

DIRECTORATE-GENERAL FOR INTERNAL POLICIES

POLICY DEPARTMENT
ECONOMIC AND SCIENTIFIC POLICY **A**

Economic and Monetary Affairs

Employment and Social Affairs

**Environment, Public Health
and Food Safety**

Industry, Research and Energy

Internal Market and Consumer Protection

**Workshop on
Childhood Vaccination
and Immunisation**

MEETING DOCUMENT



DIRECTORATE GENERAL FOR INTERNAL POLICIES
POLICY DEPARTMENT A: ECONOMIC AND SCIENTIFIC POLICY

WORKSHOP

Childhood Vaccination and Immunisation

Brussels, 19 June 2013

MEETING DOCUMENT



ЕВРОПЕЙСКИ ПАРЛАМЕНТ PARLAMENTO EUROPEO EVROPSKÝ PARLAMENT EUROPA-PARLAMENTET
EUROPÄISCHES PARLAMENT EUROOPA PARLAMENT ΕΥΡΩΠΑΪΚΟ ΚΟΙΝΟΒΟΥΛΙΟ EUROPEAN PARLIAMENT
PARLEMENT EUROPÉEN PARLAIMINT NA HEORPA PARLAMENTO EUROPEO EIROPAS PARLAMENTS
EUROPOS PARLAMENTAS EURÓPAI PARLAMENT IL-PARLAMENT EWROPEW EUROPEES PARLEMENT
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EURÓPSKY PARLAMENT EVROPSKI PARLAMENT EUROOPAN PARLAMENTTI EUROPAPARLAMENTET

**Organised by the Policy Department A-Economy & Science for
the Committee on the Environment, Public Health and Food Safety (ENVI)**

Workshop on Childhood Vaccination and Immunisation

**Wednesday, 19 June 2013 from 13.00 to 14.45
European Parliament, Room A3G-3, Brussels**

AGENDA

13.00 - 13.05

Welcome and opening by Co-chairs of the Health Working Group, Glenis WILLMOTT and Alojz PETERLE, MEPs

13.05 - 13.15

Vaccines and Immunization in Europe: General overview

Dr Piotr Kramarz, Deputy Chief Scientist, European Centre for Disease Prevention and Control (ECDC)

Part 1

Tuberculosis is not a disease of the past

13.15 - 13.25

The fight to beat TB

Dr Masoud DARA, Team Leader of WHO/Europe TB and M/XDR-TB programme.

13.25 - 13.35

Patients' voice

Ms Amy McCONVILLE, TB patient

13.35 - 13.50

Q&A

With the participation of Dr Daniel BRASSEUR, Chair of the Paediatric Committee (PDCO) and Dr Radu BOTGROS, Scientific Administrator, European Medicines Agency (EMA)

Part 2

Case study: The current measles outbreak

13.50 - 14.00

The voice of the professionals

Dr Ronald de GROOT, president of the European Society for Paediatric Infectious Diseases

14.00 - 14.10

Why measles outbreaks are so scary?

Dr. Andreas SCHULTZ Senior Consultant in Pediatrics, Tropical Medicine and Infectious diseases; Director of Médecins du Monde Germany

14.10 - 14.40

Open discussion

With the participation of Dr Daniel BRASSEUR, Chair of the Paediatric Committee (PDCO) and Dr Radu BOTGROS, Scientific Administrator, European Medicines Agency (EMA)

14.40 - 14.45

Conclusions

14.45 Closing

SHORT BIOGRAPHIES OF EXPERTS

Dr Piotr Kramarz



Piotr is a physician by training, with a PhD in immunology of viral infections, and eight years of clinical practice experience in a teaching hospital in Poland in the field of infectious diseases. He is an Epidemic Intelligence Service (EIS) alumni (class of 1997) and worked in the National Immunization Programme of the U.S. CDC during his EIS programme and later on. Since 2007 he has been working as a Deputy Head of the Scientific Advice Unit and, since April 2011, as the Deputy Chief Scientist at the European Centre for Disease Prevention and Control. Among other tasks he leads the Disease Programme Section of the Centre. His main research interests include epidemiology of vaccine preventable diseases including influenza.

Dr Masoud Dara



Dr Masoud Dara is the programme manager and team leader of tuberculosis (TB) and multidrug resistant (MDR-TB) unit of World Health Organization European Region. Dr Dara is a physician and public health expert from Belgium. In addition to his medical degree and clinical experience, he has diploma in tropical medicine and epidemiology from London School of Hygiene and Tropical Medicine and Harvard School of Public Health. Since 1990, Dr Dara has been working on TB, HIV/AIDS, public health and health in prison in the capacity of senior consultant and Medical Officer in many countries of WHO European Region and other Regions including Middle-East, Africa and Western Pacific Regions. He has also experience in health in emergency and migrants' health as the Head of Mission of Red Cross and Médecins Sans Frontières. Since 2008, Dr Dara is the Chair of International Scientific Working Group on TB Control in prisons. He is the author of several publications and guidelines.

Ms Amy McConville

Amy McConville is an established TB Patient Advocate in the UK, having been an active participant in the fight against TB since 2006. Amy is co-facilitator of the TB Action Group (TBAG), the only UK-based network of People Affected by TB. TBAG was established in 2008 by the UK's TB charity, TB Alert, to provide a voice to people who have personal experience of TB and a valuable insight into how . As a representative of TBAG, Amy has contributed towards policy development and guidance on TB care and prevention at both a national and international level. Amy is also involved in raising public awareness of issues affecting TB patients, such as low levels of awareness amongst healthcare professionals leading to delayed diagnosis and complications, through high profile media advocacy.

Prof. Dr Ronald de Groot

Professor Ronald de Groot, studied medicine in Rotterdam, followed by a residency in Gynecology/Obstetrics and Surgery as a preparation for a 2½ year period as Senior Medical Officer in Zonkwa Hospital, Nigeria. He subsequently did his pediatric training in Rotterdam (1979-1983), became chief resident (1983-1985) followed by a research fellowship (1985-1988) in pediatric infectious diseases in the University of Washington, Seattle, USA. In 1988 he returned to the Erasmus University in Rotterdam and became in 1998 head of the training program and Professor in Pediatric Infectious Diseases and Immunology. From May 2005 until September 2009 he was head of the Department of Paediatrics of the Radboud University Nijmegen Medical Centre. Since May 2005 he is Professor of Pediatrics at the Radboud University Nijmegen.

Professor de Groot's research activities include clinical and laboratory studies in the fields of vaccinology, infections by pneumococci, meningococci and HIV, respiratory tract infections and immunodeficiencies. Ronald de Groot is (co)author of over 200 peer reviewed English language papers, more than 100 contributions to books, symposia and proceedings and over 40 Dutch language peer reviewed papers. Professor De Groot is a member of the Dutch Health Council, the Central Committee on Research involving Human Subjects (CCMO) and member of a large number of national and international advisory committees. In 2008, he was the recipient of the Bill Marshall Award of the European Society of Paediatric Infectious Diseases (ESPID). Currently, Professor De Groot is the President of ESPID.

Dr Andreas Schultz

Dr. Andreas Schultz is a senior medical officer and a specialist in paediatrics, tropical medicine and international public health. He studied medicine in Germany, France and the US. Over the last 11 years he had various assignments to tropical countries mostly as head of programmes, coordinator or advisor, e.g. in India, Indonesia, Thailand, Laos and Papua New Guinea.

He has a wide experience in strategic and operational planning in health project and programme management. He maintained his academic links and develops and continues to deliver innovative courses in International and Child Health.

Dr. Andreas Schultz is currently the country director of 'Doctors of the World' in Germany. Thus, he is responsible for projects in international humanitarian aid and development cooperation and has a strong focus on child and maternal health. Dr. Schultz also acts as a board member of several institutions engaged in international health.

PRESENTATIONS

Presentation by Dr Masoud Dara

The Fight to Beat Tuberculosis

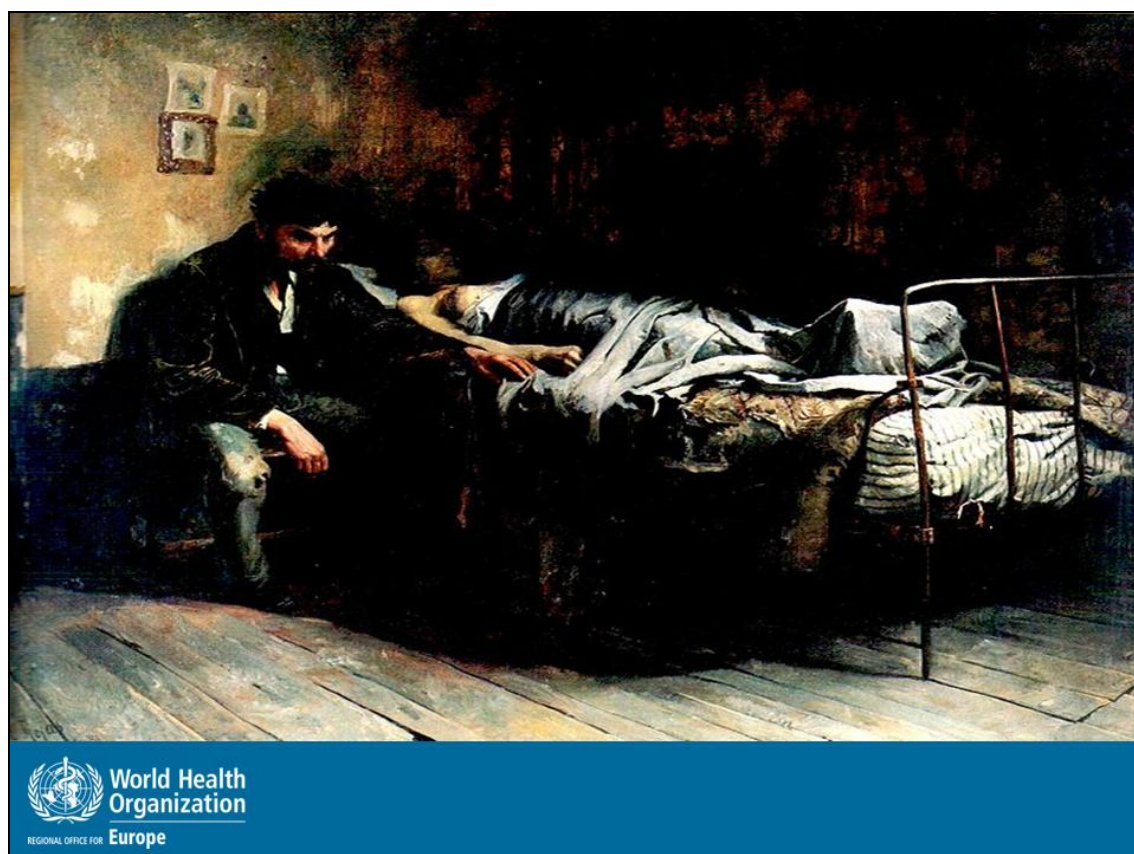
**Dr Masoud Dara, Programme Manager
TB and M/XDR-TB
World Health Organization Office for Europe
Brussels, 19 June 2013**



Outline of presentation

- TB and MDR-TB epidemiological situation
- Consolidated Action Plan to Prevent and Combat M/XDR-TB (MAP) in a nutshell
- Next steps
- Conclusions





The Global Burden of TB -2011



All forms of TB

Estimated number
of cases

8.7 million
(8.3–9.0 million)

Women: 2.9 million
Children: 0.5 million

Estimated number
of deaths

1.4 million*
(1.3–1.6 million)

Women: 0.5 million
Children: 64 000

HIV-associated TB

1.1 million (13%)
(1.0–1.2 million)

430,000
(400,000–460,000)

Multidrug-resistant TB

Up to 0.5 million

**Unknown, but
probably > 150,000**

No reason to be complacent about TB in the WHO European Region

- Total of over **500 000** estimated TB patients in the Region
- **380 000** new TB cases estimated to occur in a year
- **44 000** deaths, mostly in the east



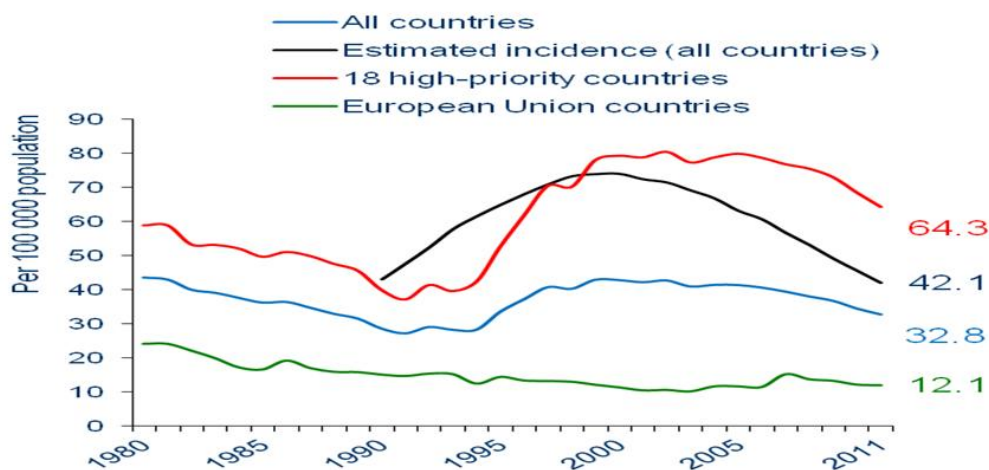
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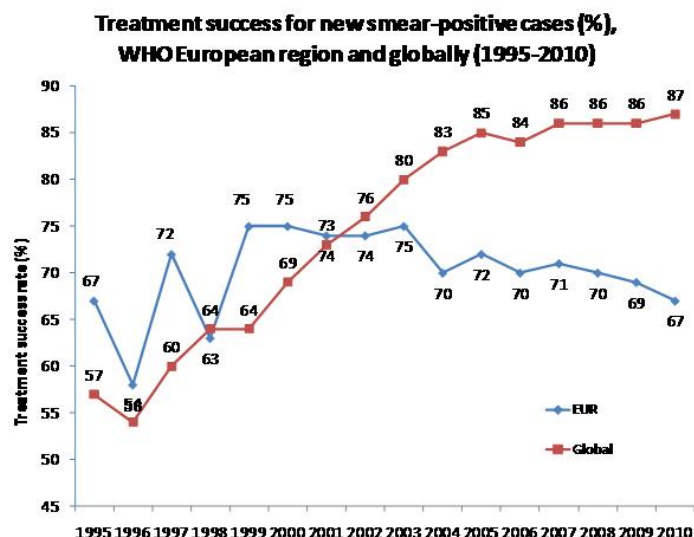
TB burden unequally distributed among countries

TB notification rate, 1980–2011



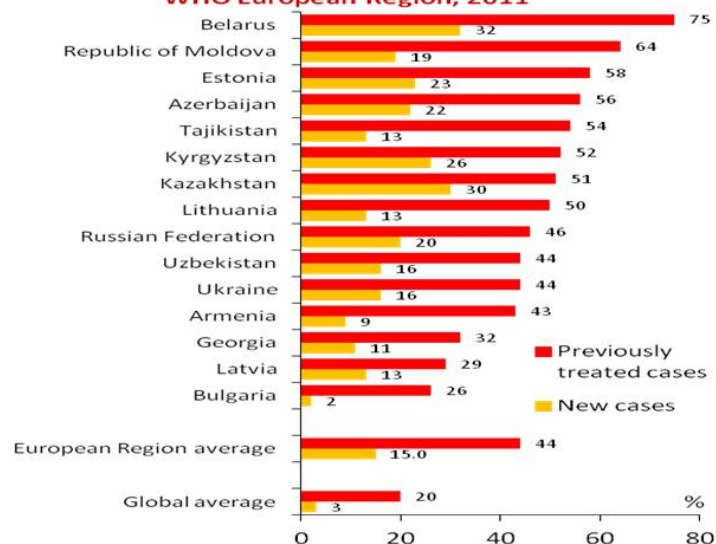
The WHO European Region has the lowest treatment success rate worldwide

While globally in other regions treatment success rate steadily is increasing, in WHO European region it is reducing.



M/XDR-TB in the European Region

MDR among TB cases (%), WHO European Region, 2011



Consolidated Action Plan to Prevent and Combat M/XDR-TB 2011-2015

- Prompt diagnosis, including newly endorsed molecular diagnostic techniques
- Equitable access to adequate treatment
- Health system approach to preventing and controlling MDR-TB
- Emphasis on involving civil society organizations
- Identifying and addressing social determinants
- Working in partnership, twinning of cities and programmes
- Robust monitoring framework, accountability and follow-up
- Including neglected aspects (such as palliative care and surgery)



Areas of intervention



Prevent the development of M/XDR-TB



Scale up access to effective treatment



Scale up access to early diagnosis



Infection control



Strengthen surveillance



Expand management capacity of the programmes

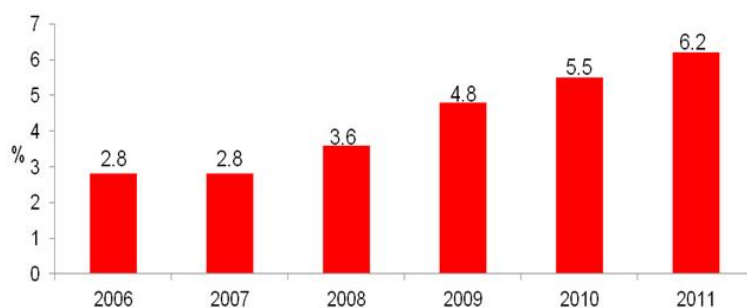


Address the needs of special populations



Leading killer among people living with HIV

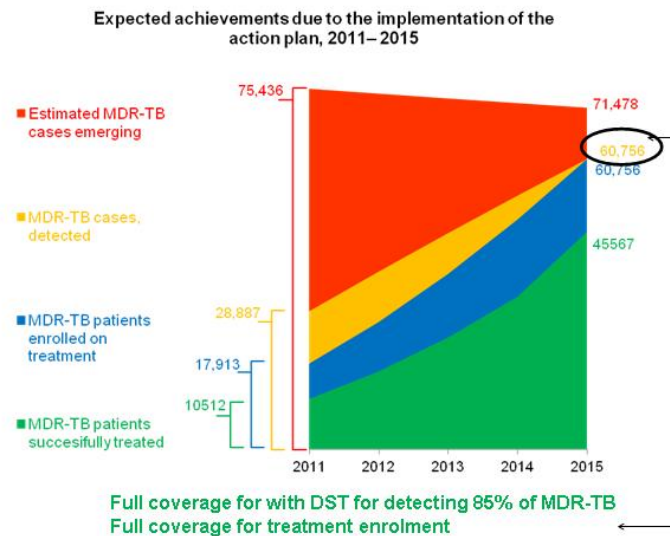
- Fewer than **13 000** TB cases with HIV co-infection were detected in the Region, or 56.5% of the estimated total.
- Only **70%** of them were offered antiretroviral treatment.



Percentage of TB cases with HIV co-infection among all HIV-tested TB cases increased by 20% a year in 2006–2011.

Expected achievements of MDR-TB Action Plan (MAP)

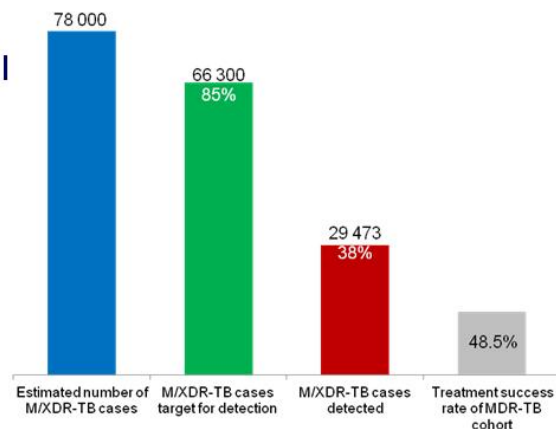
- 225 000 people with MDR-TB diagnosed
- 127 000 people with MDR-TB treated successfully
- 250 000 MDR-TB and 13 000 XDR-TB cases averted
- 120 000 lives and 12 US\$ billion saved



Numbers talk

- 78 000 people estimated to fall sick with M/XDR-TB yearly
- Only 30 000 M/XDR-TB patients diagnosed
- Fewer than 50% of MDR-TB patients successfully treated

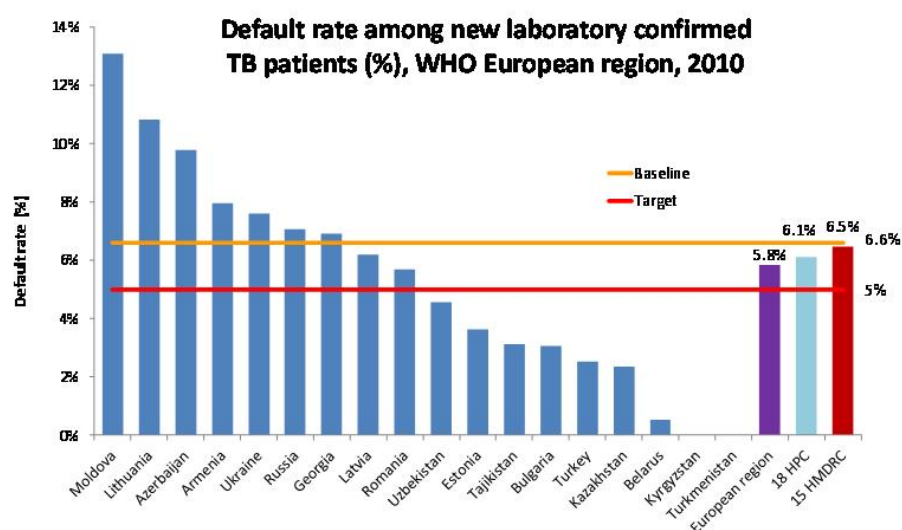
Core indicators for monitoring the implementation of the M/XDR-TB action plan, WHO European Region, 2011





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Some countries showed good progress in reducing default rate

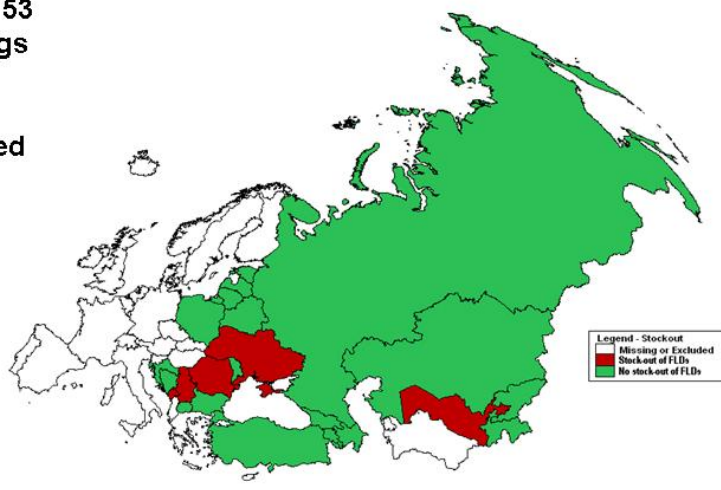


Member states with no stock-out of first-line TB drugs at any level, 2011

23 Member States out of 53 reported on first line drugs stock-out status;

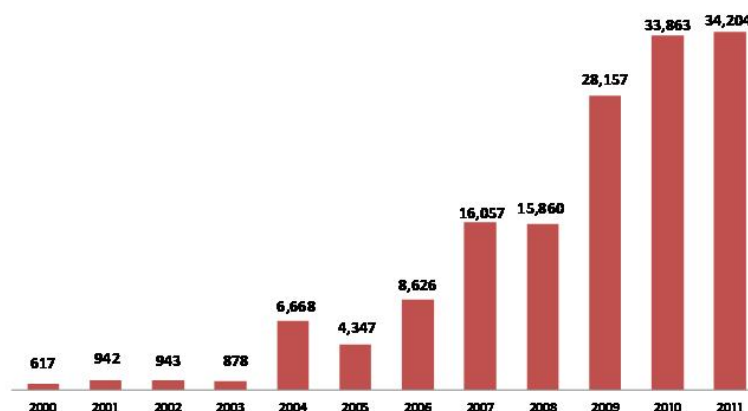
18 Member states reported no stock-out;

Stock-out reported in *Romania, Montenegro, Serbia, Ukraine, Uzbekistan.*

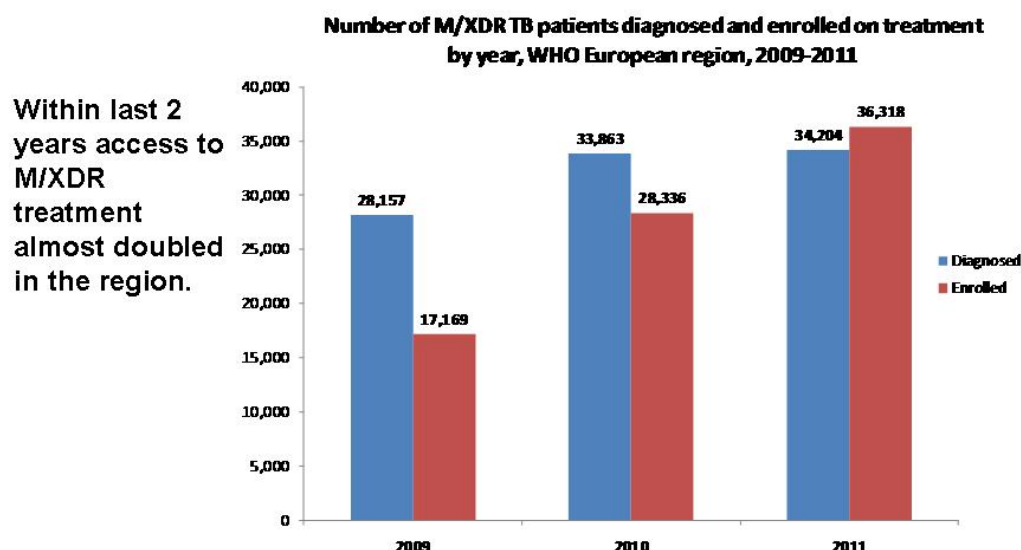


Efforts are made for increased access to diagnose MDR TB...

Number of MDR patient diagnosed by year in WHO European region, 2000-2011



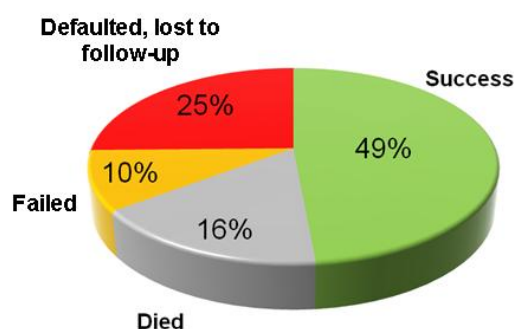
Notable progress in scaling-up access to MDR treatment ...



But...still far below to reach target of 75% of successful MDR treatment outcome

Treatment success varied from 16% to 74% among MDR-TB patients started on treatment in 2009 in the 12 MDR-HB countries of European region.

Treatment outcome of MDR TB patients started treatment in 2009, European region (n=12110)



Fourteen countries reported no data on outcomes.



Next steps

- Continuously and closely **support the Member States** in implementation of the Consolidated Action Plan;
- Prepare compendium of Best Practices
- Identify and address the social determinants of TB and M/XDR-TB
- Scale up the **best practices** and **patient-centred ambulatory care**;
- Strengthen country capacity in **surveillance** for producing reliable estimates of **MDR-TB** figures;
- Introduce **rational use of new TB drugs**;
- Develop interventions to **move toward TB elimination** in low TB incidence countries;
- Defining the **role of surgery** in TB and M/XDR-TB.

Conclusions

- Despite major efforts in rapid molecular diagnosis, there are still 2/3 of MDR-TB patients not diagnosed
- Treatment lengthy, expensive, difficult and with low success
- Ongoing substandard practices in Europe and particularly in EU with emerging extensively drug resistant TB
- Stock-out of medicines, vaccines and supplies even in EU
- TB and M/XDR-TB a serious public health threat with financial crisis and budget cuts but also due to rise of unemployment, stress and poor nutrition
- We need to join forces and learn the lessons from best examples like TB-MDR-TB epidemic control in New York.

Acknowledgements

WHO headquarters Dr Mario Raviglione and My team members in Copenhagen particularly Dr Andrei Dadu, and WHO country offices, Member States, NTP managers and partners

Thank you very much for your attention

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Presentation by Ms Amy McConville



The Patients' Voice

Amy McConville
TB Action Group

Involving People Affected by TB in the fight against the illness

- TB Action Group (TBAG) is the only network of People Affected by TB in the UK and has been at the forefront of the development of the civil society response
- Established by TB Alert in 2008 to provide a unique voice to people in the UK who have been personally affected by TB and therefore have valuable insight in to how TB services are delivered

Involving People Affected by TB in the fight against the illness

- TBAG is increasingly becoming the first port of call for policy makers who need the patient perspective
- The actions of the patient advocates within TBAG are primarily focused on the following areas; providing peer support for people during their treatment journey; raising awareness of TB and advocating for improved TB care and prevention

People Affected by TB must be heard!



BCG: the most widely used tool to prevent TB around the world

- The BCG was introduced in 1953 contributing to the steady decline in TB deaths, among the UK-born population
- Research has shown that the BCG is most effective in early childhood and is usually given to babies to prevent serious forms of TB, such as TB meningitis
- The BCG currently plays an important part in reducing the risk of TB among vulnerable groups

UK BCG Immunisation Policy

- **Pre-2005:** Universal programme introduced in 1956, initially given to school children between ages of 13-14 years old, according to (then) disease pattern. Current policy remained unchallenged for decades.
- **Post-2005:** Targeted, evidence based programme, introduced by an independent committee, aimed at populations most at risk of exposure to TB.

(Green Book, Ch 32, tuberculosis, Dept of Health)

UK BCG Immunisation Policy

- **Criteria for eligibility**
- Babies and older children who are living in high incidence areas of the UK (annual rate of +40/100,000)
- Babies and older children who have grand/parents from countries where TB is endemic (annual rate of +40/100,000)
- Health care professionals and caregivers under the age of 35 who are vulnerable to exposure from TB due to their occupation

Why it is crucial to eliminate TB as a public health threat in Europe and beyond

- Each year, an estimated 9 million people world wide become ill from TB and at least **1.4 million people will die as a result** – that's the equivalent of 8 tsunamis occurring each year
- TB is no longer a disease of the past; rates of TB in London have slowly risen by 60% over the last 25 years, with 9,000 new cases in 2011. These striking figures show that London has the highest prevalence of any major city in Western Europe – **London is now known as the 'TB capital of Europe'**

Why it is crucial to eliminate TB as a public health threat in Europe and beyond

- **The current shortfalls with the BCG vaccination**
- We are still using ancient tools to fight a 21st century disease - the BCG is the only preventative weapon to date, yet it is more than 90 years old!
- The BCG has a short life span of 15 years – it is a common myth among communities that the BCG will offer life long protection, this poses a considerable barrier to accessing early diagnosis and treatment

Why it is crucial to eliminate TB as a public health threat in Europe and beyond

- Overall the BCG has a limited efficacy of 85% which further declines when administered in countries near to the equator, due to occurring environmental forms of TB mycobacterium – but it is those countries which carry the highest burden of TB
- The BCG is not effective in protecting adults against the most common forms of the disease such as pulmonary TB, therefore it is weak in preventing the spread of the illness

Why it is crucial to eliminate TB as a public health threat in Europe and beyond

- **The urgent need for new TB vaccines:**
- It's vital that we develop TB vaccines that will protect against all forms of TB, including drug resistance which is emerging in all parts of Europe – at present, the treatment for drug resistant TB is lengthy, and carries an increased risk of toxic side effects
- A new vaccine would tackle the problem of increasing rates of TB-HIV co infection in Europe by developing a safe vaccine that can be given in children who are HIV-positive – this would enable more communities to live longer, healthier lives

Why it is crucial to eliminate TB as a public health threat in Europe and beyond

- **Put quite simply ...**
- **... Effective vaccines have an enormous potential to save millions of lives around the world ...**
- **... They are vital key tools in the fight to prevent TB deaths ...**

The story of one woman's personal experience

- **The before, during and after**
- **Impact of delayed diagnosis of up to 2 and half years - 'frustration and subsequent relief through finally being able to identify illness'**
- **Implications of potential side effects - 'fear of the drugs'**
- **Severity of illness and prolonged treatment journey with - 'no end in sight'**

The story of one woman's personal experience

- **Individual costs to the TB patient: Social, physical, emotional burden**
- **Loss of productivity / disrupted university education due to chronic health**
- **Feelings of isolation / disconnected from friends and family**
- **Sense of disempowerment / loss of control**
- **Poor emotional health and wellbeing**

The story of one woman's personal experience

- Social and psychological costs are not easily quantifiable in economic terms
- These types of costs are 'intangible' and include things such as pain, suffering, depression and self blame
- Additional costs are acquired such as extra food supplements, long term treatment costs, loss of earnings, etc

The story of one woman's personal experience

- **The economic costs to the health system**
- There are financial considerations of delayed diagnosis and further complications to the health system in countries in Europe
- **Uncomplicated v Complicated**
- A patient who does not experience delays in accessing diagnosis and treatment will have a relatively straightforward cure, leading to a greater cost effective outcome; as low as £1,100

The story of one woman's personal experience

- A patient in their most economically productive years, who requires extensive treatment for up to 2 years and surgical interventions will experience complex treatment costing the health system £10,000 +
- It's important to take in to consider the positive health benefits to the individual and the economy, to be gained from maximising wellbeing and reducing the social consequences of TB. **It is cost effective and morally right to invest in the health of all citizens!**

How can we save 9 million lives on a global scale?

- Encourage the uptake of BCG in affected communities where its impact will be most effective
- Roll out safe, effective TB vaccines that can be widely used
- Hold to account renewed commitments to increase funding for vaccine research and development at the EU level

How can we save 9 million lives on a global scale?

- Create political champions to facilitate engagement and strong commitment from the global community to address the urgent need to prevent TB; and ultimately reduce the human cost and suffering from this illness

I want ZERO deaths and no more people sick with TB!



Presentation by Dr Ronald de Groot

Current Measles Outbreak The Voice of the Professionals



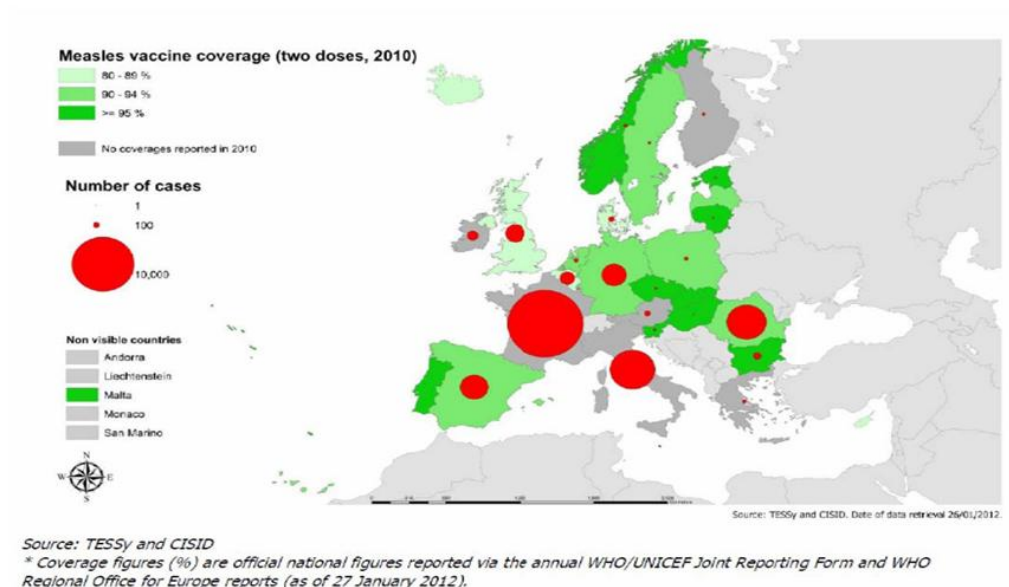
Ronald de Groot

*President of the European Society for Paediatric Infectious Diseases
Professor of Paediatrics, Radboud University Nijmegen, The Netherlands
Member of the Health Council of The Netherlands
Member of the NIP Committee of the Health Council of The Netherlands*

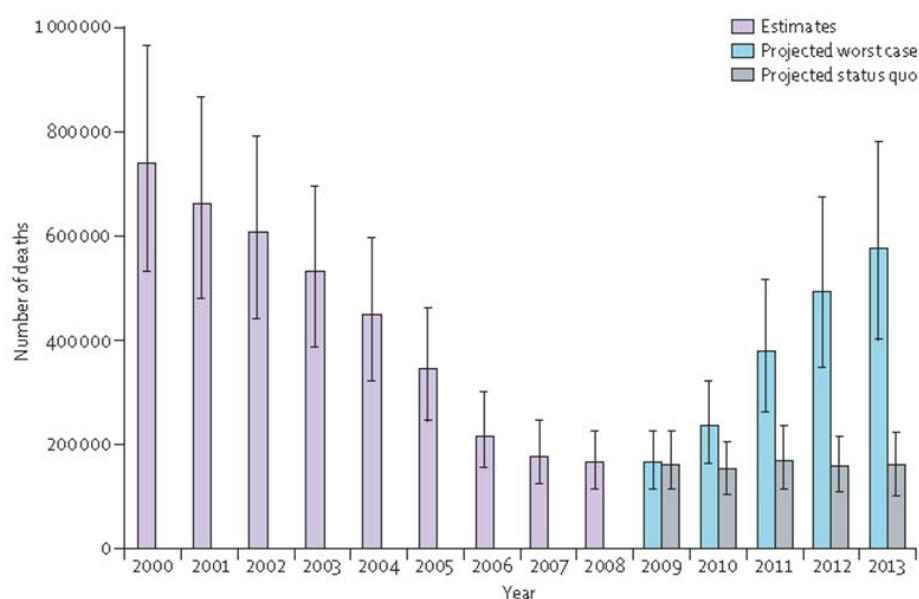
Measles: background

- Highly contagious disease, not only in children but also in adults, with a case fatality rate between 1:1,000 and 1:3,000 reported cases
- Infants < 9 months and immunocompromised individuals are at increased risk for severe disease
- Measles vaccination has reduced mortality worldwide from 873,000 in 1999 to 164,000 in 2008
- Failure to maintain high levels of measles vaccine coverage – both in Europe and in other continents – has resulted in a resurgence of disease
- Immunization against measles with two doses of the MMR vaccine is highly effective and may result – assuming that vaccine uptake is >95% – in eradication of the disease

Measles in Europe



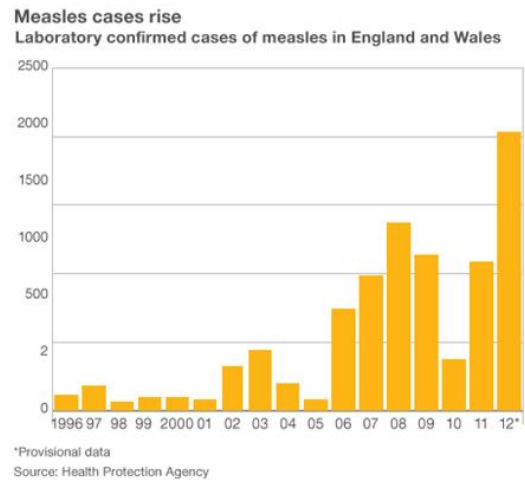
Estimated number of measles deaths worldwide 2000 - 2008



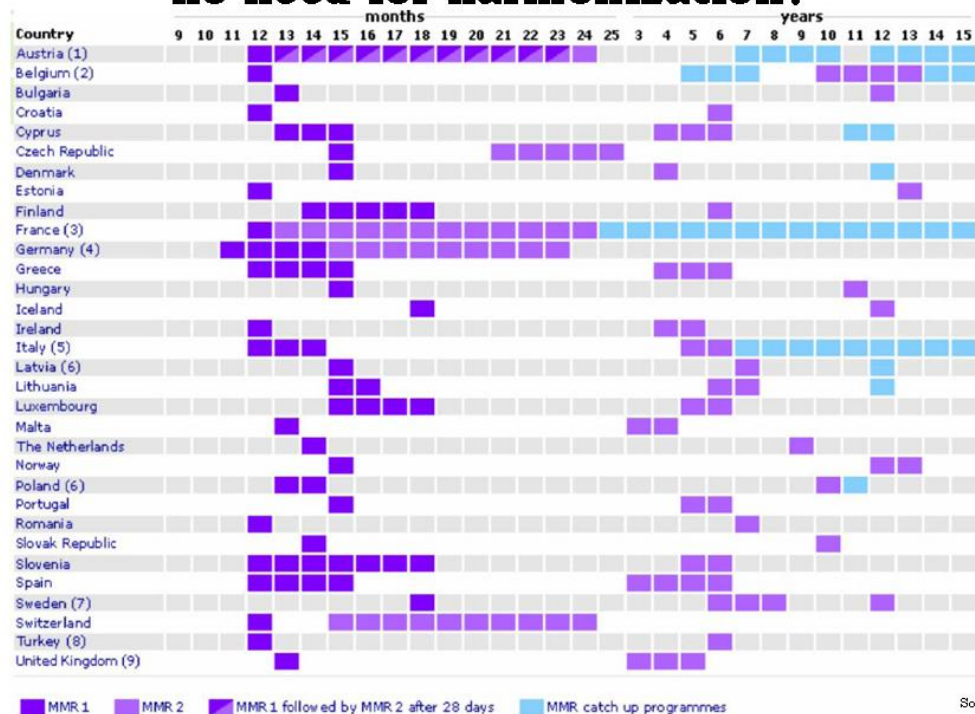
Source: Moss et al. Lancet 2012

The current measles outbreak in England and Wales: an example

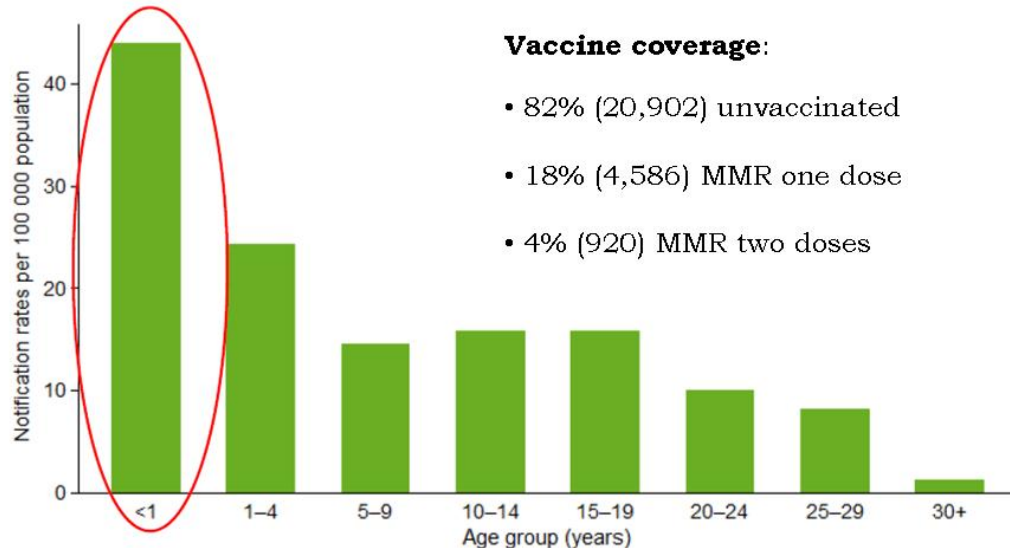
- ✓ In the UK, between 1990 and 2012 the uptake of the vaccination was impacted by a vaccine scare (the Wakefield story)
- ✓ In 2012 there were more than 2,000 cases of measles in England and Wales - the highest figures for two decades
- ✓ The measles outbreak is ongoing in the beginning of 2013 and causes substantial morbidity and even mortality
- ✓ The low vaccination uptake in the UK and many other countries indicates a failure in the public health system and needs immediate action by **all stakeholders**
- ✓ On April 25th the UK health authorities decided the immediate start of a **catch-up vaccination program**



MMR Schedules in Europe: no need for harmonization?



Measles in Europe



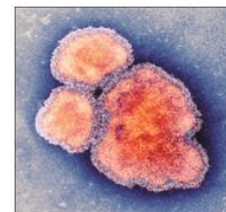
JAMA[®]

The Journal of the American Medical Association

Outbreaks Spur Measles Vaccine Studies

Tracy Hampton, PhD

- Recent measles outbreaks in the US and Europe
- 84% of US residents unvaccinated or unknown vaccination status
- Increased importations of measles in the US
- High 2-dose vaccination coverage have limited spread of measles
- Outbreaks in Quebec are raising questions about effectiveness of measles vaccine schedule
- Many adults in the US get a 3rd dose when entering college
- 65% of Canadian cases were reported in individuals aged 10 – 19 years
- 66% of Canadian cases were unvaccinated, 24% had written proof of vaccination and 10% reported being vaccinated without written proof



Recent measles outbreaks are raising some questions about vaccination to protect against infection with this highly contagious virus.

Conclusion: The Canadian results, but also those of other countries, indicate that the large majority of the outbreaks is in unvaccinated individuals. However the high proportion of individuals who were previously vaccinated once or who were first vaccinated at an early age raises concerns regarding vaccine effectiveness.

Hampton JAMA 2011;306:2440-42

Conclusions (1)

- Outbreaks of measles are **resurging** in Europe and elsewhere
- Immediate action is necessary in the form of **catch-up vaccination programs** in European countries where the number of cases of measles is increasing
- Strengthening of **surveillance** is necessary to quickly identify cases and outbreaks
- Data from ECDC suggest significant differences between administrative and survey methods used to determine **MMR vaccine coverage** in European countries: coverage <95% is common
- The development of **rapid point-of-care tests** for measles is needed
- The continued progress toward the development of **an ideal measles vaccine** must be strongly supported

Conclusions (2)

- MMR vaccination schedules need to be **harmonized** within Europe:
 - Administration of the first dose at a very young age **increases** the risk for measles later on in life
 - Administration of a second dose is **absolutely necessary** to ensure longstanding immunity
 - The **optimal timing** of the second dose needs further study
 - Is there a need for a **3rd dose of MMR** as is administered in the USA to adults entering college?

Conclusions (3)

- Keep the general public **informed and engaged!**
- **Collaborate** with health care professionals and (inter)national societies such as ESPID to **combat** the outbreak of infectious diseases like measles
- Engage **opinion leaders** from various fields on the importance of immunization
 - ESPID provides an existing network with key opinion leaders
- The lessons **go beyond** measles: in case of a local outbreak of a vaccine preventable disease, the uptake (= % people wanted to be vaccinated) will increase very abruptly due to the media coverage and sudden awareness

Conclusion (4)

- European consistency is a definitive “plus”
- ESPID is willing to play a role by issuing clear guidelines and supporting a strong and well- established scientific and healthcare network base



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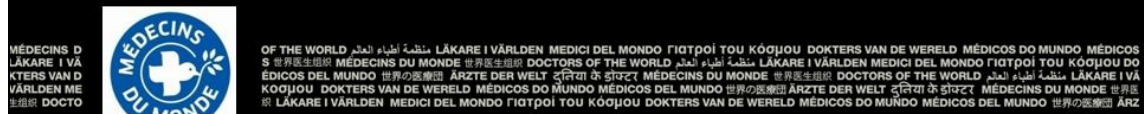


OF THE WORLD منظمة أطباء العالم LÄKARE I VÄRLDEN MEDICI DEL MONDO ΓΙΑΤΡΟΙ ΤΟΥ ΚΟΣΜΟΥ DOKTERS VAN DE WERELD MÉDICOS DO MUNDO MÉDICOS
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Doctors of the World – who we are

- A network across the EU offering service provision through 160 programmes (and 152 outside the EU)
- targets in Europe: homeless people, drug users, sex workers, asylum seekers, Roma, elderly, destitute EU citizens and third-country undocumented migrants
- systematic data collection on the social determinants of health
- 20% fixed / 80% mobile units for harm reduction realized with professional volunteers





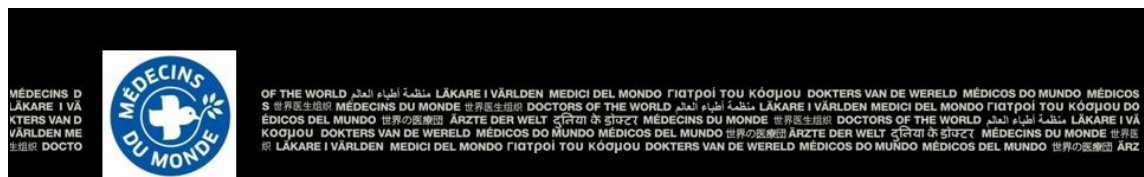
Importance of vaccination against measles

→ 85% of measles cases across Europe were unvaccinated (ECDC)

→ highly infectious, potentially very severe consequences due to immuno-attenuation (and expensive to treat)

- frequent hospitalization for adults
- pneumonia, otitis media, encephalitis
- irreversible neurological damage and death in rare cases

→ MMR vaccine is safe, effective and lifelong for most (98% immunity after 2 shots – 95% population coverage needed to eradicate measles)




Barriers to vaccination – MdM field observations

→ financial barriers – the example of Greece

- today, many Greek families do not have health coverage anymore (rising unemployment) and consequently have to pay for vaccines. The majority cannot pay: about 1.500€ to follow the national immunization schedule for a child up to 6 years old, including medical consultation fees...)

- even insured families frequently need to pay (but they cannot)



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Barriers to vaccination – MdM field observations

→ within the last six months, MdM Greece vaccinated 1.091 children from 2 months to 14 years but lack of means to cover all the needs!

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Iannis is a 13-year-old boy who lives with his mother and his younger brother in Perama. They belong to the Roma community. His mother has no income and — they have no relatives to help them. Currently they are hosted in a small flat without electricity and they receive food items from MdM's Polyclinic. Iannis cannot go to school anymore because he hasn't been vaccinated and because the director doesn't want him in the school.

"I want to continue school, I like reading... I can't understand why the teacher doesn't accept me at school; all my friends are in school now". His mother told us "I don't know what else to do, the head teacher told me that Iannis doesn't have a valid health booklet, I don't have the money to buy the necessary vaccines." A paediatrician from MdM examined Iannis and administered the necessary vaccines. Our social worker spoke with the head teacher and explained to her that she was obliged to enrol him in school. Finally, Iannis managed to go back to school. "I'm so happy to have books, thank you all so much!"

MdM Greece – Perama – September 2012

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Barriers to vaccination – MdM field observations

→ 60% of our patients (MdM survey 2012 across 14 European cities) do not know where to receive vaccination...

- legal and administrative barriers
- language barriers
- focus on day to day survival instead of prevention
- discrimination of specific population groups

→ many people without vaccination booklet that remember “having had at least one shot”, unawareness about how many shots are required (insufficient communication by health professionals)

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Barriers to vaccination – MdM field observations

→ consequences of restrictive policies

- e.g. German social welfare centers have a duty to denounce undocumented patients → although vaccination is theoretically accessible, many undocumented migrants fear being reported
- e.g. Belgium: theoretical (legal) access to healthcare for undocumented migrants but many complex administrative barriers → only 13,3% of Roma minors had an up to date vaccination booklet (2013 Brussels survey) despite free vaccination offer in preventive childcare services <7years old (32% of children had already had measles)

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Barriers to vaccination – MdM field observations

→ consequences of restrictive policies

- e.g. France violent crackdowns of Roma camps cause public health risks (e.g. vaccination campaigns are stopped, booklets get lost, interruptions of medical follow-up) but ironically...
- sanitary risks are often used by authorities as an excuse for the crackdowns...






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Myths on Roma and vaccination

- MdM survey in Nadezhda in 2009 (Sliven, Bulgaria) by Roma community mediators – 92.8 % of the women in the questionnaire answered that vaccines “are good and we trust them”
- MdM survey among Roma in Brussels (2013): 98% of mothers said they would accept their children to be vaccinated (“but where?”)
- the Roma we met are all sedentary but forced to go from one place to another by the police



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“It was more than a year ago during the outbreak of measles. My wife Magdalena who was 16 had high temperature, nausea and unwillingness to eat. Pimples appeared on her face and all over her body. I took her to a doctor: she had measles.

She was not the only one in the neighborhood. There were already many kids who got sick from measles, too. The doctor prescribed some pills. The same day it became worse. She started to wriggle and she had very high temperature. In the morning I took her to the hospital and asked them to hospitalize her. The doctors told me that there was no free space in the hospital. They gave an injection and said that she will get better and we should go home. But shortly after we got home she started shaking again with high temperature.

Shortly after, my wife died. I don't understand why she was not hospitalized. It was visible that she was in very bad condition. It seems they don't care much about us since we are Roma. It is like they want to get rid of us.”

Mr. A. age 18, Roma, citizen of Bulgaria, living in Nadezhda, the Roma neighbourhood in the city of Sliven (Bulgaria). December 2011.

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Recommendations towards Member States

- full access to vaccination for all vulnerable people (both minors and adults)
- implement opinions of the EU Fundamental Rights Agency (FRA) on access to healthcare for undocumented migrants so that **everyone** can access all forms of essential preventive and curative healthcare (both children and adults)
 - equal access to vaccination alone is not enough
 - comprehensive, in-depth prevention work requires accessible low-threshold primary care services (vaccine administration by the family doctor works best)
 - preventive and curative healthcare are **basic human rights for everyone**

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“When I started going to school here it was very difficult. I had to go and see an official doctor from the school, he asked me for my vaccination but we didn’t have any vaccination cards. When we left Romania, we could not take everything with us and my mother doesn’t know if I am vaccinated. The school told us that I need vaccination for measles, polio, diphtheria and tetanus, but they did not tell us where to get them without health insurance. I was looking forward to go to school and I was afraid that I would not be able to go.

The doctor at the MdM clinic told me after a blood test that it was good that I came here as I wasn’t vaccinated at all. So my sister and me got all the vaccinations at the MdM clinic and I started going to school.”

Ms S., age 8, living in Germany for the last 3 years, January 2012.



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Recommendations towards Member States and the Commission

- monitor the accessibility to national immunisation schemes & paediatric care for all children (under 18 years old) in Member States
- put ECDC recommendations into practice (technical report on MMR vaccination coverage 2012)
- evaluate the long-term impact of proposed austerity measures on health (systems) – “use scalpels instead of butchers’ knives”

DIRECTORATE-GENERAL FOR INTERNAL POLICIES

POLICY DEPARTMENT ECONOMIC AND SCIENTIFIC POLICY **A**

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