

Access to Childhood Vaccination

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Introduction

Following the December 2014 Council Conclusions on vaccinations as an effective tool in public health¹ and supplementing EPHA's broader monitoring of European (EU) developments in vaccination and children's health policy, this report explains and makes a case for the importance of **universal access to childhood vaccination**. This is an important issue also in light of the recent re-emergence of infectious disease outbreaks such as measles in Europe (which have resulted in a public health failure to meet the 2015 eradication target for this disease) and current discussions related to migration. Particular attention shall be paid to the EU measures and legislative framework in this area - **concrete recommendations for European and national policymakers are outlined as part of the conclusion**.

As a crucial prevention tool that can also save lives, childhood vaccinations offer all-in-one protection without requiring annual reformulation to protect against new strains, which remains a challenge in some disease areas like seasonal influenza. Childhood vaccinations can hence be seen as one of the greatest achievements in the history of modern medicine. From a public health perspective, it is therefore important to ensure that **parents are given the opportunity to vaccinate their children wherever they live and regardless of their economic situation, residency status or vulnerabilities**. Indeed, many vaccines protecting children against MMR (measles, mumps and rubella), whooping cough, diphtheria and hepatitis B are today considered essential as part of national immunisation schedules in Europe and globally.

Immunisation, eligibility, adherence

Infectious diseases have always posed a threat to the world's population, and especially to society's most vulnerable population groups including children. There is evidence that already 1,000 years ago, people understood the connection between exposure and immunity and hence practised primitive forms of inoculation.²

Since the development of the first vaccine in Europe by British physician Edward Jenner in 1796, vaccinology and immunisation have evolved tremendously. The introduction of widespread vaccinations in the 1950s drastically reduced disease rates. For example, while between 1951 and 1955 around 28,500 children became paralysed every year in Europe due to polio; the disease has been considered eliminated as of 2002. Similarly, between 2000 and 2012, measles deaths were reduced by 78% as a result of a global effort to increase access to vaccination.³ Smallpox was officially declared eradicated by the World Health Organization (WHO) in 1980; it was the first disease to have been fought on a global scale.⁴

Vaccination provides **active immunisation** against infectious diseases. By introducing a tiny amount of a virus or bacterium responsible for a disease, vaccines stimulate the immune system to produce antibodies without infecting people with the disease.⁵ Vaccination also stimulates the immunological memory against the virus or bacterium

¹ http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lsa/145973.pdf

² <http://www.publichealth.org/public-awareness/understanding-vaccines/> .

³ http://www.who.int/immunization/newsroom/measles_rubella/en/

⁴ <http://www.who.int/features/2010/smallpox/en/>

⁵ EPHA Briefing on Vaccination (2014), under review



contained in the vaccine. As a consequence, if the disease spreads, a vaccinated person is less prone to be infected because the immune system will recognise it and immediately produce the antibodies needed to fight it.

However, certain persons are **not eligible for childhood vaccinations**, e.g. when an infant is still too young to be immunised (e.g. measles vaccination is recommended from the age of 12 months) or too ill to cope with the effects of the vaccination. The same goes for children with immunosuppressive illnesses like childhood cancer or leukaemia. For them, it is all the more important that the other children around them are immunised, since the transmission of infections could lead to death or long-term health problems.

In order to protect children at risk, it is thus crucial that the great majority of the population is sufficiently immunised. This concept is called **herd immunity**. When 95% of the population is vaccinated⁶, it is difficult for infectious diseases to spread because there are not many people who can be infected. This means that if the vaccination rate threshold is reached, many infections can be prevented, which is advantageous from a public health and community perspective.

Furthermore, some eligible children in Europe are not vaccinated because their parents decide not to do so as a result of their own **vaccination hesitancy**. There could be many reasons for the latter including, for example, fear of adverse reactions or harm, lack of knowledge, conflicting media messages or disbelief in the body of scientific evidence. Distrust has proven to be a growing issue in the United States and in many European countries⁷. As a result, e.g. measles rates have multiplied in recent years. It has also triggered public debates about parents' rights and responsibilities. New policy measures, e.g. the 2015 Präventionsgesetz (Prevention Law) in Germany, obliges parents to consult their family doctor about childhood vaccinations before sending their children to kindergarten.⁸

Ironically, childhood vaccination appears to be a victim of its own success. So many diseases have been successfully eliminated or controlled that many parents think it is unnecessary or harmful to vaccinate against diseases they have never experienced themselves. Others are concerned about over-vaccinating their children and about the adjuvant materials used to make them.

In order to encourage as wide acceptance of childhood vaccination as possible, it is thus **crucial that the concerns of parents are addressed in a non-confrontational fashion**. This can only be done by properly **informing about and building trust** in vaccinations. Health professionals must provide sufficient information about vaccinations, their achievements, their comparative risks and benefits, and they must be able to identify and respond to the concerns of parents and children / adolescents themselves from a wide range of cultural backgrounds and/or with different medical belief systems.

Crucially, **healthcare workers should practise what they preach** since unvaccinated health workers can pose an equally important threat to sick children and their parents, and as vectors they increase the risk of infectious disease and healthcare-associated infections in their health institutions. The complacency of health professionals is easily passed down to patients. For healthcare workers in particular, prevention and vaccination

⁶ This figure is for measles, the percentage is slightly lower for e.g. diphtheria and whooping cough

⁷ <http://www.euractiv.com/sections/health-consumers/distrust-vaccinations-rise-across-eu-313296>

⁸ www.eph.org/a/6403



are closely linked. Hence education about vaccination is as important for them – as trust bearers - as it is for parents.

Increasing access and reaching undeserved groups

The opinions of the European Union Agency for Fundamental Rights (FRA) on access to healthcare for migrants in an irregular situation call for enabling all children and adults to access all forms of essential preventive and curative healthcare including vaccination. FRA states this is a basic human right.⁹

Nonetheless, **lacking or insufficient access to healthcare** remains an important barrier, also in Europe, with the result that many eligible children and adolescents do not get vaccinated. Non-immunised children are at a significantly higher risk of contracting infectious diseases in comparison to vaccinated children. Europe's growing population of undocumented, itinerant, homeless or otherwise deprived individuals is at a particular risk. **Social determinants such as poor or no housing, malnutrition, limited access to water and basic sanitary installations etc. play a crucial role in explaining excess morbidity.** But people who need the protection offered by vaccination the most also face the highest barriers to access it.

An example of a population group facing multiple vulnerabilities due to social determinants (inadequate housing and sanitation, little access to water and electricity, etc.) are **Roma communities**, in which the proportion of e.g. measles tends to be higher than among non-Roma.¹⁰ Evidence suggests that migrant Roma in particular have lower if not much lower childhood vaccination rates.¹¹ Unsurprisingly, many Roma are also experiencing serious problems related to accessing healthcare (both due to spatial segregation or due to frequent changes of residency). Low health literacy and infrequent exposure to health professionals result in limited parental agency, low knowledge about vaccinations and unhealthy choices.

Migrants and asylum seekers are a growing population group in many EU Member States and the ongoing humanitarian crisis in the Mediterranean and in Central and Eastern Europe is calling for a much better coordinated European response to the question of how to host, and potentially disperse, refugees. Regrettably, many migrants - regardless of the 'category' they initially belong to - end up living in Europe undocumented and in constant fear of expulsion, hence they deliberately avoid contact with public authorities, including health institutions. Furthermore, although undocumented migrants and their children have theoretical access to basic healthcare services in many EU countries, evidence suggests that administrative hurdles and uncomfortable questions prevent them from taking advantage of these offers. In Germany there is even an obligation for health professionals to report the residency status of their patients.¹²

Although the overall measles vaccination rate in Europe is still near 95% (but with big variations between population sub-groups as outlined above), **vaccination rates in low-to-medium income third countries are much lower** (e.g. on the African continent it is

⁹ http://fra.europa.eu/sites/default/files/fra_uploads/1771-FRA-2011-fundamental-rights-for-irregular-migrants-healthcare_EN.pdf

¹⁰ <http://www.vaccines.today.eu/vaccines/how-can-roma-children-be-protected-from-measles/>

¹¹ http://ec.europa.eu/health/social_determinants/docs/2014_roma_health_report_en.pdf

¹² Vernon, G. (2012), 'Denunciation: a new threat to access to health care for undocumented migrants', Br J Gen Pract. 2012 Feb; 62(595): 98–99, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3268483/>



74%, in Syria only 61%).¹³ This means that particular attention must be paid to providing universal access since otherwise, migrants' health problems will remain undetected, and the newcomers themselves, their children and the wider community are put at risk.

If people do not have sufficient and easy access to health services including vaccinations, the vaccination ratio will increase unavoidably. For example, a 2015 study undertaken by Médecins du Monde International Network analysing data collected in their clinics in 26 cities across 11 European countries revealed the disturbing fact that **only about 35% of children in families facing multiple health vulnerabilities were vaccinated against MMR (mumps, measles and rubella) or whooping cough, while over half (58%) had not been vaccinated against tetanus.**¹⁴

Moreover, the report also reveals that **austerity measures** implemented in several EU Member States in response to the economic crisis are further aggravating this situation, especially in Greece, as many impoverished and/or unemployed parents do not have health insurance anymore and cannot afford vaccinations; yet the latter are often compulsory for children wishing to attend school.¹⁵ At the same time, vaccine shortages for certain diseases present a growing problem in some Member States and globally.

Around the world, **1.5 million children** die every year of vaccine-preventable disease, and 1 in 5 children do not receive the full course of basic vaccines. This is a particular problem in sub-Saharan Africa, which accounts for 50% of all deaths among young children and almost half of the world's maternal deaths. It is also the region hardest hit by HIV/AIDS, malaria and tuberculosis.¹⁶

It is thus of utmost importance that universal access to childhood vaccination is guaranteed across Europe, and EPHA is strongly in favour of expanding access options for children beyond the current available channels, e.g. by funding mobile medical units to better reach vulnerable populations.

EU measures

The key EU document specifically on childhood vaccinations is the Council Conclusions on childhood immunisation adopted in June 2011¹⁷. In this document, the Council recognises that, although childhood immunisation remains the responsibility of individual Member States, there is added value in addressing childhood immunisation at EU level. Therefore, the Council invites both Member States and the Commission to take various actions, including sharing experiences and best practices to improve the vaccination coverage of children against vaccine-preventable diseases.

As a result, the Commission, together with the European Centre for Disease Prevention and Control (ECDC) and the European Medicines Agency (EMA), have taken measures to support the Member States in their childhood vaccine strategies.

¹³ <http://apps.who.int/gho/data/view.main.80100?lang=en>

¹⁴ <http://carusel.org/blog/wp-content/uploads/2015/06/138-pages-full-report-mdm-intl-network-11-countries.pdf>

¹⁴ <http://www.medecinsdumonde.org/Access-to-healthcare-in-Europe-in-times-of-crisis-and-rising-xenophobia>

¹⁶ http://europa.eu/rapid/press-release_MEMO-14-362_en.htm

¹⁷ <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2011:202:0004:0006:EN:PDF>



The ECDC is also in the process of developing various web-based vaccination resources for healthcare professionals and the public, including a website on vaccination, an interactive database on vaccines, and a vaccination schedule platform allowing comparison of vaccination schedules across countries. In addition, ECDC has developed various guidance documents such as the scientific panel on childhood immunisation schedule, as well as tailored communication materials aimed at the public and a 'communication action guide' for healthcare workers to enhance uptake of childhood immunisation.¹⁸

A taskforce consisting of DG Health & Consumers (DG SANTÉ), DG Research, ECDC and EMA has also been established to create a platform for discussing vaccine/vaccination issues between all relevant stakeholders in the relevant EU institutions.¹⁹

As regards the issue of access to vaccinations, the Commission adopted in May 2012 a Communication on National Roma Integration Strategies in which it highlighted the need to strengthen vaccination among Europe's largest ethnic minority.

Going beyond infancy and early childhood, the 2014 EPSCO Conclusions on vaccinations as an effective tool in public health, adopted under the Italian Presidency, invited Member States to offer appropriate vaccination to population groups considered to be at risk by taking a life-long approach to vaccination programmes. However, the Conclusions were missing a strong health equity dimension regarding easier access to vaccinations for vulnerable groups.²⁰

Furthermore, In order to improve access to vaccination for populations with low vaccination uptake, the Promovax project (co-funded by the EU Health Programme) developed a healthcare worker toolkit and educational material for migrants. The 'Vaccine European New Integrated Collaboration Effort' (VENICE) network is strengthening the monitoring of vaccination coverage.

Regarding global health, the GAVI Alliance - a public-private global health partnership focusing on saving children's lives and protecting people's health by increasing access to immunisation in poor countries - will be provided with funding of €200 million for the period 2016-2020 to immunise 300 million children. EU Commissioner for International Cooperation and Development, Neven Mimica, confirmed the EU's augmented support in early 2015.

At international level, the WHO's European Vaccine Action Plan 2015–2020 (EVAP) complements the Global Action Plan and is aligned to the WHO Health 2020 and other key regional health strategies and policies. It includes objectives, priority action areas and indicators, taking into account the specific needs and challenges of WHO European Region Member States.²¹ One priority action is to 'increase demand for routine childhood vaccination and for inclusion of new and underused vaccines in the national immunization schedule'.

¹⁸ <http://ecdc.europa.eu/en/healthtopics/immunisation/comms-aid/Documents/Vaccine-comms-action-2013.pdf>

¹⁹ http://ec.europa.eu/health/vaccination/docs/ev_20121016_co02_en.pdf

²⁰ www.eph.org/a/6261

²¹ http://www.euro.who.int/_data/assets/pdf_file/0007/255679/WHO_EVAP_UK_v30_WEBx.pdf?ua=1



Conclusion

Like other medical interventions, vaccination is subject to the social gradient and health inequalities are arising as a consequence. Vaccination remains a two-speed process, since higher income countries are developing faster and the gap between low and high-income countries is increasing.

A multidisciplinary and pan-European approach must thus be undertaken in order to have better coverage rates. Moreover, health literacy is extremely important for both the public and health professionals, however it is not enough by itself to solve the problem of access and develop a common, global understanding of vaccination itself.

Evidence shows that vulnerable groups have poor health status in comparison to the majority population. If vulnerable groups do not receive vaccinations, and especially their children, health inequalities will increase and put them – and by extension also other people, especially those who cannot be immunised themselves - at a significantly higher risk to catch infectious diseases. Furthermore, herd immunity will get lost and disease outbreaks among these communities could lead to stigmatisation and xenophobia.

In the interest of public health, respect for basic human rights and social inclusion, there is a need for unconditional access to essential childhood vaccinations. In terms of concrete steps to be taken at EU and national level, the following actions should be considered, which are complementary to the recommendations contained in the December 2014 Council conclusions:

- Promote universal and free of charge access to national immunisation schemes and paediatric care for all children residing in Europe. Enabling access and knowledge about where to go must be pursued in a stronger and more persistent manner, and in particular vaccination should occur in accessible settings²² where groups facing multiple vulnerabilities and destitute families can be reached easily in a simple, unbureaucratic manner
- The principle of universal access to vaccination should be integrated into policies aimed at groups facing multiple vulnerabilities, such as Roma integration strategies and the European Agenda on Migration
- When assessing the Member States' budgets and financial situations, the EU shall not issue recommendations that undermine the EU Member States' efforts in this field or that contradict or hamper the implementation of the recommendations and opinions of the FRA and the ECDC²³
- Healthcare workers must be educated about vaccination to ensure that correct messages are passed on; as 'trust bearers' it is important that they practise what they preach
- Health literacy must also be improved among parents to address various concerns about the safety and effectiveness of childhood immunisation. The link

²² This should include funding for mobile medical units to reach the groups facing multiple vulnerabilities, and making vaccination more readily available in community pharmacies, schools, etc.

²³ <http://fra.europa.eu/en/news/2012/ecdc-consultation-meeting-immunisation-and-roma>



between individual decisions and the health risks of non-vaccination to other children and individuals must be emphasised more strongly to avoid the re-emergence of communicable diseases and meet eradication targets

- The European Commission should support evidence-based policies on vaccination and highlight its cost effectiveness and benefits across the life course. Messages about vaccination need to be consistent, clear and coherent at all levels (EU, national and WHO) in order to alleviate distrust and fear.
- Member States should ensure that individual vaccination records are understandable, accurate, concise and up-to-date
- The European Commission and the Member States should engage in open, transparent dialogue and address concerns related to ‘vaccine hesitancy’

About EPHA

EPHA is a change agent – Europe's leading NGO advocating for better health. We are a dynamic member-led organisation, made up of public health NGOs, patient groups, health professionals, and disease groups working together to improve health and strengthen the voice of public health in Europe. EPHA is a member of, among others, the Social Platform, the Health and Environment Alliance (HEAL), the EU Civil Society Contact Group and the Better Regulation Watchdog.

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