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IMMUNIZE AND PROTECT YOUR CHILD

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Joint WHO/UNICEF Statement

Planning Accelerated Immunization Activities

The following article is a summary of **Planning Principles for Accelerated Immunization Activities**, a joint WHO/UNICEF statement of guidelines intended to highlight some broad principles of program acceleration. These guidelines will be updated and revised as necessary to conform to new immunization policies as they evolve.

WHO and UNICEF are committed to achieving the goal of making immunization available to all children by 1990. Yet coverage remains unacceptably low in many countries, and accelerated activities are often necessary to raise coverage to levels which will have a significant impact on morbidity and mortality. Meeting the challenge will require an intensive mobilization of political will, application of new techniques of communication and social mobilization, and sustained management support.

Planning for acceleration

The key to deriving maximum benefit from accelerated immunization activities is planning. National or local immunization days can be effective means of increasing coverage in the short term, but will rarely lead to sustainable programs by themselves. Though good planning is necessary for routine immunization services, it is even more critical in the case of national immunization days when supplies and personnel must be available at precise times and places.

Training and supervision. All individuals involved must be identified well in advance and trained to know exactly what they are expected to do. Adequate supervisory staff and good communications are vital to ensure that errors or unforeseen problems are quickly identified and corrected.

Supplies. Planning should take into account the realities of lead-times required to procure supplies and equipment. Before deciding to use the strategy of immunization days or setting a target date for the day, program managers must confirm that adequate supplies of vaccines can be provided on time. A lead time of three to four months is

usually necessary to ensure vaccine supply, and an even longer time may be required to provide the necessary training and logistic components of the program.

Social mobilization. The public side of the program also requires meticulous planning and ample lead time. Effective social mobilization depends on tailoring the content and delivery of messages to the different groups involved in fomenting participation. The messages, means and materials used to reach the target audiences



Good advance planning and publicity will help ensure maximum attendance at vaccination sessions and motivate mothers to bring their children back to complete their immunization schedules.

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must be compatible with long-term programs as well as short-term intensified programs.

Feedback. Health staff and community workers should receive feedback on their performance, including results of the coverage achieved.

Financing. Finally, one should consider the costs of acceleration and the sources of financing. Funds can often be mobilized from a variety of volunteer services for the short term, but are rarely so freely available over a period of several years. The long-term objective is national fiscal and technical self-sufficiency.

Improving existing primary health care services

The long-term goal of acceleration is to strengthen the health infrastructure to assure continuous provision of immunization and other primary health care services. But strengthening the existing delivery and information systems can also help to increase coverage rapidly in the short term. Some ways in which existing health services might be improved include the following:

- Ensure staff receive adequate *training, supervision, and logistic support*. Clinics need to be organized so that immunizations are offered at all times, waiting lines are short, and mothers are well informed of when to bring their children back. All health personnel should be aware that minor illnesses or malnutrition are not contraindications for immunization.

- Mobilize *community resources*. Community members should play a major role in deciding the time and place of immunization clinics. They can also help identify children who require immunization and "channel" them to the health services. In Colombia, channeling is carried out by a respected community member and a health worker who visit homes together, identify children, register them for the program and provide health education and motivation.

- Direct *health education* efforts toward school children who can motivate their parents to assure that younger children in the household are fully immunized. Community efforts on behalf of immunization should be encouraged to develop into permanent support for primary health care as a whole.

Four specific areas of action may be suggested to increase immunization coverage by accelerating and strengthening existing services:

- 1) Provide immunization or information about immunization at every health contact.

- 2) Reduce dropout rates between first and last immunizations by involving the community more, providing immunization services at more convenient times and places, and increasing outreach clinics. Intensified efforts should also be made to inform parents of the need to return, to identify all eligible children, and to follow up those who are missed.

- 3) Increase the priority given to the control of measles, poliomyelitis and neonatal tetanus.

- 4) Provide immunization services to the disadvantaged in urban areas.

Acceleration by national immunization days

There may be strong incentives for recommending a mass mobilization activity, particularly where political commitment to an immunization effort is high. Typically, such an effort involves the support of volunteer workers, backed by intensive publicity, who supplement the routine health services in order to provide immunization to all members of the target group living in a particular city, district, or country. The activity may last only a single day, or a series of single days, or it may be continuous for several days or weeks.

Strategies for success

The success of mass mobilization efforts requires meticulous planning and organization of logistics, staffing, and publicity to assure that vaccine is available when and where needed, that volunteers are adequately trained, and that the public is well informed about the program and motivated to participate. The personal involvement of political leaders at the highest levels has also been an important ingredient.

Risks as well as benefits

The risks as well as the benefits of national immunization days need to be considered. The fundamental issue is *sustainability*. Few societies can mobilize full participation in national days for more than a few years. Where infrastructure and managerial skills are weak, efforts may falter earlier, and even initial efforts may exact an exorbitant cost in terms of other health activities suspended in order to concentrate on immunization activities. Negligible benefits in reducing morbidity and mortality may result due to the failure to immunize a sufficient proportion of infants under one year of age, who are often harder to reach than older children able to walk on their own.

The failure to sustain immunization services in the wake of the high levels achieved in national campaigns can result in epidemics once enough susceptible children are born into the population to sustain disease transmission. Health authorities may respond with another mass program, and the cycle is repeated: waves of disease followed by waves of immunization.

National and community commitment

Commitment must be sought both within and outside the health sector. The support of national political leaders for immunization days should be translated into a national political objective which transcends individuals and pol-

itical parties. Parents need to be motivated not only to participate in national days, but to seek routine services and not simply wait for the next campaign.

Target groups and documentation

Careful thought should be given to the age groups to be targeted and the documentation required. If vaccines against all the EPI diseases are included, which is strongly encouraged, record keeping and immunization according to previous immunization history are mandatory to assure that each child receives the correct number of doses. The upper age limit for administration of all vaccines will generally be two years, though it may be higher if the epidemiological situation warrants. Children younger than six weeks should not receive DPT and those younger than nine months should not receive measles vaccine.

During the second year or cycle of the immunization days, the number of eligible children will decline, approximating the number of children born since the start of the previous year or cycle, plus those remaining below the age ceiling who were missed previously. If the initial cycle has been successful, the number of eligibles will decline sharply. For the subsequent annual cycles to remain effective, a channeling strategy which actively seeks out susceptible children is likely to be needed.

Oral polio vaccine

Where only oral polio vaccine is provided, some programs have offered immunization to all children below the upper age limit regardless of previous immunization history, and have not provided individual immunization records. This has the advantage of logistical simplicity; however, lack of immunization records complicates the task of evaluation.

Tetanus toxoid

In countries where neonatal tetanus remains a problem, public health officials should consider providing women of childbearing age with tetanus toxoid during the immunization day in addition to the immunizations for children. An immunization record for women is advised under these circumstances as hyperimmunization with tetanus toxoid can provoke adverse reactions.

Role of volunteers

The role of volunteers needs to be carefully defined. While it may be easy to train them to properly administer oral polio vaccine, the injectable vaccines pose considerably more challenge, and unacceptable rates of vaccine wastage and abscesses may occur. Untrained volunteers are perhaps best used to help in registering the target population prior to the program and to help assure that those registered come for immunization when the services

are offered. Registration completed some two months before the campaign will help the organizers finalize decisions concerning logistics and immunization sites, dates, and times. In settings where remote or dispersed populations make advance registration unfeasible, detailed current population estimates are important for sound program planning.

Social mobilization

Regardless of the acceleration strategy adopted, the key element is mobilization of effective consumer demand and multisectoral resources. A variety of informational and promotional techniques should be used to motivate mothers to bring their children, especially those under one year of age, to be immunized.

Social mobilization is equally applicable to mass campaigns, national immunization days, intensified expansion of primary health care infrastructure, and the various *combinations* of these approaches. Social mobilization may involve national political leaders and celebrities, the mass media and less formal communication channels, community action by public and private sector organizations, and the more traditional health education techniques.

The various program approaches should be seen as complementary and even synergistic. A successful mass campaign or series of national immunization days (or weeks) can be a stepping stone not only to sustained immunization services, but also to the development of a broader set of activities to improve child survival and primary health care.

Evaluation

Evaluation should be given special emphasis in the early planning and implementation stages of any accelerated immunization strategy. Objective data are required to assess the results of the strategy, particularly as the publicity and enthusiasm surrounding an event such as a national immunization day make subjective judgements unreliable.

Data priorities: vaccination coverage and disease incidence

Data priorities include estimations of the immunization coverage obtained among children in their first year of life, which might be obtained by using the EPI cluster sampling technique, and subsequent estimates of the impact of the accelerated strategy on disease reduction, perhaps by reviewing incidence trends in facilities considered to have reliable diagnostic and reporting capabilities. Data concerning poliomyelitis, measles and neonatal tetanus should receive first priority as these diseases are clinically distinctive and true incidence can be expected to decline rapidly in the face of effective immunization.

Questions to be answered

Less formal data will also be useful to improve future performance and guide managers in other countries who are trying similar approaches. The persons responsible for planning and implementing the strategies for acceleration should answer the following series of questions:

- What worked best? What were the major shortcomings and deficiencies?
- What problems were encountered; how were they overcome?
- In light of present knowledge and experience, what should be done differently next time?
- How were the human, institutional, material and financial resources mobilized and managed?
- How were communications planned and implemented?
- What were the total costs of the effort, and the costs of the various components?
- What is the relationship between the accelerated program and ongoing immunization services?
- What effect has the mass campaign had on other ongoing health activities?
- How could international support (particularly from WHO and UNICEF) be improved?

Elements of accelerated immunization efforts

Some desirable features of accelerated immunization efforts are listed below:

- Administration of all antigens included in the routine national immunization schedule for infants.
- Establishment of a time frame which permits delivery of three doses of DPT and polio vaccine, that is, a minimum of three immunization days or weeks, with an interval of four weeks between immunizations.
- Use or introduction of records and a reporting system that can be used by the routine health services.
- Ordering of cold chain equipment, supplies and

transport which conform to that which is already in routine use within the health services.

- Organization of a volunteer structure that is coordinated with the permanent health staff and the established health facilities.
- Use of a broadly based, multisectoral approach, especially for communications and motivation, but without bypassing or alienating the regular ongoing health system.
- Information and media publicity which make the public aware of the permanent delivery system and the need to be fully immunized, as well as any special strategy such as national immunization days.
- Use of a vaccine distribution system capable of being replicated on a smaller scale by the permanent logistics networks.
- Evaluation of the coverage achieved in children below the age of 12 months.
- Evaluation of program impact in reducing the incidence of the target diseases, with particular emphasis on poliomyelitis, measles and neonatal tetanus.
- Identification of evaluation plans and the persons responsible for carrying them out, prior to the start of the program.

In sum, sound program planning and reinforcement of the existing primary health care infrastructure are essential for both the long and short term success of immunization programs. The use of national immunization days to supplement routine services should be considered as one way, but not the only way to accelerate programs.

Evaluation should be an important part of all immunization activities, especially accelerated ones, so that national authorities can quickly identify problems and modify their strategies accordingly.

Source: Adapted from Planning Principles for Accelerated Immunization Activities. A Joint WHO/UNICEF Statement, 25 July 1985 (The complete document is available upon request to the EPI Newsletter editor).

Reappraisal of Early OPV and DPT Immunization

In most developing countries the incidence of pertussis and poliomyelitis is high during the first year of life. Immunization against these diseases should therefore be initiated at the earliest possible age. Present immunization schedules are based upon data from industrialized countries where the incidence of these diseases is very low in young infants. As research continues on immunization, new information allows reappraisals of current schedules in highly endemic areas. The following review is presented to support changes in OPV and DPT vaccine scheduling.

Oral polio vaccine (OPV)

Live OPV virus stimulates antibody formation by inducing a mild infection in the gastrointestinal tract and the blood of immunized children. The presence of circulating maternal antibodies may modify the infection created by the attenuated vaccine virus, and reduce both the serum and gut response to OPV immunization. While circulating maternal antibodies may suppress the infants' serum antibody response, only very high maternal antibodies titers can prevent the intestinal phase of successful

TABLE 1. Serum antibody response and viral excretion rates following trivalent oral polio vaccine immunization in the first week of life

Reference ^a	Number of infants	Age (in days)	Percentage with antibody response			Percentage with viral excretion		
			1	2	3	1	2	3
Krugman ^b 1961	115	0-2	4-10	30-58	8-18	between 56 and 90		
Farmer 1969	22	0-3	27	36	45	not available		
De-Xiang 1984	108	3	30	30	18	41	41	27
Gelfand ^b 1960	21-26	2-3				85	95	77
Levine 1961	53	3-5				70	—	70
Prem 1960	62-73	5-7	70	18	85	not available		

^aFor full list of references, see *Bulletin* article.

^bUsed monovalent strains 1, 2 and 3.

poliomyelitis immunization. Even those children who do not develop serum antibodies may be protected if they have had the vaccine intestinal infection. A number of studies have demonstrated that OPV results in intestinal infection in infants of all ages including neonates (*Table 1*). Children given OPV at birth in addition to the usual primary series had higher antibody levels earlier in life.¹ The administration of OPV to neonates does not interfere with vaccine doses given later and no evidence of immune tolerance has been found. A study from India showed that seroconversion response to three poliovirus types in infants receiving their first dose of OPV vaccine during the neonatal period was no less than that of older infants (*Table 2*).

OPV can be given to breast-fed babies. However, because of high immunoglobulin levels in colostrum, nursing infants given vaccine in the first days of life may have slightly decreased responses to OPV. There is no significant effect of breast-feeding on older infants and

thus there is no reason to withhold breast milk from infants who receive OPV at, or after, 6 weeks of life.

Diphtheria, tetanus toxoid and pertussis vaccine (DPT)

Several factors influence the host response to immunization with DPT vaccine, including the quantity and potency of antigens, the interval between doses and the reliability of antibody testing. Breast-feeding, however, has no effect on the immune response to DPT.

The infant's immune system is capable of responding to all three components of DPT as early as 1 week of life. The presence of moderate-to-high levels of passively acquired maternal antibodies may modify or block the response in the first few weeks of life. However, adsorbed toxoids are much more effective than the fluid toxoids utilized in many studies reported in the early literature.

The first dose of DPT usually does not induce protective levels of antibodies. However, it serves to prime the immune system for subsequent doses. This priming effect can be effectively accomplished by beginning immunization at 4-6 weeks of age.

Table 3 shows that the initiation of immunization with DPT vaccine at 4-6 weeks of age induces significant levels of antibodies against all components of the vaccine.

Conclusions

Immunization of neonates with OPV is a safe, effective means of improving protection against disease and OPV may be administered simultaneously with BCG vaccine. Although the serological response in the first week is less than that observed from immunization of older infants, 70-100% of neonates benefit by developing active infections and local immunity in the intestinal tract. In addition, 30-50% of the infants develop serum antibodies to one or more poliovirus types. Many of the remaining infants have been immunologically primed and they respond promptly to additional doses later in life.

TABLE 2. Serum antibody response in neonates and infants to three doses of OPV according to age at which immunization was started^a

Age at which the first dose was given	Number of children studied	Percentage with antibody response ^b		
		1	2	3
1	23	83	83	78
2	30	80	90	70
3	25	64	96	56
4	26	90	95	65
5	19	47	68	42
6	16	69	81	63
1-6	139	73	87	63
6-20 ^c	86	72	88	79
6-51 ^d	61	66	95	72

^aAccording to T.J. John (1984)

^bAntibody response based on increased levels above that expected from the decline in maternal antibody

^cInfants with maternal antibody

^dInfants without maternal antibody

¹ See *Weekly Epidemiological Record* 59(48):369-371, 1984.

TABLE 3. Serum antibody response to DPT vaccine used in 3-dose schedule with the first dose given at different ages beginning from 1 week of age

Diphtheria antitoxin

Reference ^a	Number of infants	Age at immunization in weeks			Age at antibody testing (months)	Serum antibody response percentage with ≥ 0.01 IU/ml
		1st dose	2nd dose	3rd dose		
Di Sant Agnese 1949	123	1	5	9	3.5	85
Bradford 1949	38	6	10	14	6	97
	45	6	10	14	9	100
Barr et al. 1955	30	1	6	14	6	100
	30	1	6	14	12	93
Goerke et al. 1958	88	2	6	10	3.5	100
Gaisford et al. 1960	31	1	5	9	3.5	100
Barrett et al. 1962	35	4-8	8-12	12-16	4-5	100

Pertussis agglutinin

Reference ^a	Number of infants	Age at immunization in weeks			Age at antibody testing (months)	Serum antibody response percentage with ≥ 0.01 IU/ml
		1st dose	2nd dose	3rd dose		
Sako 1947	1,294	4-8	8-12	12-16	6-8	28
Di Sant Agnese 1949	125	1	5	9	3.5	54
	108	1	5	9	6	33
Peterson & Christie 1951 ..	289	6	12	18	7.5	71
Provenzano et al. 1959	25	4-12	8-16	12-20	6-8	NA/NC
Baraff et al. 1984	13	8	18	26	9	NA/NC
Murphy et al. 1984	23	8-12	12-16	16-22	6-9	NA/NC
Swatz et al. 1984	44	8	12	26	7	NA/NC

Tetanus antitoxin

Reference ^a	Number of infants	Age at immunization in weeks			Age at antibody testing (months)	Serum antibody response percentage with ≥ 0.01 IU/ml
		1st dose	2nd dose	3rd dose		
Di Sant Agnese 1949	128	1	5	9	3.5	100
Bradford 1949	38	6	10	14	6	100
	45	6	10	14	9	100
Barr et al. 1955	61	1	6	14	6.5	100
Gaisford et al. 1960	31	1	5	9	3.5	100
Barrett et al. 1962	35	4-8	8-12	12-16	4-5	100

^aFor full list of references, see *Bulletin* article.

NA = not available.

For the 10-40% of infants in many countries whose only encounter with preventive services is at the time of birth, this single dose of vaccine will offer some protection against disease, and they will be less likely to be a source of transmission of wild polioviruses during infancy and childhood. For the 20-40% of infants who receive only one or two additional doses of poliovirus vaccine, the initial dose at birth will help ensure higher levels of immunity against poliomyelitis.

Immunization with tetanus toxoid is highly effective and diphtheria toxoid only slightly less so, when given in the first week of life. The pertussis component of DPT, however, does not confer effective immunity against whooping cough prior to 4 weeks of age.

Specific recommendations

1. In countries where poliomyelitis has not been controlled, OPV should be given at birth or at the first contact with health services. Regardless of the time of the first dose, three additional doses at 4-week minimum intervals should be given beginning at 6 weeks of age.

2. Routine immunization with DPT can be safely and effectively initiated at 6 weeks of age.²

Source: *Weekly Epidemiological Record* 60:37(284-286), 13 September 1985 (abstracted from a paper submitted for publication in the *Bulletin of the World Health Organization* 63(6), 1985).

² See *Weekly Epidemiological Record* 60(3):15, 1985.

Reported Cases of EPI Diseases

Number of reported cases of measles, poliomyelitis, tetanus, diphtheria and whooping cough, from 1 January 1985 to date of last report, and for same epidemiological period in 1984, by country

Subregion and Country	Report for week ending	Measles		Polio-myelitis§		Tetanus				Diphtheria		Whooping Cough	
						Non-neonatorum		Neonatorum					
		1985	1984	1985	1984	1985	1984	1985	1984	1985	1984	1985	1984
NORTHERN AMERICA													
Canada	7 Sep.	2,031	...	—	...	2**	...	...	...	5	...	1,036	...
United States	5 Oct.	2,495	...	5	3	50**	...	...	...	1	...	2,177	...
CARIBBEAN													
Antigua & Barbuda	10 Aug.	1	...	—	—	—	...	1	...	—	...	—	...
Bahamas	5 Oct.	21	...	—	—	5	...	—	...	—	...	1	...
Barbados	5 Oct.	2	4	—	—	—	3	—	—	—	—	—	—
Cuba	20 Apr.	1,277	1,552	...	—	...	1	...	—	...	—	18	39
Dominica	7 Sep.	60	8	—	—	—	—	—	—	—	—	—	1
Dominican Republic	*	...	...	...	—	...	...	...	...	...	...	...	...
Grenada	5 Oct.	7	...	—	—	—	...	—	...	—	...	—	...
Haiti	*	...	...	...	...	...	...	...	...	...	...	...	...
Jamaica	10 Aug.	46	220	...	—	...	2	...	1	...	5	1	26
St. Christopher-Nevis	18 May	22	1	—	—	—	—	—	—	—	—	—	—
Saint Lucia	10 Aug.	7	...	—	—	—	...	—	...	—	...	—	...
St. Vincent and the Grenadines	23 Feb.	1	1	...	—	...	—	...	—	...	...	1	—
Trinidad & Tobago	7 Sep.	3,158	3,303	—	—	8	12	—	—	—	—	—	—
CONTINENTAL MID AMERICA													
Belize	5 Oct.	5	...	...	—	2	...	...	...	...	...	35	...
Costa Rica	23 Feb.	—	—	—	—	—	—	—	—	—	—	20	54
El Salvador	20 Abr.	1,046	934	2	17	17	26	9	8	3	8	66	126
Guatemala	18 Mayo	945	...	13	14	22	...	2	...	8	...	477	...
Honduras	7 Sep.	5,539	1,272	...	...	14	11	3	13	—	—	180	368
Mexico	5 Oct.	17,065	3,515	108	116	240**	278**	...	...	4	0	1,790	1,341
Nicaragua	*	...	...	...	—	...	...	...	...	...	...	...	...
Panama	13 Jul.	583	243	—	—	1	3	6	3	—	—	80	112
TROPICAL SOUTH AMERICA													
Bolivia	23 Mar.	73	615	...	...	5**	8**	...	...	8	6	311	318
Brazil	23 Feb.	8,562	7,915	113	109	316	352	75	85	313	451	3,410	3,192
Colombia	*	...	...	4	16	...	...	...	...	...	...	...	...
Ecuador	23 Mar.	597	2,863	—	—	15	16	19	14	7	13	191	127
Guyana	20 Apr.	43	45	...	—	2	4	...	...	43	—	1	—
Paraguay	10 Aug.	284	314	3	1	40	42	47	54	13	7	238	285
Peru	*	...	...	...	...	...	...	...	...	...	...	...	...
Suriname	18 Mayo	65	16	—	—	—	2**	...	...	—	—	—	—
Venezuela	13 Jul.	16,628	5,329	2	8	—	...	—	...	4	1	1,508	682
TEMPERATE SOUTH AMERICA													
Argentina	13 Jul.	4,438	4,563	—	2	48**	105**	...	...	7	8	3,082	6,988
Chile	5 Oct.	6,764	2,900	—	—	20**	19**	...	...	141	101	602	589
Uruguay	23 Feb.	7	—	—	—	—	1	—	—	—	—	6	20

* No 1985 reports received.

** Tetanus data not reported separately for neonatal and non-neonatal cases.

Total tetanus data is reported in non-neonatal column.

§ Data for polio is through week 43 (ending 26 Oct.).

— No Cases

... Data not available

PAHO Member Countries Endorse Polio Eradication Resolution

Health authorities from PAHO's 38 Member Countries gathered in Washington from 23 to 28 September 1985 to define policies for the coming year, review health programs and approve the organizational budget. The EPI resolution to *accept the proposal for action for the eradica-*

tion of indigenous transmission of wild poliovirus from the Americas by 1990 was unanimously adopted by the Directing Council on 28 September. The full text of the resolution is shown below.

THE XXXI MEETING OF THE DIRECTING COUNCIL.

Having considered the Director's report on the Expanded Program on Immunization in the Americas (EPI) and the report of the 95th Meeting of the Executive Committee;

Noting the overall improvement made at national level in the implementation of this program and the impact already achieved in reducing morbidity by poliomyelitis;

Believing that an attempt to eradicate poliomyelitis presents a challenge and a stimulus to the world to mobilize the resources to achieve the objective, and that the support required is available nationally and internationally; and

Recognizing that the realization of this objective will enhance the overall success of the EPI,

RESOLVES:

1. To congratulate the Director on the report presented.
2. To reassure its full commitment to reach the overall goals of the EPI by 1990.
3. To accept the Proposal for Action for the eradication of indigenous transmission of wild poliovirus from the Americas by 1990 and declare the goals established in the Proposal for Action as one of the major objectives of the Organization.
4. To urge Member Governments:
 - a) To take the necessary steps to accelerate their EPI programs to assure the achievement of the overall objectives of the EPI and of the eradication of

- indigenous transmission of wild poliovirus from the Americas by 1990;
 - b) To make the needed commitment and allocate the necessary resources for program implementation;
 - c) To promote support towards these goals within those technical and financial multilateral agencies of which they are also members.
5. To draw the attention of the Member Governments to the necessity that:
 - a) Immunization programs not be implemented at the expense of efforts to develop the infrastructure of health services and their overall promotion, prevention and care activities;
 - b) The strategy of campaigns and the tactic of national vaccination days be viewed as ad hoc measures, to be gradually replaced by regular immunization services performed routinely by health services.
 6. To request the Director:
 - a) To seek the additional political and material support needed for the realization of these goals from multilateral, bilateral and nongovernmental agencies;
 - b) To initiate immediate action as outlined in the Proposal for Action to assure the necessary technical and financial support for the eradication of indigenous transmission of wild poliovirus from the Americas by 1990;
 - c) To submit a progress report to the 97th Meeting of the Executive Committee and the XXII Pan American Sanitary Conference in 1986.

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References to commercial products and the publication of signed articles in this newsletter do not constitute endorsement by PAHO/WHO, nor do they necessarily represent the policy of the Organization.

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