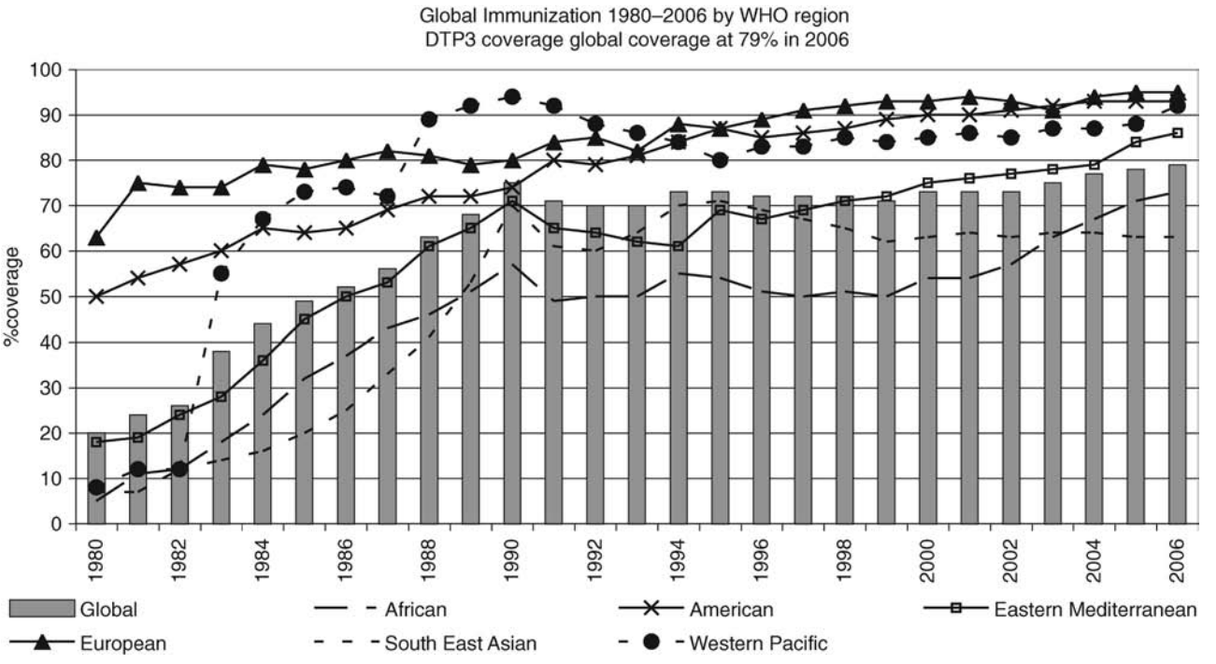

Figure 3 Global immunization DTP3 coverage based on official reports from countries to WHO, 1980 to 2006. *Source*: WHO/UNICEF coverage estimates 1980 to 2006, August 2007 193 WHO Member States.

As the technical, financial, political, and logistical challenges to reaching all children with the EPI vaccines were systematically addressed, the period 1985 to 1990 saw a tremendous rise in routine immunization activities worldwide. By 1990, vaccines were protecting nearly 75% of the world's children from measles, tetanus, polio, diphtheria, and pertussis. In the 1990s, a period of stagnation in immunization coverage followed, which was slowly overcome in the first years of the new millennium (Fig. 3).

Accelerating Disease Control

As national immunization services were established or strengthened in developing countries, from the late 1980s onward WHO's technical oversight body for EPI turned its attention to the accelerated control of key EPI target diseases. In doing so, EPI was in fact returning to its original mandate in that ''the primary concern of EPI is not immunization but disease control, using immunization as the strategy'' (40). This shift in emphasis was motivated by a number of other factors, not the least of which was the need to maintain donor and political support for what had become a very successful public health program.

Consequently, in 1989 new EPI goals were established that went beyond the raising of routine immunization coverage to include the eradication of poliomyelitis, the elimination of neonatal tetanus (NT), and the reduction of measles mortality and morbidity by 90% and 95%, respectively (41). The international political importance of these ambitious goals increased substantially in 1990 when they were endorsed at the World Summit for Children, the largest ever gathering of heads of states (5).

Despite this early attention, outside of the American and Western Pacific regions, there was limited progress toward any of these goals prior to the mid-1990s. The main reason for this was the widespread deterioration in the quality, coverage, and commitment to routine immunization that had begun in the early 1990s because of a number of factors (42). Of particular importance, the rapid gains of the EPI expansion in the late 1980s appears to have fuelled among donors a false sense of the robustness of the program, leading to a rapid contraction of international financial support, usually before other more sustainable funding had been secured (43–45). Around the same time, structural adjustment programs began to markedly affect national budgets and staffing patterns in many developing countries. These problems were further compounded by health sector reform processes, which frequently led to a stagnation of EPI performance, as the highly centralized EPI structures were integrated with other child health services and/or critical functions and the staff were devolved to the subnational level (46). Even within the UN agencies, the growing demands of other public health priorities and programs limited the time, attention, and resources that staff of all levels could devote to immunization.

By 1995, however, efforts to achieve the specific disease-control goals of EPI had stimulated the development of new strategic approaches for reaching every child, including close collaboration with many new partners. In particular, the goal of global polio eradication had a massive impact, as it grew into the largest public health initiative ever. Spearheaded by WHO, Rotary International, UNICEF, and the U.S. Centers for Disease Control and Prevention (CDC), the goal of polio eradication brought together a broad coalition of donor and technical partners to support national efforts to improve the reach of immunization services and establish effective surveillance. Through a combination of routine immunization, national immunization days (mass vaccination campaigns), surveillance for acute flaccid paralysis (AFP), and house-to-house mop-up activities, polio fell from an