Ten South American countries strengthen their capacities in risk communication and community engagement

Professionals responsible for communication, health promotion, risk management, and emergency at health institutions from 10 South American countries met in Lima (Peru) from 18 to 20 October 2023, to strengthen capacities and share lessons learned in Risk Communication and Community Engagement (RCCE) during health emergency preparedness and response, including situations in which vaccination plays a critical role in preventing and mitigating threats.

This subregional workshop – organized by the Pan American Health Organization (PAHO/WHO) Health Emergencies Department (PHE) and the Special Program for Comprehensive Immunization (CIM) – aimed to consolidate a strategic framework for technical cooperation to address RCCE. “During critical situations such as epidemics and pandemics, effective communication plays a crucial role in coordinating emergency response. Furthermore, providing timely and relevant information to the population accelerates sound decision-making, allowing people to make informed decisions and access quality services,” explained Maureen Birmingham, the PAHO/WHO Representative in Peru.

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What I have learned …

By Anne Eudes Jean Baptiste, Regional Immunization Advisor for the Special Program for Comprehensive Immunization (CIM) at the Pan American Health Organization (PAHO)

My journey in the field of medicine, public health, and epidemiology spans nearly two decades, during which I have overseen complex programs for the World Health Organization (WHO), the United States Centers for Disease Control and Prevention (CDC), and other health agencies and organizations.

From 2018 to early 2023, I was a Medical Officer at WHO Nigeria. In 2019, I supported the Government of Nigeria in planning and executing large-scale vaccination campaigns, including multifaceted combined meningitis A and measles supplemental immunization activities (SIAs) in high-risk states/districts.

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The event included keynote speeches on generating vaccine demand, social and behavioral drivers, vaccination-related constructs, events supposedly attributable to vaccination or immunization (ESAVI), and crisis communication related to vaccine safety and vaccination. Communication on vaccination-related risks was also discussed, with case resolutions on messages to communicate risks and influence risk perception, handling false information, crisis communication regarding ESAVI, collaboration with partners, social listening, and information monitoring.

Participants also had the opportunity to share lessons learned about vaccination promotion initiatives such as the yellow fever vaccination campaign in the Plurinational State of Bolivia; the national measles, rubella, and polio vaccination campaign in Ecuador; vaccination promotion strategies in Argentina; the study on COVID-19 vaccination perception in Uruguay; as well as vaccination in Indigenous populations in Brazil and Paraguay.

Participants completed practical exercises and developed a roadmap based on the instruments and theoretical frameworks of the 2005 International Health Regulations (IHR), focusing specifically on the three indicators of the RCCE component of the State Party Self-Assessment Annual Reporting (SPAR) instrument.

Anali Lopez, a spokesperson from the National Directorate of Epidemiology and Strategic Information of the Ministry of Health, emphasized that the training allowed her to remember and learn about new concepts and theoretical frameworks, as well as to reflect on her own capacities and work on a proposal to link a new health risk management area with the existing communication department.

Patricia Schroeder, Director of Communication of the Uruguayan Ministry of Public Health, shared her country’s experience in managing the COVID-19 pandemic and the successful vaccination campaign, highlighting the participation of civil society and the collaboration of public and private institutions as key factors in the response’s success. She also highlighted the importance of professionalizing communications and maintaining solid multidisciplinary teams over time, regardless of changes in government.
Building better immunity: A life course approach to healthy longevity

For the first time, in 2019 the Region of the Americas reported more adults aged 65 or older than children younger than 5 years. These demographic shifts are expected to continue over time. As countries recognize the opportunities and challenges associated with this demographic shift, they must maximize the impact of their public health interventions – such as vaccination – beyond the traditional target groups. This can contribute to longer, healthier lives for individuals and communities.

As life expectancy increases, it is crucial to recognize that the wide range of vaccines available need to be administered in a timely way and at different points in a person's life. The Life Course Approach (LCA) emphasizes that human health is a product of genetics and environment. The factors that shape a person's immune system include environmental influences, public health interventions, healthcare services, personal behaviors, and social constructs. These factors interact continuously with genetic predispositions to determine a person's dynamic health status at each stage of life.

The LCA provides a framework to help health officials identify key moments where health interventions can be adjusted to obtain maximum benefits. A life course approach to immunization states that persons should receive all vaccine doses at specific moments to: a) prevent infections; b) train the immune system to continuously mount the appropriate responses; c) reduce the interaction between chronic disease, proinflammatory cells, and a weakened immune system as one ages; and d) reduce the morbidity and mortality rates in the community when the persons at highest risk of infection, disease, and death are prioritized for vaccination.

Therefore, adapting a national immunization program to the needs and demands of each age group is an intervention that builds the resilience and plasticity of individual immune systems while closing the most urgent immunity gaps of each age group. This makes individuals able to maintain good health over their lifetimes.

A renewed focus on the LCA in immunization can highlight vaccine benefits beyond childhood. It can also provide routine structured opportunities for catching up all persons who missed the recommended vaccine doses.

In conclusion, national immunization programs must be redesigned to extend vaccination services to all age groups, including vaccine booster administration and catch-up doses. The PAHO publication Building better immunity: A life course approach to healthy longevity provides guidelines on how to implement these changes.1 This document is currently in English and Spanish but will soon also be available in French and Portuguese.

Contributed by: Enrique Vega, Margherita Ghiselli, Evelyn Balsells, Beatriz Nascimento Lins de Oliveira, Carolina Hommes, Ana Lucía Rosado, and Brenda Cadena, PAHO.


Vaccination knowledge, attitudes, and practices among health workers with an emphasis on COVID-19 vaccines in Paraguay

Introduction

In the last decade, national immunization programs have had to contend with a decrease in vaccination coverage, weakening of epidemiological surveillance, inadequate financing for long-term sustainable vaccination, and growing vaccine hesitancy – linked in part to fake news – among health workers and the general population.2

In the last decade in Paraguay, vaccination coverage with biological tracers3 has remained below 95%. In addition, during the pandemic, a decrease in vaccinations was observed, which increased the risk of vaccine-preventable disease outbreaks due to the accumulation of susceptible individuals, thereby putting the country at risk of vaccine-preventable diseases.4,5

Health workers are a priority population for the administration of some vaccines, such as influenza, COVID-19, and hepatitis B; furthermore, they play an instrumental role in promoting vaccination and in channeling the public toward vaccination services, by facilitating access to information about their benefits, safety, and importance for disease prevention.

Therefore, it is necessary to develop communication strategies specifically focused on this population, taking into account the dual role they play as vaccine recipients and promoters of immunization to their peers and the community. This study – aimed at generating evidence on the knowledge, attitudes, and practices of health workers in relation to vaccines and vaccination – was developed within this framework.

Methods

Between 1 July and 21 August 2023, a mixed-methods survey was carried out to assess vaccination knowledge, attitudes, and practices among health workers, focusing on COVID-19 vaccines in Paraguay. A total of 1627 health workers from the country’s 18 health regions were surveyed. The survey was conducted online using non-probability snowball sampling, with the approval of the Paraguayan Ministry of Health Ethics Committee and the PAHO Ethics Committee. Participants provided their consent online before accessing the survey virtually. Results were analyzed using the WHO model6 on the behavioral and social drivers (BeSD) of vaccination, as well as fixed-effects multivariate logistic regression to assess Likert scale questions that showed sufficient variability.

Results

Many respondents expressed concern about the mild and serious adverse effects of vaccines in general. This result confirmed the findings of other studies with similar characteristics carried out worldwide in relation to concerns about the safety, effectiveness, and possible side effects of the COVID-19 vaccine,7,8,9 which may determine whether or not it is accepted.

Quantitative results

Vaccines in general

- Ninety-nine percent of respondents agreed that vaccines are safe, effective, and that the benefits outweigh the risks. In addition, 98% believed that a vaccination policy for health workers would improve vaccination adherence among co-workers.
- On average, 97% of respondents recommended vaccines to patients, participated in campaigns, informed patients about vaccines, and promoted the vaccination schedule for health workers to co-workers.
- The least recommended vaccines were those for poliovirus (IPV) (91%) and human papillomavirus (HPV) (91%).
- Seventy percent of respondents were concerned about mild and severe adverse effects related to vaccines in general, with nurses expressing greater concern than physicians.
COVID-19 vaccines

- Ninety-nine percent of participants were vaccinated against COVID-19. Of these, 51.6% said that they were fully vaccinated and 47.7% said that they were not fully vaccinated.

- Ninety-seven percent intended to recommend COVID-19 vaccines to eligible people, and knew the COVID-19 vaccination schedule for health workers and where to obtain information about the country’s vaccination plan.

- In terms of knowledge of the COVID-19 vaccination schedule, by age group: 96% knew the schedule for adults aged 18 years and over; 91% knew the schedule for adolescents aged 12–17 years; and 89% knew the schedule for children aged 5–11 years.

- Survey participants said that the main factors affecting their opinions about COVID-19 vaccines were: constantly changing scientific literature on topics related to SARS-CoV-2 (90%); recommendations issued by scientists or international organizations (89%); information gained from training sessions, seminars, webinars, and podcasts (88%); personal experience (87%); work experience (85%); the speed with which vaccines were researched and developed (82%); the actions and opinions of colleagues (68%); the actions and opinions of friends and family (54%); social media (50%); and the actions and opinions of religious leaders (49%).

- Of the participants who were not fully vaccinated (47.7%), 68.6% said that they would get vaccinated as soon as they were able to do so or were eligible. The main reason for delaying additional doses of the COVID-19 vaccine was illness or some health-related reason other than COVID-19 (65%).

- Of the participants who had not received any doses of the vaccine (0.7%), 51% said that they would never be vaccinated against COVID-19. The main reasons were concerns about adverse reactions, lack of confidence, unreliable evidence, and the speed with which vaccines were developed.

Qualitative results

- Respondents said that they were confident in the benefits of vaccines, although more information about them is needed; therefore, vaccine information campaigns should be advocated, and vaccines should be promoted with an emphasis on age group.

- Concerns about vaccine safety was the factor most often mentioned by respondents, which is consistent with the quantitative findings.

Recommendations

- In Paraguay, the percentage of health workers reluctant to recommend vaccines in general to their patients, and the degree of reluctance among health workers to be vaccinated against COVID-19, is low. However, it is important to encourage activities that promote vaccination, not only among health workers but also among the general population.

- Promote interventions that increase health workers’ understanding of vaccine development processes, as well as confidence in vaccine safety, efficacy, and benefits.

- Strengthen and promote the development of a specific vaccination policy for the country’s health workers, which will improve vaccination adherence.

- Strengthen actions that increase the risk perception of COVID-19 as a disease, compared to adverse events of the vaccine.

- Promote operations that include timely, transparent communication campaigns – with messages adapted to the national reality – about vaccination in general and vaccination against COVID-19 in particular.

Contributors: Silvia Battaglia and Soraya Araya, from the Ministry of Public Health and Social Welfare of Paraguay; Tamara Rivera, Irene Melamed, Fabiana Michel, and Martha Velandia from PAHO’s Special Program for Comprehensive Immunization (CIM); as well as Dale Rhoda and Jennifer Brustrom from Biostat Global Consulting.
PAHO and CDC work together to build regional capacities to address public health challenges

For more than 20 years, PAHO and the CDC have shared the goals of saving lives and protecting the people of the Region of the Americas from health threats while using evidence and data for better decisions to address priority public health challenges.

CDC is the leading data-driven public health service organization in the United States and the largest government agency worldwide working in disease control and prevention. It generates strategic information and puts science and advanced technology into action to protect the public's health, safety, and security. CDC works in more than 60 countries, collaborating with ministries of health and other partners to prevent diseases, build resilience to emergencies, and respond quickly on the front lines where outbreaks occur. It is headquartered in Atlanta, Georgia, and has experts located throughout the United States and the world.

With nearly 80 years of experience, CDC has long been actively engaged with PAHO, providing financial support and technical collaboration in key areas of public health to build regional capacities, protect people from health threats, and address public health challenges in the Americas.

Continuous support to strengthen health systems and better respond to health threats

CDC has been a critical strategic partner of PAHO and is one of the major contributors to strengthening public health systems in Latin America and the Caribbean. The long-standing collaboration has been formalized through several multi-year cooperative agreements that have led to substantial achievements.

PAHO collaborates with CDC on multiple technical programs through direct engagement with its various centers, institutes, and offices. Also, PAHO receives critical financial support in priority areas of operation. CDC's deep involvement extends beyond routine monitoring of project implementation and focuses on mutual support and constructive collaboration for the benefit of the people of the Americas. This collaborative effort has provided a platform to share knowledge and expertise at the regional, subregional, and country levels.

Acknowledged as a strategic partner in PAHO's annual and multiannual plans, CDC collaborates with PAHO at the regional level and in multiple Latin American and Caribbean countries. Also, CDC supports the ministries of health of several countries in Central America, South America, and the Caribbean through its five Country Offices and one Regional Office. Across all venues, CDC puts its extensive technical resources and expertise to the service of local governments to build country-level capacities on numerous public health topics.

PAHO and CDC continue to work together to strengthen national immunization programs. The collaboration focuses on reducing the number of children who have never received a single vaccine dose; improving epidemiological and laboratory surveillance; protecting and maintaining the elimination targets set against polio, rubella, measles, congenital rubella syndrome, hepatitis B, and neonatal tetanus; developing greater in-country capacity to respond to outbreaks of vaccine-preventable diseases; expanding vaccination services across all stages of the life course; strengthening immunization information systems; implementing a regional surveillance system for ESAVI; and implementing evaluations of national immunization programs. During the COVID-19 pandemic, CDC funds were essential to maintain these core functions and allow persons of all ages to continue receiving life-saving vaccines.

Given its public health expertise, extensive knowledge of health systems, and networks of subject-matter experts throughout the world, CDC is an exceptional partner for PAHO. Its ongoing technical and financial partnership contributes to positive health outcomes in the Americas. CDC's commitment to the Region and willingness to share its knowledge and resources has made it possible to provide technical support to countries beyond a single organization's capacity.

Contributed by: Regina Campa Sole, Margherita Ghiselli, and Martha Velandia, PAHO.
Vaccine mandates have always been controversial. And the controversy reached new heights during the COVID-19 pandemic. While some of the debates over the past three years focused on whether vaccine mandates “work,” most centered on their ethical justification, i.e., whether it is right to use such tools even if they are capable of achieving public health aims.

As we, as a society, prepare for future infectious disease threats, a crucial question we should ask ourselves is: must we return to square one and rehash these ethical debates when the next epidemic or pandemic occurs? Or are there things we can learn so that we can begin from a more sophisticated starting point when considering vaccine mandates in the future?

Recently, we (the authors) published an article in *Vaccine* that identified five arguments that were frequently deployed in opposition to vaccine mandates during the COVID-19 pandemic, which we argue should be dispensed with in order that we, as a society, can engage with more compelling and plausible arguments for and against their use in the future. We briefly summarize these five arguments and our response to them in the following.

First, one must completely dispense with arguments that invoke the Nuremberg Code. The Code sets out principles for the ethics of human experimentation, which, among other things, emphasize the importance of voluntary consent for participation in research. However, vaccines used in vaccine mandates are not experimental and are not used as a part of research. They are authorized for use by national regulatory authorities. Authorization indicates that sufficient causal evidence and a positive risk-benefit ratio exist to justify the use of the medicine in practice. Hence, the Code is not relevant to these debates. If opponents of vaccine mandates are concerned that mandates violate informed consent, then it would be more appropriate and relevant to discuss laws regarding informed consent for medical interventions, not the Nuremberg Code.

However, objections to vaccine mandates that claim they violate informed consent do not have much merit, either. For starters, vaccine mandates and laws requiring informed consent for medical interventions have coexisted for decades in numerous jurisdictions. This tells us that mandates and informed consent need not be antagonistic. Because vaccine mandates rarely require anyone to be vaccinated, but rather make vaccination a condition of work, school, or travel, individuals can still make voluntary decisions about vaccination.

For example, if vaccination is considered a bona fide occupational requirement to practice as a nurse, then one must decide how much one really wants to be a nurse; if the conditions to be a nurse are too demanding or run counter to one’s personal convictions, then one retains the choice to not be a nurse. The choice to get vaccinated has not been rendered involuntary since one does not have to work in a profession where vaccination is a bona fide occupational requirement. Attention should be focused instead on whether vaccine mandates are designed with consequences so severe as to negate meaningful choice and whether vaccination ought to be considered a bona fide occupational requirement in the first place.

This speaks to a third, more general objection often raised against vaccine mandates, which is that they are coercive. Coercion is a rich and often misunderstood concept, but it is commonly defined as using force or threats to compel someone to do something they would not otherwise do. In a sense, vaccine mandates are straightforwardly coercive insofar as they compel people to get vaccinated by threatening them with being fired, for example, if they do not.

However, this means that governments and employers are routinely coercive; the former threatens us with penalties such as fines and jail time if we do not behave in particular ways, like pay our taxes or dispose of toxic waste appropriately. The latter threatens us with being fired if we fail to meet the conditions of our jobs, which include occupational health and safety standards. Hence, the mere charge of coercion is not enough to tell us that something is necessarily wrong and unjustified. Instead of remarking about “coercion” and assuming this ends the debate about vaccine mandates, more should be done to examine just when and under what conditions coercion, in the form of vaccine mandates, is and is not ethically justified.
Related to worries about coercion are concerns that vaccine mandates infringe upon individual liberty or freedom. Much like worries about coercion, vaccine mandates could be seen as straightforward infringements of certain freedoms. However, again, much like worries about coercion, this does not tell us much about whether that necessarily makes them right or wrong. People do not have unfettered freedom to do whatever they would like. For instance, if my actions could harm you, there may be sufficient reason for the government to intervene to protect you (and your rights) – it is not just me who has rights; other people have them too.

Consequently, governments have a responsibility to balance my rights and yours, and affect a balance between the rights of the individual and the interests of society. This can often require that limits be placed on guaranteed civil liberties such that we all can enjoy our rights to the fullest extent possible. So, instead of remarking about “freedom” and assuming this ends the debate about vaccine mandates, we ought to evaluate whether vaccine mandates are minimally impairing of rights and whether their overall impact on a person’s rights is necessary and proportionate to achieve important societal or public health objectives.

Finally, because vaccine mandates mean that those who are unvaccinated may be treated differently than those who are vaccinated (e.g., ability to cross borders, participate in certain workforces), many worry that vaccine mandates are discriminatory. However, merely treating people differently does not constitute discrimination in the important moral sense. People are routinely treated differently when it comes to things such as school (e.g., admission averages), jobs (e.g., experience, training), and travel (e.g., passports, visas), and yet we do not think this is discriminatory.

What matters from a moral perspective when it comes to discrimination is differential treatment on the basis of important protected grounds, like gender identity, race, or disability. Because for most people vaccination is modifiable and can reflect a bona fide occupational requirement, some human rights authorities have noted that vaccination requirements are not necessarily discriminatory so long as protections are established that make sure those who are unable to be vaccinated (e.g., due to medical contraindications) are reasonably accommodated.

Many will recognize that these five objections to vaccine mandates are rather weak and will note that more forceful objections exist. Yet, the aforementioned objections nonetheless seem to be ubiquitous. Hence, making progress in debates about the ethics of vaccine mandates, and beginning from a more sophisticated starting point when discussing these measures in the future, is predicated on dispensing with these objections and focusing on more plausible ethical reasons to object to, or support, vaccine mandates.


Contributed by: Maxwell Smith, Western University, and Ezekiel Emanuel, University of Pennsylvania.

Enhancing capacity for outbreak response and microplanning through workshops in Guatemala

The Guatemalan Ministry of Health, with technical and financial support from PAHO, is organizing regional workshops to strengthen the capacities of healthcare personnel in outbreak response and immunization activities microplanning. The workshops are targeting professionals from all 29 Departments of Integrated Health Service Networks and 110 municipal health districts of high risk for measles/rubella and polio, using tools developed by PAHO. To date, PAHO has trained 313 participants from 16 Departments.

PAHO developed a pedagogical pathway to deliver the topics, which began with an analysis of the situation of vaccine-preventable diseases in the Region of the Americas and in Guatemala in particular; an overview of measles, rubella, and polio epidemiological surveillance; a municipality-level risk analysis for measles/rubella; and the development of mitigation plans using the problem tree methodology. PAHO provided training on general actions to be taken in response to outbreaks and conducted a simulation exercise based on a local experience of isolating a vaccine-derived polio virus type 1 (VDPV1) in a residual water sample collected in March 2019 in Guatemala.
After conducting the situational analysis, the microplanning process for the implementation of extramural activities was introduced. PAHO used an adapted tool to structurally plan lifecycle prevention packages, which includes immunization, anthropometric monitoring, supplementation, deworming, and antenatal care activities in accordance with the current country regulations. This tool further enhances the microplanning process of extramural strategies by providing a guided and automated procedure, with the goal of delivering primary healthcare services to prioritized communities. PAHO is planning to measure the impact of these workshops by monitoring surveillance and vaccination coverage indicators.


_image of the Guatemala’s 2023 microplanning tool, which includes immunization, anthropometric monitoring, supplementation, deworming, and antenatal care activities._

Anne Eudes Jean Baptiste, in Borno State, Nigeria, in 2019. Twenty-two of the 27 local government areas, including 37 internally displaced persons, were affected by a large measles outbreak. An outbreak response immunization campaign was conducted in the 13 most-affected districts in response to the situation.

The 2019 vaccination campaign targeted and reached over 22.2 million children from 9 to 59 months of age. From 2020 to 2022, I was instrumental in developing proposals to Gavi, the Vaccine Alliance, for the elimination of yellow fever in Nigeria through the Eliminating Yellow Fever Epidemics (EYE) strategy. The yellow fever mass vaccination campaign led to the vaccination of over 45 million people against yellow fever during the COVID-19 pandemic. Additionally, I had the privilege of supporting efforts in Maternal and Neonatal Tetanus Elimination (MNTE) in geopolitical zones of the country, while also supporting the implementation of the Nigeria Polio Transition Plan.

During the COVID-19 pandemic, I served as the Incident Management System (IMS) COVID-19 Pillar Lead for vaccination and continuity of essential health services. In this role, my team and I actively supported the development of Nigeria’s National Deployment and Vaccination Plan (NDVP), including the creation of a training manual and micro-plans. We also developed strategies and funding outlines to ensure the availability of adequate vaccines to cover the needs of the targeted population, contributing significantly to the effective management of COVID-19 vaccination efforts. Motivated by my experience and pledge to health initiatives, I came back to the Region of the Americas at the end of March 2023.

What I have learned …

By Anne Eudes Jean Baptiste, Regional Immunization Advisor for the Special Program for Comprehensive Immunization (CIM) at the Pan American Health Organization (PAHO)

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Image of the Guatemala’s 2023 microplanning tool, which includes immunization, anthropometric monitoring, supplementation, deworming, and antenatal care activities.


Anne Eudes Jean Baptiste, in Borno State, Nigeria, in 2019. Twenty-two of the 27 local government areas, including 37 internally displaced persons, were affected by a large measles outbreak. An outbreak response immunization campaign was conducted in the 13 most-affected districts in response to the situation.
What have I learned?

I have come to believe deeply in two foundational principles that I consider vital ingredients of successful health programs, particularly in the field of immunization. The first principle that I hold in high regard is the concept of integration, particularly the integration of immunization programs with other health strategies. This principle possesses immense potential to enhance the impact of vaccination efforts. The concept is both simple and transformative: by integrating immunization into broader health strategies, we can achieve higher vaccination coverage and greater operational efficiency. It further translates to greater value in improving access and efficiency, such as through the sharing of costs, resulting in more life-saving interventions made accessible to the communities we serve.

The second principle that I hold dear is country ownership and political will. Country ownership is key in advancing any health programs including immunization. Country-owned approaches are “development initiatives that are designed, implemented, and led by the recipient country.” It emphasizes the critical role of countries’ leadership, systems, and resources in implementing programs and achieving sustainable development. It also indicates that health programs are not imposed upon recipient countries from outside, but are instead conceived, implemented, and managed by the recipient country itself. This principle aligns closely with the goals of the Immunization Agenda 2030, an ambitious ten-year plan characterized by four core principles (people-centered, partnership-based, data-guided, and country-owned).

The success of the immunization program in our Region, whether in the eradication and elimination of diseases such as polio, measles, rubella, or tetanus, was profoundly influenced by country systems; a very high level of political commitment among governments; the dedication, commitment, and exceptional work of thousands of healthcare workers; a high degree of community participation; strong collaboration of various agencies and organizations; and the availability of well-managed resources under strong PAHO leadership. Our Region has shown that the principles of integration and country ownership were not merely theoretical concepts.

However, considering the challenging economic circumstances prevalent in many parts of the Americas, we are at a critical turning point. Hence, with more than three years of the COVID-19 pandemic, health systems face significant challenges. One of the major consequences has been the exacerbation of the preexisting decline in vaccination coverage. To illustrate with the case of polio vaccination, coverage had fallen below the 95% recommended to prevent the reintroduction of the virus in the Region. In 2021, only 80% of children had received the third dose of the polio vaccine (polio3) needed for full immunization, down from 88% in 2018. Nevertheless, the 2022 WHO/UNICEF estimates of national immunization coverage indicate a modest recovery. There has been a slight increase in coverage in 2022, with polio3 vaccination rates reaching 82%. This is a positive development, but it is important to remember that much work remains to be done.

In closing, I firmly believe that adhering to the principles discussed earlier will enable us to ensure that immunization programs become sustainable, resilient, and responsive to the unique needs of each country, ultimately leaving no one behind in our pursuit of better health for all.
The *Immunization Newsletter* is published four times a year, in English, Spanish, French, and Portuguese, by the Special Program for Comprehensive Immunization (CIM) of the Pan American Health Organization (PAHO), Regional Office for the Americas of the World Health Organization (WHO). The purpose of the *Immunization Newsletter* is to facilitate the exchange of ideas and information concerning immunization programs in the Region and beyond.

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