

TABLE 2

## Response to questions about important components included in national plan

Components of the plan	All 56 countries (31 have a Published plan; 25 with draft or no plan)				EU member states (18 have a Published plan; 7 with draft or no plan)				non-EU countries (13 have a Published plan; 18 with draft or no plan)			
	% of countries with a plan	% of countries with draft or no plan	Plan	Draft plan	% of countries with a plan	% of countries with draft or no plan	Plan	Draft plan	% of countries with a plan	% of countries with draft or no plan	Plan	Draft plan
Clear division of responsibilities, obligations and mandates?	81%	16%	25	4	78%	14%	14	1	85%	17%	11	3
Surveillance systems?	97%	36%	30	9	94%	71%	17	5	100%	22%	13	4
Laboratory capacity and role?	94%	28%	29	7	100%	57%	18	4	85%	17%	11	3
Healthcare organisation?	87%	20%	27	5	83%	14%	15	1	92%	22%	12	4
Maintenance of essential community services?	77%	16%	24	4	72%	0%	13	0	85%	22%	11	4
Strategy for antivirals?	81%	8%	25	2	83%	0%	15	0	77%	11%	10	2
Strategy for vaccines/vaccination?	87%	20%	27	5	89%	14%	16	1	85%	22%	11	4
Strategy for information to public and media?	84%	16%	26	4	72%	14%	13	1	100%	17%	13	3
Other public health measures (views on public gatherings etc.)?	77%	16%	24	4	72%	14%	13	1	85%	17%	11	3
Has the national plan been tested in a 'table top' or equivalent exercise?	13%		4		6%		1		23%		3	

TABLE 3

## Components of national influenza programme (non-pandemic) in European Region countries

Components of national influenza programme	All countries (56)		EU member states (25)		non-EU countries (31)	
Does a surveillance system for influenza exist?	98%	55	100%	25	97%	30
Is there a vaccination programme for risk groups?	88%	49	100%	25	77%	24
Are influenza vaccines offered free of charge for risk groups?	63%	35	72%	18	55%	17
Does the government maintain a stock of anti-viral drugs?	43%	24	52%	13	36%	11
Is there laboratory capacity for diagnosis of influenza?	80%	45	96%	24	68%	21

## References

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2. Editorial team and Paget, WJ. Considerable progress in European preparations for a potential influenza pandemic. Eurosurveillance Weekly 2004;8(52):23/12/2005 (<http://www.eurosurveillance.org/ew/2004/041223.asp#2>)

## HIB VACCINATION: RECENT PAPER FROM FINLAND SUGGESTS THAT A PROLONGED THREE DOSE SCHEDULE OFFERS EFFECTIVE PROTECTION AGAINST DISEASE

Editorial team

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Published online 13 January 2005

(<http://www.eurosurveillance.org/ew/2005/050113.asp#1>)

A recent study in Finland concluded that two vaccine doses in early infancy, followed by a late booster, are efficacious in protecting children from *Haemophilus influenzae* type b (Hib) infection, and will practically eliminate Hib meningitis [1].

Hib vaccine campaigns have successfully reduced mortality from and the incidence of Hib meningitis infection in many countries, but nevertheless vaccine failures have been recognised. Most countries in Europe use four doses of vaccine, with a booster dose in the second year of life. The exceptions include the United Kingdom and Ireland, where three doses are given in early infancy, and many Scandinavian countries (and Italy) where two doses in early infancy are followed by a single dose on or after 11 months of age. (<http://www.euibis.org>)

The authors looked at records of *H. influenzae* cases in the Greater Helsinki area, to see what impact vaccination had made. Since 1988, the Finnish vaccine schedule has included only three vaccine doses, rather than the four doses recommended by the manufacturers, yet

only three cases of Hib meningitis infection occurred between 1991 and 1999, all in vaccinated or incompletely vaccinated children. During the same period, three cases of *H. influenzae* meningitis, caused by *H. influenzae* type f and a non-typable strain, occurred. The authors concluded that three doses of conjugate vaccine (two early doses with a late booster) are clinically effective in protecting children from Hib infection, and that epidemiological data such as these may be more useful than measuring antibody levels when judging the effectiveness of a vaccination programme.

In response to this study, a team in the United Kingdom described the UK experience, where a vaccine schedule of three doses at 2, 3 and 4 months with a large catch-up campaign for older children led to a 95% reduction in the attack rate of invasive Hib disease between 1992-1998 [2].

There was a large protective effect in unvaccinated age groups of children due to herd immunity (indirect protection). To assess individual protection from the vaccine, data on invasive Hib disease in 1996-2003 occurring in children born between 1996-1999 was analysed, and it was shown that direct protection from Hib conjugate vaccines given in an accelerated schedule declines rapidly over time. Therefore, excellent disease control does not necessarily imply high levels of indirect protection, and caution is needed in the longer term. The potential for disease to re-emerge after it has been initially controlled by a vaccine programme has been illustrated by recent increases in both the UK and the Netherlands [3].

The European Union Invasive Bacterial Infection Surveillance scheme (EU-IBIS, <http://www.euibis.org/>) is pooling surveillance data from European countries, including data on vaccine failures, and this will help to inform analysis on invasive meningitis trends, including those that may result from differences between national vaccination programmes.

## References

1. Peltola H, Salo E, Saxén H. Incidence of *Haemophilus influenzae* type b meningitis during 18 years of vaccine use: observational study using routine hospital data. *BMJ* 2005; 330: 18-9. (<http://bmj.bmjjournals.com/cgi/content/full/330/7481/18>)
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3. Rijckers GT, Vermeer-de Bondt PE, Spanjaard L, Breukels M, Sanders EAM. Return of *Haemophilus influenzae* type b infections. [letter] *Lancet* 2003; 361(9368):1563-4

## WORLD HEALTH ORGANIZATION DEVELOPS GUIDANCE FOR VACCINE SAFETY INFORMATION ON THE WEB

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Eurosurveillance editorial office

Published online 13 January 2005

(<http://www.eurosurveillance.org/ew/2005/050113.asp#2>)

The World Health Organization (WHO) Global Advisory Committee on Vaccine Safety (GACVS, [http://www.who.int/vaccine\\_safety/en/](http://www.who.int/vaccine_safety/en/)) was established in 1999 to respond promptly, efficiently, and with scientific rigour to vaccine safety issues of potential global importance. In 2003, GACVS launched the Vaccine Safety Net project. As part of this project, guidelines for websites which provide information on vaccine safety have been produced ([http://www.who.int/vaccine\\_safety/good\\_vs\\_sites/en/](http://www.who.int/vaccine_safety/good_vs_sites/en/)).

By encouraging websites that provide accurate information to be of high quality and the first source of information for the media and public, it is hoped that the guidelines will counter the proliferation of websites providing false or misleading information about vaccine safety, thus undermining public health messages.

The guidelines specify content that should be included on the site, and credibility information, as well as guidance on accessibility of the website and design. Organisations providing information on vaccine safety are advised to consider the guidance and enhance their information if necessary.

Since setting these guidelines, the WHO has evaluated a number of vaccine safety information websites against these criteria, and websites that meet these are published on the WHO immunisation safety website ([http://www.who.int/immunization\\_safety/safety\\_quality/approved\\_vaccine\\_safet\\_websites/en/](http://www.who.int/immunization_safety/safety_quality/approved_vaccine_safet_websites/en/)). This site already includes various European websites, and many more European and worldwide websites will be evaluated in the coming months.