media (in local language), were engaged. UNICEF played a key role in communication with development and dissemination of social media packs for all social media platforms. Opportunities of media briefings for COVID-19 were also used to reinforce messages for continuation of routine immunization.
- Real-time, concurrent house-to-house monitoring was initiated in high-risk areas to identify gaps in routine immunization. This was combined with session site monitoring of immunization, coupled with real-time corrective actions.
- Regular review meetings were held through virtual platforms.
The way forward is to

➢ Ensure that no one is left behind because of the COVID-19 pandemic and undertake triangulation of data to carry out focused actions.
➢ Continue capacity-building of health workforce through face-to-face and virtual platforms.
➢ Re-establish and strengthen review and feedback mechanisms, including face-to-face meetings.
➢ Ensure orientation of middle-level managers.
➢ Sustain and strengthen civil society and non-governmental organization (NGO) networks.
➢ Ensure continuation of the WHO SIMO network and UNICEF field staff members that played a very important role in revitalization of RI and COVID-19 vaccination.

3.1.2 Revitalizing routine immunization services in the South-East Asia Region

Dr Jayantha Liyanage, Regional Adviser, ISS, IVD, WHO SEARO, summarized the actions taken by the countries for revitalization of RI services during the pandemic in a presentation.

A virtual meeting of RWG was conducted in April 2020 to identify support required by countries for immunization and VPD surveillance. Subsequently, the WHO South-East Asia Regional Immunization Technical Advisory Group (ITAG) meetings in July 2020 and August 2021 reviewed the status of routine immunization, together with the national immunization programmes and partners.

The annual reports submitted to ITAG by the national immunization programmes have analysed revitalization of RI at national and subnational levels. The recommendations from ITAG have been followed through country-focused virtual meetings hosted by Gavi, UNICEF and WHO. The activities are in accordance with the Regional Vaccine Action Plan 2022–2026, which emphasizes the need to focus on revitalization of routine immunization while supporting COVID-19 vaccination.

The impact of the COVID-19 pandemic on routine immunization in each of the South-East Asia Region countries was highlighted. Routine immunization was impacted significantly in Bangladesh and Bhutan in 2020. However, programmes have recovered and sustained vaccination coverage in 2021 despite the COVID-19 Delta
and Omicron waves, when compared with the 2019 coverage. India, Maldives, Sri Lanka and Thailand experienced a immunization coverage decline in 2020 with recovery and also had some reduction in 2021. Indonesia had a significant reduction in routine immunization coverage, which continued in 2021, despite making a recovery in the latter half of 2020. Significantly low coverage in the Democratic People’s Republic (DPR) of Korea, Myanmar and Timor-Leste was also affected by reasons beyond the COVID-19 pandemic.

National guidelines on immunization/VPD surveillance during the COVID-19 pandemic developed in 2020 by most countries; updated in 2021, based on learnings from 2020

- Alternative strategies/innovations for conducting fixed and outreach sessions during high transmission of COVID-19
- Catch-up vaccination for missed children (infants, schoolgoing children, adolescents) and pregnant women
- Infection prevention and control during EPI sessions
- High coverage of COVID-19 vaccination in health-care workers
- Communication strategies and tools
- Real-time monitoring of routine immunization coverage nationally and subnationally in most countries
- The upper age limit to provide vaccines through routine immunization was increased in some countries

National guidelines on conducting immunization sessions and VPD surveillance during the COVID-19 pandemic were developed in 2020 by most countries and updated in 2021, based on learnings from 2020. Key elements include:

- Alternative strategies and innovations for conducting fixed and outreach sessions during the COVID-19 pandemic;
- Catch-up vaccination for missed children (infants, school attending children, adolescents) and pregnant women;
- Infection prevention and control during EPI sessions;
- High coverage of COVID-19 vaccination among health-care workers;
- Communication strategies and tools;
- Real-time monitoring of routine immunization coverage nationally and subnationally in most countries; and
- The upper age limit of routine immunization raised above two years in countries for catch-up vaccination of missed children.

Following are the key highlights from countries on revitalization of routine immunization:

- Bangladesh: Routine immunization programme performance was regained by 2021, and the country is moving to developing the National Immunization Strategy.
- Bhutan: Routine immunization programme performance was regained by early 2021. The focus is on COVID-19 booster doses and vaccinating >5-year-old children with COVID-19 vaccine.
- DPR Korea: Routine immunization has been halted since 2021 due to non-availability of vaccines following complete border closure.
India: The country adopted a tailored approach for strengthening routine immunization through Mission Indradhanush (MI) in 2021 and 2022. Implementation of Mission Indradhanush 4.0 was carried out (February to April) in 416 selected districts.

Indonesia: The country analysed immunization coverage by provinces and triangulated with the VPD surveillance data to identify areas at high risk. A high-level national meeting was held with provincial policy makers, pledging for revitalization of routine immunization, and a study on behavioural and social drivers of vaccination and vaccine acceptance was conducted. The findings from the analysis of routine immunization coverage, VPD surveillance data and the studies were extensively discussed in a recent meeting to develop a proposal for Gavi middle-income country support. Indonesia is planning for a National Children Immunization Month (BIAN) in two phases (May–June and July–August 2022).

Myanmar: Routine immunization coverage has significantly reduced. The routine immunization revitalization plan was developed in 2020 by all stakeholders and discussions were initiated to operationalize the action plan, which was subsequently updated in 2021.

Nepal: Routine immunization coverage has significantly reduced. Plans are in place for identification and vaccinating the children, who missed any vaccination, during the upcoming typhoid conjugate vaccine TCV immunization campaign.

Sri Lanka: There has been some reduction in routine immunization coverage and delays in reporting coverage to the national level were also a factor for the coverage dip. Following control of the COVID-19 situation, district-level immunization programme reviews and other interventions have been restarted.

Thailand: Routine immunization coverage has significantly reduced. Following successful COVID-19 vaccination, the government is focusing on improving routine immunization in provinces with low performance and improving demand generation.

Timor-Leste: Routine immunization coverage has reduced very significantly. The limited operational costs to conduct routine immunization sessions were identified as the key reason. Many of the interventions in the post-transition plan are yet to be implemented. There is an urgent need to conduct a multistakeholder dialogue or joint appraisal.

The way forward is to

- Support countries in implementing already identified interventions to revitalize routine immunization.
- Ensure joint advocacy by immunization partners with policy makers, including engagement of all stakeholders in multi-stakeholder dialogues.
- Highlight the need for intensified data analysis and alert system for evolving risks, as demonstrated by Bangladesh.
- Ensure close follow-up with priority countries on implementation of ITAG recommendations, NITAGs and immunization programme reviews and other relevant assessments:
  - use of country-specific matrices for regular follow-up calls and country visits; and
  - integration of recommendations in new national immunization strategies under development.
➢ Expand technical support to subnational levels.
➢ Address vaccine hesitancy and demand generation in identified countries is a priority.
➢ Ensure continuous monitoring of performance and taking corrective action, including communication activities, catch-up vaccination and building capacity of mid-level managers.
➢ Ensure partner support at the subnational level and advocacy at highest levels. Monitoring needs to be carried out at the subnational level for tailored actions.

3.1.3 Discussions

➢ Bangladesh and Bhutan have recovered from the immunization coverage decline experienced in 2020, but other countries did not recover fully, leading to coverage gaps in children, who are growing older. Hence, raising the age for catch-up vaccination by countries would be essential.
➢ Advocacy through religious leaders and islamic foundation societies for revitalization of routine immunization, following the Bangladesh example, can also be used in other countries such as Indonesia.
➢ It is critical for India and Indonesia to implement identified strategies for revitalization. More efforts are needed for DPR Korea, Myanmar and Timor-Leste for revitalizing routine immunization.

3.2 Catch-up immunization activities for children and women who missed vaccination

3.2.1 Presentation on catch-up immunization activities, conducted in countries, and the planned activities for 2022

Dr Azhar A. Raza, Regional Immunization Specialist from UNICEF ROSA presented on catch-up immunization in the Region. Catch-up vaccination refers to the action of vaccinating an individual who, for whatever reason, is missing or has not received doses of vaccines for which he/she is eligible, as per the national immunization schedule, and the objective is to close the immunization gaps. Service delivery failures or competing immunization priorities are the key triggers for immunization catch-up.

In the South-East Asia Region, Bangladesh, India and Nepal conducted catch-up immunization activities in 2021. These activities were able to reach unvaccinated and partially vaccinated children. Bangladesh, India, Indonesia and Nepal planned immunization catch-up activities in 2022 with the measles/TCV vaccination campaign in Nepal or during the World Immunization Week (24–30 April in Bangladesh). Implementing catch-up vaccination should be a regular feature of routine immunization plans, not merely considered after a pandemic or a crisis.
Additional follow-up points:

➢ Engagement of religious leaders has played an important role in catch-up with immunization and motivating communities and should thus continue.

➢ There is a need for advocacy with national governments to raise the age for vaccination to ensure that children, who have missed routine doses during the pandemic, are identified and vaccinated.

3.2.2 Overcoming the impact of the COVID-19 pandemic on immunization coverage of India through “Mission Indradhanush” in 2021 and 2022

Dr Sachin Rewaria, National Professional Officer- Science and Training in the WHO Country Office for India presented the experience of conducting catch-up immunization under Mission Indradhanush in 2021 and 2022 during the pandemic.

Routine immunization coverage in India had been steadily increasing. However, following the COVID-19 pandemic, there was a 6% decline in DTP3 coverage in 2020, resulting in India becoming the country with the largest number of unvaccinated and under-vaccinated children globally.

The Government of India has been undertaking catch-up immunization campaigns through its flagship programme, known as Mission Indradhanush. Intensified Mission Indradhanush 3.0 campaigns were conducted in February and March 2021 in 250 out of the 734 districts in the country, just before the second COVID-19 wave, triggered by the Delta variant.

India conducted a deep-dive study in July 2021 in seven states to identify the reasons for a decline in immunization coverage. The following key reasons were identified: interruption of immunization services during the lockdown from April to May 2021, large-scale migration of population resulting in missed and delayed vaccination, vaccine stockouts, engagement of manpower in COVID-19 activities and data issues.

Based on a composite index derived from pentavalent, measles and inactivated poliovirus vaccine (IPV) coverage, VPD incidence, the actual number of children missed, vaccine hesitancy and migration, 416 districts had been identified for three rounds of Mission Indradhanush in the months of February, March and April 2022.

Key guiding strategies laid out by the Ministry of Health (MoH) for MI 4.0 are:

➢ The target of Mission Indradhanush is to reach at least 90% full immunization coverage with a focus on identification and vaccination of beneficiaries missed during the pandemic.

➢ The focus is on containment zones, where sessions were not held, and pockets from where migrants migrated during the lockdowns.

➢ Timings for session sites are to be flexible, especially in urban slums.

➢ There will be implementation of innovations, such as vaccination on demand and where sessions will be conducted, based on timings suggested by the resident welfare associations.

➢ Sessions will be conducted for seven continuous days, including Sundays and holidays, since the same workforce is providing COVID-19 vaccination.

➢ IPC at session sites is to include:
  • IEC materials on COVID-19-appropriate behaviour (CAB) on session sites;
  • staggered mobilization of beneficiaries;
  • messages on COVID-19 vaccination and continuation of CAB; and
  • disinfecting seating space and equipment after completion of session.
The way forward is to

➢ Bring attention to immunization – frequent reviews, sensitization.
➢ Identify and vaccinate 3.5 million children, who missed vaccination in 2020:
  • Ensure catch-up vaccination plans/Mission Indradhanush; and
  • Identify and plan vaccination of migrants.
➢ Focus on system strengthening through frequent reviews of immunization performance and development of coverage improvement plans.
➢ Develop coverage improvement plans for high-risk states/districts:
  • further deep dives to guide actions.
➢ Focus on timeliness and missed opportunities for vaccination:
  • Improve availability of all vaccines on session site.
  • Sensitize vaccinators to administer multiple injections.
➢ Adapt communication strategy – include timeliness and missed opportunities.
➢ Improve immunization data management:
  • denominator issue; and
  • data quality assessments.
➢ Ensure recognition for best-performing health workers for motivation purposes.
➢ Ensure high-quality polio immunization campaigns.

3.2.3 Nepal experience of tracing and vaccinating due and defaulter children under 5-years-of-age during the measles rubella (MR) immunization campaign in the middle of the COVID-19 pandemic and plans during the TCV vaccination campaign in 2022

Dr Rahul Pradhan, National Professional Officer in the WHO Country Office for Nepal shared the experience of tracing and vaccinating defaulter children under five years of age during the MR immunization campaign in the middle of the COVID-19 pandemic.
Nepal conducted a nationwide MR vaccination campaign in 2020 for children aged 9 to 59 months. The campaign was conducted in two phases, the first from mid-February to mid-March and the second from mid-May to mid-July. Along with MR, oral polio vaccine (OPV) was provided in (selected) 19 high-risk districts for children aged 0–59 months. However, lockdowns due to the COVID-19 pandemic started in the third week of March. The campaign was used to identify and vaccinate missed children. All eligible children were provided with invitation cards for the campaign. Children aged up to two years were asked to bring the invitation cards and their routine immunization cards to the MR session sites. Health-care workers (HCWs) used missed doses of MR vaccine as a flag to identify children, who might have missed other EPI antigens.

Information on these children was recorded and they were subsequently followed up by the programme for vaccination. HCWs were also trained to identify zero-dose children within the community and motivate them for vaccination.

Additional activities carried out for finding and vaccinating missed children included the following:

- age for catch-up vaccination extended to 5 years;
- national guidelines and training materials developed for including vaccination of missed children, followed by cascaded training at all levels;
- communication and advocacy for catch-up and MR vaccination through:
  - use of mass media, such as radio/FM (in local languages), TV, newspaper advertisements, SMS, communication channels, phone messages;
  - miking at the local level, including that in hard-to-reach (HTR)/marginalized/risk areas, and interaction with religious/community leaders;
  - involvement of immunization committees at all levels, districts, pallikas and wards; and
  - invitation cards for the campaign utilized for messaging.
- microplanning at the health facility/ward level;
- rapid convenience monitoring, including independent monitoring (house-to-house), with a focus on hard-to-reach areas;
- social and behaviour change communication strategy to increase demand for routine immunization and strengthen community-engagement; and
- interim guidance for reproductive, maternal, newborn, child and adolescent health (RMNCAH) services during the COVID-19 pandemic.

Typhoid conjugate vaccines were introduced in Nepal from 8 April 2022. The target population to be covered was 7.4 million children and adolescents aged between 15 months to 15 years. Immediately following the TCV campaign, TCV was to be introduced in routine immunization at 15 months of age. The programme will utilize the opportunity to strengthen and promote routine immunization through IEC by identifying children, who have missed any routine antigen, as per MR catch-up campaign experience. The introduction of TCV was also be used to strengthen and promote good hygiene behaviours by advocating widely for improved hygiene.
Discussions and the way forward

Actions needed to sustain the gains and bring the identified missed children into the fold of routine immunization include:

- Conduct periodic immunization performance reviews.
- Develop continuous improvement plans.
- Have a communication strategy.
- Engage in data management.
- Ensure continuation of immunization monitoring at all levels, including the community and HMIS data analysis and tracking.

3.3 Synergizing routine immunization services and COVID-19 vaccinations

3.3.1 Combining COVID-19 vaccination with routine immunization: Country perspectives

Dr Pankaj Bhatnagar, Technical Officer (Health Systems), WHO-SEARO presented on integration of COVID-19 vaccination and routine immunization on behalf of WHO and UNICEF. Integration was defined as using an opportunity to provide routine immunization and COVID-19 vaccination activities in combination, and it is not defined as the integration of COVID-19 vaccination into the routine vaccination programme of the country, given that there is no Strategic Advisory Group of Experts on Immunization (SAGE) guidance on this yet.

At the service level or the health centre level, COVID-19 and routine immunization vaccination can be combined in different ways, such as: a) the same fixed or outreach site can provide RI and COVID-19 vaccination on different days as is being carried out in Bangladesh and India; b) both vaccinations are provided from the same centre and on the same day, but with different timings, e.g. morning sessions for RI and afternoon sessions for COVID-19 vaccination, this is being done in Maldives; and c) the same health centre provides both vaccinations during the same timings, this is being practised in a limited number of settings, where coverage with primary COVID-19 vaccines is high. However, effective microplanning is needed to manage workload and logistics and train health workers, with considerations for space constraints (for social distancing) and health worker fatigue.
Combining COVID19 vaccination and RI activities at different levels

➢ To optimize the resources and tools available for optimum benefits for both COVID-19 vaccination and RI.

- National/provincial/district
  - programme planning and review meetings;
  - logistics planning – distribution, cold chain;
  - demand generation activities using COVID-19 communication and reinforcing the importance of RI;
  - trainings – refresher;
  - monitoring and supervision.

- Data recording and reporting systems
  - including recording of COVID-19 vaccination in home-based records for paediatric populations above 5 years of age;
  - updating RI microplanners to include COVID-19

- Health centres (fixed/outreach) providing C-19 and RI vaccinations on the same day
  - different session timings for C-19 and RI;
  - same session timings for C-19 and RI

- Special approaches to reach health-care workers, immunocompromised people and people with comorbidities with COVID-19 vaccines

Currently, the COVID-19 vaccination and routine immunization are siloed, and the same structures and health-care workers are used, despite the different target age groups. Furthermore, in countries in the Region, the focus is still on reaching the remaining population for COVID-19 vaccination. Very few countries in the Region are integrating COVID-19 and routine immunization; Bangladesh, Nepal and Sri Lanka have implemented some integration, while Indonesia and Timor-Leste have a plan to integrate COVID-19 vaccination with routine activities, but these are still under consideration, given the constraints.

The next steps include:

➢ documenting lessons learned from combining activities;
➢ developing regional guidelines for microplanning, mobilizing people and resources, conducting immunization sessions and monitoring;
➢ mobilizing partner support to advocate with governments for integration of activities; and
➢ technical and financial support to countries to implement such an integration.

3.3.1 Sri Lanka experience of combining routine immunization sessions and COVID-19 vaccination

Dr Preshila Samaraweera, National Consultant in WHO Country Office for Sri Lanka presented the country’s experience of combining routine immunization sessions and COVID-19 vaccinations. When Sri Lanka moved into the “new normal” status, integration was explored because the same health-care personnel provided vaccinations in a routine immunization session and COVID 19 sessions. In 2021, the vaccinators had to conduct two or more sessions in the same area to cover both routine and COVID-19 vaccinations. Integration was successfully planned and opportunities and challenges were observed.

Sri Lanka is divided into 356 subnational areas under the Ministry of Health. Every day, each medical officer of health (MoH) area organizes four COVID-19 immunization sessions at fixed or outreach centres. For combining routine immunization with COVID-19 vaccination, two out of the four centres conduct daily for some location in the MoH area at mother and child health (MCH) clinics that provide routine immunization. Field-level immunization clinics are known to the community for vaccination and are well-accepted since beneficiaries get the vaccination at their convenience. This strategy needed adequate publicity to make the community aware of the availability of COVID-19 vaccination in routine immunization clinics.
Lessons learned through the combination of COVID-19 vaccination with routine immunization sessions include the opportunity to screen parents and caregivers for COVID-19 booster doses during routine immunization sessions, use of targeted questions to identify high-risk, unvaccinated households, the ability to use field-level immunization clinics, which are well-accepted by the community, and a need for adequate communication to make the public aware of the availability of COVID-19 vaccination in routine immunization clinics.

There was robust public trust, staff were well trained in immunization, vaccination data was managed by days of operation, cold chain equipment were updated, and the vaccine management systems were improved. On the other hand, there was health worker fatigue while maintaining routine services by the same staff, vaccine hesitancy for the third COVID-19 dose, inability of high-risk, unvaccinated individuals to visit community clinics, and a lack of effective communication to address vaccine hesitancy.

Few targeted questions facilitated the identification of high-risk, unvaccinated household individuals (e.g. those above 60 years, parents with comorbid conditions, immunosuppressed individuals, etc.). They were followed up on at community clinics or vaccinated through mobile clinics.

4. Synergizing partner support for immunization

4.1 Operationalizing Gavi 5.0 in the South-East Asia Region

Ms Colette Selman highlighted that the Gavi 5.0 strategy is very much linked to the Immunization Agenda 2030, the Sustainable Development Goals and the Global Action Plan for Healthy Lives and Well-being for All. It leads to leaving no one behind with regard to immunization, with specific targets to reduce the number of zero-dose children by 50% by 2030. Hence, by the end of its time period in 2025, the Gavi 5.0 strategy is targeting to be on track with 25% reduction.

The South-East Asia Region is well on track in terms of both the key programme shifts and the quality of the work. The key shifts from Gavi 4.0 to Gavi 5.0 include the following:

- zero-dose children and missed communities as the starting point for country dialogue in planning for or reprogramming Gavi investments;
- a single theory of change at the country level for how all Gavi support aligns to identify and reach zero-dose children;
- greater focus on demand, community engagement and overcoming gender barriers as key enablers of reaching zero-dose;
- more deliberate approach to engaging a broader set of partners, including CSO and humanitarian actors;
- more differentiation of Gavi support and processes across country types and contexts; and
- a more purposeful advocacy to secure political commitment to prioritize zero-dose communities.

The identify, reach, monitor, measure and advocate (IRMMA) framework uses the zero-dose strategy to strengthen primary health care across life course. Gavi will use a systemic approach for zero-dose and expects countries to identify the barriers for zero-dose children, including the socioeconomic and gender barriers and the knowledge gaps. For improving reach to these children, the country will need to factor
in how all Gavi support can be used to reach zero-dose children, how strategies can be tailored to specific settings, how strategies can be community-centric and incorporate integrated services and which partners have comparative advantage to deliver and how they can be engaged.

IRMMA Framework – using the zero-dose strategy to strengthen primary health care across the life course

It will be important to monitor progress, including improving timely monitoring of progress in reaching zero-dose children, e.g. at the subnational level, assessing if programmes are on track, which trends might require course correction and what strategies are most cost-effective in redressing inequalities.

Advocacy for zero-dose will be important with key decision-makers at the national and subnational levels. For advocacy, evidence and arguments that will be most compelling, including factoring in those that might object and how they can be convinced, will be essential.

Consideration needs to be given to seeing what the different entry points are and how one can support the other; for example, how routine immunization can support MR elimination and vice versa. The idea is to capture opportunities requiring planning, financing and programme management to come together in identifying zero-dose children and then sustaining that over time.

Key focus areas in 2022

- Bring back the focus on restoring, strengthening, and sustaining immunization coverage, reaching zero-dose/missed children. Work with local partners, develop tailored reach strategies, and implement innovative approaches.
- Introduce and scale up new vaccines.
- Ensure quality follow-up campaigns, with tailored subnational strategies, seeking opportunities for integration with other antigens and support.
- Strengthen political commitment and sustainable, pro-equity financing for immunization. Support sustainable transition.
- Support countries in achieving their COVID-19 vaccination targets, prioritizing vulnerable populations and seeking integration opportunities with routine immunization.
- Use all funding levers in a holistic way and catch up on delays in implementation of Gavi support: HSS grants, partners’ engagement framework (PEF) targeted country assistance (TCA), new applications.
- Continue to build countries’ capacities, through management surge support and technical assistance.
The Gavi 5.0 funding levers provide support for vaccines and the health system. A new funding component under 5.0 is the equity accelerator funding for countries, which are eligible and have received funding, which is specifically provided as a top-up for countries to reach zero-dose. Tailored strategies need to be developed under this for zero-dose. Gavi continues to have cold chain equipment support and has new guidelines and this is the middle-income strategy. This is being developed and includes funding for countries in post-transition. Hence, these countries have an opportunity of moving forward to either make one integrated request for funding or through a full-portfolio planning process or through standalone applications. Even with the standalone applications, countries still need to show the linkages between the different strategies.

Gavi has a new secretarial organizational set-up under which there are three segments – core country segment, high-impact country segment and fragile and conflict country segment. India is in the high-impact country segment. Other Gavi-eligible countries in the Region are placed in the rest-of-the-world team under the core country segment. Gavi has a differentiated approach to these different units and, as indicated under the portfolio management model, it will be more differentiated in the way it works with countries.

Countries that are coming up for a new full-portfolio planning process will be offered training in the application process and the tools. Portfolio planning requires a lot of preparation, so the important programmatic pieces, such as identification of the zero-dose, EVM assessments, health sector plans, etc., are considered in the application.

Countries in the SE Asia Region have moved in terms of their status of transition. Bangladesh has come into the accelerated transition phase, which means that five years from now, the country will fully transition from Gavi support and is expected to fully finance all the vaccines.

4.2 Partner updates

BMGF: Increase focus on routine immunization.

USAID: US Congress dedicated significant funding support for COVID-19 response and routine immunization to avoid backsliding. The funding supports cold chain equipment, cold chain monitoring and evaluation support for COVID-19. Countries such as Indonesia and Timor-Leste have received money that is tagged for COVID-19 vaccination, but it has some flexibility and will also be supportive of routine immunization.
In India, the US Agency for International Development (USAID) supports planning and monitoring of routine immunization and on-the-ground support in focus states. COVID-19 funding has been provided for initiating the environmental surveillance activities for COVID-19, building on the polio environmental surveillance, and to the Child Survival Collaborations and Resources Group (CORE) social mobilization network for demand generation. USAID also supports WHO and CORE for continuation of polio eradication endgame strategy. It supports John Snow India (JSI) for demand generation.

**World Bank:** The World Bank has provided US$ 2 billion to countries for COVID-19 response, including purchase of emergency use listing (EUL) vaccines. This funding was partially used because not all countries could buy those vaccines since there was no flexibility to procure vaccines that were not emergency-use listed by WHO. Additionally, the World Bank is supporting projects in primary health care and sectorwide approaches in the countries. There is a need to tailor strategies, as per country needs, and now the World Bank would focus on global preparedness for future pandemic response.

5. **Conclusions and follow-up actions**

- RWG partners have been providing optimum support for mitigating the impact of the COVID-19 pandemic on immunization and vaccine preventable diseases surveillance. To revitalize immunization to the pre-pandemic level and beyond, the following could be the focus areas:
  - Support for countries to implement the already identified interventions to revitalize routine immunization (i.e. Mission Indradhanush in India, the MR mass campaign together with the catch-up campaign to vaccinate the children who missed RI in Indonesia, the TCV campaign together with the catch-up campaign to vaccinate the children who missed routine immunization in Nepal, linking routine immunization with COVID-19 vaccination in difficult-to-reach communities in Timor-Leste).
  - Documentation of the successful revitalization of routine immunization in Bangladesh and Bhutan and share with other countries.
  - Support for triangulation of immunization coverage data and vaccine preventable diseases surveillance data to identify pockets of zero-dose and partially immunized children and vaccinate. Support for intensified data entry at the subnational level and alert system for evolving risks for routine immunization and address them.
  - Support re-establishing and strengthening national- and subnational-level review and feedback mechanisms, including face-to-face meetings.
  - Provision of technical support to subnational levels and promote engagement of all stakeholders at the subnational level. Provide partner support and WHO/UNICEF guidance to countries on how to rationally use the health workforce, given the fatigue faced, to provide routine immunization services and COVID-19 vaccination simultaneously or on the same day in different sessions.
➢ Support countries in demand generation and addressing vaccine hesitancy.

➢ Conduct comprehensive microplanning for catch-up immunization activities for countries with high-burden and inadequate vaccination coverage (India, Indonesia and Myanmar) and effective planning in countries aiming to conduct catch-up vaccination campaigns (Nepal and Timor-Leste).

➢ Provide partner support to Timor-Leste, where routine immunization has been severely affected by the pandemic, including workforce fatigue, human resource constraints and competing resources between COVID-19 vaccination and catch-up campaigns.

➢ Use supplementary immunization activities as an opportunity to record immunization cards in real-time and identify zero-dose and under-immunized children to inform and strengthen routine immunization.

➢ Use the RWG as a platform to continue to share learnings and support partners and countries.

➢ Strategize and tailor to country needs, looking at the bigger picture to support needs at the country level, as they are identified.

➢ Plan for a face-to-face RWG meeting in 2022.
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Annex 2

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