From 2003 to 2007, the estimated incidence of cervical cancer in Chile was 14.6 per 100,000 people. This was close to 1,279 new cases per year, taking fourth place after breast cancer, non-melanoma skin cancer and bladder cancer. In terms of mortality, 584 women died from cervical cancer in 2012, with an adjusted mortality rate of 5.58 per 100,000 women. In 1990, the adjusted rate reached 14.34 and in 2012, 5.58 per 100,000 women1.

Regarding condylomata, they correspond to 31% of the total of Sexually Transmitted Infections (STIs) diagnosed at the STI specialized centers in the public health system in Chile. The Department of Health Economics and the National Program for the Prevention and Control of HIV/AIDS and STIs in the Ministry of Health estimates that in 2010, 7,219 people were diagnosed with condylomata (65% women; 35% men). A report on estimated spending on condyloma diagnosis and treatment among adults and pregnant women in 2009 and 2010 revealed the financial impact associated with this diagnosis.

Human papillomavirus (HPV) is the primary cause of cervical cancer. To prevent cervical cancer, the Ministry of Health implemented HPV vaccination in 2014 through its National Immunization Program, the schedule for which has two doses with a 12-month interval between doses. Given the immune response and effectiveness of the vaccine when administered before onset of sexual activity, the vaccination strategy began with the first dose among girls in the 4th grade (9 years old) and in 2015, vaccination with the second dose began for the cohort of girls that had begun vaccination in 2014, whom had started 5th grade (10 years old).

Additionally, in 2015, a catch-up campaign was carried out aiming to protect all girls finishing primary education against HPV, administering a first dose to girls who were in 6th grade (11 years old) and 7th grade (12 years old).
Public Health Responses and Challenges

This outbreak occurred in the context of a global YF vaccine shortage. Indeed, the situation of vaccine scarcity is worrisome for other endemic countries in the Region of the Americas, half of whose demand is typically procured through the Revolving Fund; there is currently an unmet demand for what the countries require. The Revolving Fund is actively searching for solutions with other manufacturers.

Brazil is one of the few YF vaccine manufacturers globally and has been an important contributor to the International Coordinating Group (ICG) emergency YF vaccine stockpile that consists of approximately 6 million doses available to support countries in emergency/outbreak situations in Africa and Latin America.

Prior to the YF outbreak, a total of 3,529 municipalities in 19 of 27 states in Brazil, including the Federal District, were considered to be endemic for sylvatic YF. These areas with permanent recommendations for YF vaccination covered a target population of 88.3 million inhabitants aged ≥9 months and a cohort of 1.3 million infants aged less than one year. YF vaccine was available for free and year-round at over 36,000 vaccination posts. All children received a two-dose YF series at 9 months and 4 years of age. Additionally, all residents or travelers to these areas, aged over 5 years received one dose of the YF vaccine in endemic areas, as one dose is sufficient to provide sustained immunity and life-long protection against the disease, reaching high vaccination coverage of the entire population residing in these areas. TAG also reemphasized the importance of vaccinating travelers to endemic areas. TAG endorsed the latest WHO recommendation of using fractional doses in response to outbreaks in situations of vaccine shortage.

Given that areas of Brazil were affected during the outbreak, where no cases had been detected in years, the TAG urged countries to continue strengthening epidemiological, virological, vector, epizootic and adverse events following immunization (AEFI) surveillance and to reassess the YF risk in endemic countries taking into account ecological and entomological factors, population movements, among others.

PAHO/WHO activated a dedicated Incident Management Structure (IMS) to support Brazil locally and provide support for collaboration with PAHO and WHO.

Also in response to the outbreak, the Brazilian National Immunization Technical Advisory Group (NITAG) convened an emergency meeting on 22 March 2017, recommending to temporarily suspend booster dose recommendations as part of the outbreak response, use fractional doses as part of the immunization strategy to respond to the outbreak, suspend the recommendation to separate the measles-mumps-rubella (MMR) and YF vaccine administration during the outbreak and co-administer if necessary to provide protection, particularly against YF.

When faced with a suspected or confirmed human or non-human primate case, vaccination actions including ring vaccination, and vector control strategies are intensified.

From January-May 2017, the Ministry of Health distributed approximately 26.3 million doses of YF vaccine to Minas Gerais, Espirito Santo, São Paulo, Bahia and Rio de Janeiro in an effort to intensify vaccination. In addition, around 7 million doses were distributed for routine vaccination and travelers across the country. Brazil has also distributed 3.5 million doses to municipalities with vaccination recommendations; the doses were received from the global emergency stockpile of the ICG on vaccine provision for yellow fever. AEFI Surveillance has been strengthened at the national and regional levels with support from dedicated expert committees for the classification of serious adverse events. As of May 2017, vaccination coverage has improved considerably in the affected areas; however, vaccination activities need to continue and ensure the homogeneity of coverage levels in all municipalities reaching 95% coverage.

In conclusion, the YF outbreak in Brazil originated in municipalities in the South East of the country that had recommendations in place for routine YF vaccination, but had accumulated large susceptible populations following extended periods of suboptimal vaccination coverage levels. The outbreak further spread to new areas that had not reported cases for years or that had been classified as non-endemic during previous risk assessments. Considering the dynamic nature of the disease and the constant evolution of factors that affect it, including human, host and vector behaviors, population movements and ecological factors, it is crucial to maintain high coverage levels in areas that are currently endemic in the Americas, while continuing to be vigilant through strengthening active surveillance of the virus and anticipating potential outbreak threats through continuous systematic risk assessments including the risk of YF re-urbanization. 

References

Regarding the catch-up campaign that began in 2015, 82% of the girls vaccinated in 2015 completed the series in 2016.

All vaccinations are registered in the Electronic Immunization Registry system, known as the National Immunization Registry (RNI). The system also captures rejections to the vaccination and the reasons, allowing to follow up on that information. Table 3 shows that the percentage of rejections at the country level over the target population has remained under 7%. This information facilitates planning targeted interventions aimed at the population rejecting the vaccine.

Table 3. Number and percentage of HPV vaccination

<table>
<thead>
<tr>
<th>Year/% of rejections</th>
<th>2014</th>
<th>%</th>
<th>2015</th>
<th>%</th>
<th>2016</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country total</td>
<td>5,510</td>
<td>5.6%</td>
<td>18,153</td>
<td>4.6%</td>
<td>24,310</td>
<td>6.6%</td>
</tr>
</tbody>
</table>

Source: RNI

Table 4 shows that of the 5,510 girls who rejected the HPV vaccine in 2014, 1,461 decided to be vaccinated the following year, as did 350 in 2016. This is a reversion rate of 32.9% in this group. In 2015, a total of 15,085 girls rejected the first dose, yet more than 20% reversed their decision in 2015 and 2016.

Table 4. Reversion rate with HPV vaccination rejections

<table>
<thead>
<tr>
<th>Year/grade level</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rejections</td>
<td>5,510</td>
<td>5,832</td>
</tr>
<tr>
<td>2015 vaccine acceptors who were rejecters in 2014</td>
<td>1,461</td>
<td></td>
</tr>
<tr>
<td>2016 vaccine acceptors who were rejecters in 2014 and 2015</td>
<td>350, 1,551</td>
<td></td>
</tr>
<tr>
<td>% of schoolgirls that reversed their decisions</td>
<td>32.9%, 26.6%, 21.3%</td>
<td></td>
</tr>
</tbody>
</table>

Source: RNI

Table 1 shows the coverage reached per year since integrating the HPV vaccine into the vaccination schedule.

Table 1. HPV vaccination coverage for the routine immunization program by year of vaccination, 2014-2016

<table>
<thead>
<tr>
<th>Programmatic/ routine HPV vaccination coverage in Chile</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>4th grade 1st dose</td>
<td>4th grade 1st dose</td>
<td>5th grade 2nd dose</td>
<td>4th grade 1st dose</td>
</tr>
<tr>
<td>86%</td>
<td>85%</td>
<td>85%</td>
<td>77%</td>
</tr>
</tbody>
</table>

Source: RNI/MINEDUC (Ministry of Education)

99% of the girls who began the schedule in 2014 completed it in 2015. In 2016, coverage for the complete series decreased to 87%.

Table 2. Vaccination coverage for the catch-up campaign by year of vaccination, 2015-2016

<table>
<thead>
<tr>
<th>HPV catch-up vaccination coverage</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>6th grade 1st dose</td>
<td>7th grade 1st dose</td>
<td>7th grade 2nd dose</td>
</tr>
<tr>
<td>84%</td>
<td>82%</td>
<td>70%</td>
</tr>
</tbody>
</table>

Source: RNI/MINEDUC

Regarding the catch-up campaign that began in 2015, 82% of the girls vaccinated in 2015 completed the series in 2016.

The vaccine is safe and effective, given evidence from millions of doses administered at the global level. From 2014 to date, more than 855,000 doses of the vaccine have been administered in the country in the routine schedule and catch-up campaigns. During this period, there were 129 reports of events supposedly attributable to vaccination or immunization (ESAVI) for the HPV vaccine, for the most part described and known. The overall rate for ESAVI reported in Chile was considerably lower than reports from other countries and in medical literature.

Vaccination is also supported by a communication campaign including graphic and audiovisual materials in which different authorities and celebrities participate. The slogan of the strategy is TOGETHER FOR WOMEN. Chile Prevents Cervical Cancer.
Vaccination Week in the Americas Celebrates 15 Years

This year the countries and territories of the Americas and the Pan American Health Organization (PAHO) celebrated the 15th Vaccination Week in the Americas from 22-29 April.

The slogan for 2017’s campaign was “#GetVax to celebrate a healthy tomorrow,” encouraging people and their families to get vaccinated today and enjoy good health tomorrow, given that vaccines offer protection against highly contagious, debilitating and potentially deadly diseases.

Countries and territories in the Region aimed to vaccinate more than 60 million people against a range of diseases. For example, Brazil targeted 50 million in its yearly massive influenza campaign. Other vaccination campaigns targeted rubella, measles, diphtheria, mumps, whooping cough, neonatal tetanus, yellow fever, rotavirus, bacterial pneumonia and the human papilloma virus (HPV).

Furthermore, millions of people have been vaccinated to keep the western hemisphere free of polio for 25 years.

Since 2000, new vaccines against rotavirus, pneumococcus and HPV have been introduced in countries and territories of the Region. Currently, 34 countries and territories vaccinate against pneumococcus, 20 against rotavirus, and 24 against HPV. These achievements have been possible thanks to the dedication of thousands of health workers, who play a key role to reach everyone in their communities and take vaccines to the most vulnerable populations and hard-to-reach zones.

“We have achieved a healthier region thanks to vaccination,” said the chief of PAHO’s Comprehensive Family Immunization Unit, Cuauhtémoc Ruiz-Matus. “We will continue working so no children will suffer or die from a disease that we can prevent with vaccination,” he added.

Actions for Vaccination Week in the Americas have also gone beyond the immunization field. Health personnel have taken advantage of the initiative to implement other health actions, like deworming, vitamin A administration, and breastfeeding promotion. Similarly, community mobilization for vaccination has helped close gaps that separate people from needed attention.

Vaccination Week in the Americas started in 2003 as an effort by the countries of the region to combat a measles outbreak between Colombia and Venezuela. Although health workers vaccinate people daily, the special effort to combat the outbreak grew into an annual event to promote vaccination and reach those who may have missed routine immunization. Versions of Vaccination Week were subsequently adopted in other WHO regions, and in 2012, it became a global movement when the World Health Assembly endorsed World Immunization Week and 180 countries around the world began celebrating it.

Regional Launches in Mexico and Brazil

A series of launch events for Vaccination Week will take place in Mexico and Brazil. On April 24, Mexico hosted the first regional launch. This activity took place at 10am in the main courtyard of Mexico’s Secretary of Health, located in Lieja 7, Mexico City. The Secretary of Health, José Narro, and PAHO Director, Carissa F. Etienne, participated along with other authorities.

Mexico has a long history in carrying out vaccination campaigns and other integrated activities to protect its population’s health. The country holds National Health Weeks in February, May and October. The intensive vaccination activities it carries out each May have contributed to the regional achievements of Vaccination Week in the Americas.

The second event took place on 29 April, when an indigenous village in the Brazilian state of Rondônia, known as Linea 9 Amaral and belonging to the indigenous group Suri, hosted a regional launch of Vaccination Week to bring vaccines to a priority group of this initiative. The activity took place under the framework of celebrations for Vaccination Month of Indigenous People, organized by Brazil.

For more information on Vaccination Week in the Americas, visit www.paho.org/vwa.
PAHO Publishes Maternal and Neonatal Immunization Field Guide for Latin America and the Caribbean

The Comprehensive Family Immunization Unit of the Pan American Health Organization published the Maternal and Neonatal Immunization Field Guide in early 2017. This guide provides a practical road map of maternal and neonatal immunization to healthcare workers at all levels of the health system, integrating immunization programs with maternal and child health services. The guide might also be of use for health education programs.

The following chart shows the Regional Maternal and Neonatal Immunization Schedule and was excerpted from pages 31-32 of the guide, which can be found in its entirety (in English and Spanish) at http://bit.ly/MNIFGLAC.

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**Regional maternal and neonatal immunization schedule**

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Pre-pregnancy</th>
<th>Pregnancy</th>
<th>Post-partum</th>
<th>Year of PAHO/TAG recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus/diptheria</td>
<td>Yes, ideal time</td>
<td>Yes, two doses if she was not previously vaccinated</td>
<td>Yes, to complete schedule</td>
<td>2017²</td>
</tr>
<tr>
<td>Inactivated influenza</td>
<td>Yes, ideal time</td>
<td>Yes, if she was not vaccinated during pregnancy, to protect the newborn</td>
<td></td>
<td>2012¹</td>
</tr>
</tbody>
</table>

**VACCINES RECOMMENDED DURING PREGNANCY IN SPECIAL SITUATIONS ONLY**

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Pre-pregnancy</th>
<th>Pregnancy</th>
<th>Post-partum</th>
<th>Year of PAHO/TAG recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tdap</td>
<td>Yes, during outbreaks (ideal moment between 27-36 weeks of gestation)</td>
<td>Yes</td>
<td></td>
<td>2014⁴</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Yes, if she did not complete schedule and if under high risk situation (e.g., more than one sexual partner during the previous six months, STD, IDU, partner a for HBsAg)</td>
<td>Yes, to complete schedule (three doses)</td>
<td></td>
<td>2013¹</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>Yes, during outbreaks</td>
<td></td>
<td></td>
<td>2013¹</td>
</tr>
<tr>
<td>Yellow fever</td>
<td>Yes, ideal moment (in endemic areas)</td>
<td>Yes, prior to travel to endemic areas under current outbreak, with prior risk/benefit analysis</td>
<td></td>
<td>2013¹</td>
</tr>
</tbody>
</table>

**VACCINES NOT RECOMMENDED DURING PREGNANCY**

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Pre-pregnancy</th>
<th>Pregnancy</th>
<th>Post-partum</th>
<th>Year of PAHO/TAG recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rubella</td>
<td>Yes, ideal moment</td>
<td>No</td>
<td>Yes, if not vaccinated during pre-pregnancy</td>
<td>2013</td>
</tr>
<tr>
<td>Measles</td>
<td></td>
<td></td>
<td></td>
<td>2013</td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
<td></td>
<td></td>
<td>2013</td>
</tr>
<tr>
<td>HPV</td>
<td>Yes, ideal moment</td>
<td>No</td>
<td></td>
<td>2013</td>
</tr>
</tbody>
</table>

**VACCINES RECOMMENDED FOR THE NEWBORN**

<table>
<thead>
<tr>
<th>Newborn vaccines</th>
<th>Birth dose</th>
<th>Year of PAHO/TAG recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCG</td>
<td>As soon as possible after birth</td>
<td>2004</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>In the first 24 hours after birth</td>
<td>2011⁵</td>
</tr>
</tbody>
</table>

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STD: sexually transmitted disease; IDU: injection drug user; HBsAG: hepatitis B surface antigen.

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¹ WHO position paper on tetanus vaccination, Wkly Epidemiol Rec., No 6, 2017; 92: 53–76
⁵ WHO position paper on yellow fever vaccines and vaccination, No. 27, 2013; 88: 269–284.
The Caribbean Prepares to Introduce the Human Papillomavirus Vaccine in the Routine Schedule

Representatives from Antigua and Barbuda, Belize, British Virgin Islands, Curacao, Guyana, Jamaica, Montserrat, St. Lucia, St. Kitts and Nevis, St. Vincent and Grenadines and Turks and Caicos, as well as immunization and communication experts from PAHO/WHO met in Miami, Florida in the United States on 22-23 May 2017 to support Caribbean countries to elaborate a plan to introduce the human papilloma virus (HPV) vaccine, with a strong focus on preparing key messages about the vaccine and anticipating communication needs and a crisis response.

Many countries in the Region, during introduction of the HPV vaccine, have needed to respond to clustered anxiety temporarily associated with vaccination among adolescents, including messages that reemphasize evidence on the vaccine’s safety and efficacy. For this reason, PAHO convened a meeting to help Caribbean countries develop HPV vaccine introduction plans and to provide training around effective communication strategies.

The first day of the meeting included presentations about the HPV-associated disease and its prevention, PAHO/WHO recommendations on the use of HPV vaccines, lessons learned on the introduction of the HPV vaccine in Belize and a review of the main considerations when elaborating an introduction plan. The participants worked in groups to elaborate and/or review HPV vaccine introduction plans.

The second day was focused on providing training on how to develop an effective communication plan for HPV vaccination in the routine program, including the development of key messages. Guyana and Canada presented their lessons learned on effective communication around HPV vaccination. In their work groups, participants developed plans for communication strategies to support the introduction and scale-up of the vaccine.

The meeting evaluation indicated that participants were content with the meeting outcomes, some commenting that it was the best meeting they had attended.

NITAG Launches in Haiti

Newly appointed members of the National Immunization Technical Advisory Group (NITAG) in Haiti, General Director of the Ministry of Health, EPI Manager, Members of the Ministry, civil society organizations (CSO) representing, CDC, UNICEF and PAHO/WHO launched the NITAG of Haiti in Port-au-Prince, Haiti on 8 March 2017.

On behalf of the Ministry of Health, the General Director of the Ministry of Health launched the NITAG. He thanked each of the newly appointed members one by one. The areas of expertise represented in the NITAG are: pediatrics, epidemiology, research and vaccinology, gynecology, sociology, anthropology, bacteriology and virology, public health, communication and social mobilization, health economy and immunization logistics. As of March 2017, the NITAG has a total of 13 members.

The launch ceremony continued with a review of the NITAG terms of reference, which include the mandate of the NITAG, its role and responsibilities and information on the organization of the Secretariat. The terms of reference also include the frequency of the meetings (two annual ordinary sessions and possibility for the chair or the Ministry of Health to request an extraordinary meeting) and the functional modalities of the NITAG meetings.

The terms of reference include the request that each member of the NITAG has to declare the absence of conflict of interest before they participate to any session. The official ceremony continued with a presentation made by Dr. Jean Andre from PAHO’s Haiti office. He provided information on NITAGs in the global and regional context (GVAP and RIAP), enforced the importance of NITAGs and explained the support that can be provided notably by the NITAG Resource Center.

The chairman of the NITAG ended the ceremony asking for the first meeting to be organized rapidly as public health in general and immunization in particular in Haiti is urging all goodwill to start work.
What is a Fractional Dose of IPV?

A fractional dose of the inactivated polio vaccine (fIPV) is equal to 1/5 of a standard dose. Studies show that two doses of fIPV administered by intradermal injection produce an even stronger immune response than a single full dose of the inactivated polio vaccine (IPV).

In March 2017, the Technical Advisory Group (TAG) on Vaccine-preventable Diseases recommended that all countries using more than 100,000 doses of IPV each year switch to fIPV.

1. When to give fIPV

Fractional IPV (fIPV) should be given at the first and second vaccination visits (usually at 2 and 4 months) along with the other recommended vaccinations (pentavalent, pneumococcal, rotavirus).

2. How to give fIPV

- IPV vials: A 5-dose vial, will provide 25 fractional doses per vial. Remember open vials of IPV can be used for up to 28 days, as per the multi-dose open vial policy.
- 0.1 ml dose: A fractional dose is 1/5 of a standard dose = 0.1 ml.
- Intradermal: fIPV is administered with a 0.1 ml syringe.
- Upper arm: fIPV is given as an intradermal injection (ID), at a 10-15° angle, by the same technique as the BCG injection. Administer fIPV in the upper arm (opposite to that in which the BCG was given).

3. Give with other vaccines

Remember to record IPV administered as fractional dose (fIPV)

Help the children in your community by giving the right vaccines at the right time. It will save you time, make the health clinic more efficient, and improve coverage. Most importantly it will protect children from serious and sometimes deadly diseases.

Key messages to deliver to caregivers

1. fIPV is very safe
   - Vaccines like IPV protect babies when they need it most.
   - It is safe for your child to get 3 or more injections at one visit.
   - IPV is needed to protect every child and is safe to give at 2 and 4 months.

2. fIPV is very effective
   - Two fractional doses of IPV (given intradermally) produces even better immunogenicity than a single standard dose (intramuscular).
   - It is very important to bring your child back for the second dose of IPV to ensure full protection!

3. You can lessen pain
   - Hold your baby on your lap. Baby’s feet should be between your thighs to help keep baby still. Hold arms still. You can breastfeed while baby is getting vaccinated.
   - Get all recommended shots on time. It is better for your child to experience discomfort during one visit, rather than discomfort during two separate visits.
   - Be gentle around baby’s injection sites. Injection sites may have some redness and feel sore.

4. Baby’s vaccines are important
   - Polio can paralyze your children – but vaccines can protect them from polio.
   - In addition to polio, vaccines can protect your children from other very serious and sometimes deadly diseases.
   - Vaccinations give kids a healthy future.

Sources:

What I Have Learned...

By Dr. Teodoro Carrada Bravo, former field epidemiologist and health educator for the Mexican Social Security Institute

Upon returning to Mexico from London, England in 1974, I was hired as a field epidemiologist and health educator by the Mexican Social Security Institute. I dealt with frequent outbreaks of measles, paralytic poliomyelitis, whooping cough, human rabies, typhoid fever, cholera, cutaneous leishmaniasis, neonatal tetanus, dengue hemorrhagic fever and syphilis, mainly in the country’s marginalized neighborhoods and rural communities.

On 30 July 1985, I went to Ticul, Yucatán, a Mayan-speaking town, where three suspected pediatric cases of pharyngeal diphtheria had been reported in a family that had never been vaccinated. I examined the patients and close contacts and took throat swabs. In the afternoon, I photographed the organs and took additional specimens for bacteriological and histopathological study. The following day, the cultures turned out positive. Microscopic examination of the colonies revealed clumps of bacilli with metachromatic granules (Albert’s stain). The laboratory of the H. Nocuchi Institute in Mérida confirmed toxicity of the isolated strain by intradermal neutralization test in a guinea pig.

Having established harmonious coordination with the health sector, a vaccination survey was conducted in children aged <9 years: only 49% of respondents had complete vaccination schedules with three doses of DPT. Additionally, 70 serum samples were obtained and diphtheria antitoxin levels were <0.01 IU/ml or negative in 34.2%. I reported on the magnitude and severity of the outbreak to the local physicians, and at night in my hotel I prepared notes for the press that would not cause alarm. During the next two weeks, 14,172 doses of DPT were administered in Ticul and neighboring villages. New suspected cases were treated with antibiotics and ≥20,000 IU of diphtheria antitoxin. These measures halted the outbreak. Diphtheria had not been reported in Yucatán since 1978. On my return to Mexico City, I submitted the epidemiological report and wrote a scholarly communication that was accepted for publication in the Boletín del Hospital Infantil de México [1986; 43 (11): 688-692].

The role of the field epidemiologist is to work quickly and well, using the almost-always limited local resources. It is most important to win the trust and support of the affected population. The struggle was tough and complex, but this is how Mexico was freed from deadly diphtheria and other long-standing diseases.

In my happy old age I am very pleased to share this experience with you, which was successful thanks to the support of my Yucatecan colleagues, and professional training received in the classrooms and laboratories of the University of London, my beloved alma mater, to which I owe eternal gratitude.

The objective of the “What I have Learned” column is to provide a space for immunization professionals from across the Americas to share their unique experiences and lessons learned. Individuals who are interested in authoring a column are encouraged to contact Octavia Silva at silvao@paho.org.