

Summary of the Twenty-Fifth Meeting of the  
International Task Force for Disease Eradication (ITFDE)



In 1994, the World Health Organization region of the Americas (AMR) was certified as free of indigenous polio and immediately established a regional goal to eliminate measles by the year 2000. The operational strategy used included “catch-up” mass measles immunization campaigns that initially targeted all children 9 months-14 years of age, regardless of immunization or disease history, in order to quickly raise immunization levels to 90% or more. Programs then sought by means of adequate routine immunization to “keep-up”, maintaining high immunization levels in the face of continuing new births (susceptibles). Those efforts were supplemented as needed by “follow-up” campaigns about every four years targeting 1-4 year-olds, in order to ensure first measles immunizations to children who had been missed by routine immunization services, and simultaneously deliver a second dose of measles vaccine to young children who had already received their first dose.

Most American countries conducted “catch up” campaigns between 1989 and 1998, and “follow up” campaigns starting in 1996. Many American countries had already stepped up measles immunization by including it with polio immunization during the latter years of the regional campaign to eliminate polio. The last endemic cases of measles in the Americas occurred in Venezuela in November 2002. More recently, in 2014, measles reestablished transmission in eastern Brazil for a period of 15 months, following importation in December 2013. Since July 2015 Brazil has once again is free of endemic measles. In addition to high levels of performance on epidemiologic surveillance, and laboratory diagnosis, “keep up” (routine) and “follow up” immunizations have been required to prevent the numerous cases of measles imported from other regions from re-establishing endemic transmission in the Americas. Other noteworthy elements of the success in the Americas include high levels of political support and relatively high routine immunization levels in the countries, vaccine laws to ensure funding as a line item for immunization in national budgets, and a special Vaccine Revolving Fund that the Pan American Health Organization (PAHO) established to facilitate advantageous procurement and timely availability of measles vaccine. In 2003, PAHO established a new goal of eliminating rubella and congenital rubella syndrome from the Americas by 2010, which was achieved in 2009, using measles- and rubella-containing (MR) vaccine. In April 2015, the Americas became the first WHO region to be verified by an independent commission as rubella free. Experience from the Americas has been used to establish the use of MR (or measles,

(MCV1) for children aged 1 year to 90% nationally and 80% in every district; 2) reduce global annual measles incidence to <5 cases per million population; and 3) reduce global measles mortality by 95% from the 2000 estimate.<sup>1,2</sup>



opportunity exists to position measles and rubella elimination as the highest disease control priority within the Global Vaccine Action Plan and to instill real accountability for achieving these goals. The role of WHO in this context should be to strengthen and promote coordination among regions and within countries between polio and measles-rubella initiatives.

## Rubella Eradication

Rubella virus usually causes a mild fever and rash in children and adults. However, infection during pregnancy, especially during the first trimester, can result in miscarriage, fetal death, stillbirth, or a constellation of congenital malformations known as congenital

Recent and future RCV introductions provide an opportunity to establish and achieve regional rubella and CRS elimination goals. During 2012–2014, a rubella elimination goal was established in the Western Pacific Region, and a goal to control rubella and CRS was established in the South-East Asia Region as an initial step toward establishing an elimination goal. The interruption of rubella virus transmission announced in April 2015 in the Region of the Americas provides evidence that rubella and CRS elimination can be achieved by introduction of rubella vaccine into routine childhood vaccination schedules accompanied by a wide age range (i.e., infants to 15 years, and in some cases up to 39 years) immunization campaign. However, key challenges to achieving rubella elimination goals include civil unrest (Eastern Mediterranean Region), weak health care delivery systems with low routine vaccination coverage (African and South-East Asia Region), and sub-optimal acceptance rate (European Region). It is recognized that routine immunization services in the Americas are stronger than in most other WHO regions.

High-quality rubella and CRS surveillance is needed to monitor the impact of rubella vaccination programs, and verify achievement of rubella and CRS elimination goals. Guidelines for rubella and CRS surveillance<sup>1</sup>, and a framework for verifying elimination of rubella and CRS have been published.<sup>2</sup> Countries need to institute CRS surveillance and report both rubella and CRS cases to WHO at least monthly. There has been a recent decrease in the number of countries reporting their rubella and CRS cases which is particularly concerning regarding the attention given to monitoring control and elimination goals.

A vaccine delivery system that achieves and maintains high coverage with both MRCV and MCV and integrated measles and rubella surveillance is a necessary foundation for continued progress toward measles elimination and rubella and CRS control and elimination. Implementation of additional global WHO recommendations regarding the use of RCV can help countries that have introduced RCV optimize their use of the vaccine.<sup>3</sup> The recommendations include adding RCV to measles vaccine when the latter is administered in routine immunization services for vaccination of health workers; addition of use of RCV to all measles campaigns; and a review of measles and rubella epidemiology to determine target age ranges. In addition, the recommendations include improved monitoring of activities reflecting RCV use, including joint measles and rubella vaccination coverage surveys and regular analysis of measles and rubella surveillance data. Such





6. The ITFDE still firmly believes that both measles and rubella eradication are technically feasible, but the very high contagiousness of measles is the biggest challenge to success, and measles and rubella eradication would require a sustained

- a. strengthening the investment case for eradication;
- b. recognizing the significance of eradication as a public health and social movement, an issue of equity;
- c. linking eradication to the Global Health Security agenda;
- d. establishing a robust strategy to communicate the urgency of eradication to decision makers; and
- e. identifying champions for eradication, particularly from countries bearing the greatest disease burden.

Table 1

## Status of Measles and Rubella Elimination by WHO Region

WHO Region	Coverage as of 2014		Reported Measles Cases 2014	Reported Rubella Cases 2014	Target Years for Elimination Measles/Rubella	Salient Challenges
	MCV1	MCV2				
Americas	92%	51%	1,817	4	2000/2010	Importations
Europe	94%	84%	14,176	640	2015/2015	Priorities
Western Pacific	97%	93%	131,043	12,814	2012/2020*	China
Southeast Asia	84%	59%	28,403	9,263	2020/TBD	India, Indonesia
Eastern Mediterranean	77%	66%	18,129	2,945	2	