Lessons from the Big Six – closing the immunity gap for measles elimination and rubella/CRS control

New Delhi, India

31 January–02 February 2018
Lessons from the Big Six – closing the immunity gap for measles elimination and rubella/CRS control (SEA/Immun/120)

© World Health Organization 2017

Some rights reserved. This work is available under the Creative Commons Attribution-Non-commercial-ShareAlike 3.0 IGO licence (CC BY-NC-SA 3.0 IGO; https://creativecommons.org/licenses/by-nc-sa/3.0/igo).

Under the terms of this licence, you may copy, redistribute and adapt the work for non-commercial purposes, provided the work is appropriately cited, as indicated below. In any use of this work, there should be no suggestion that WHO endorses any specific organization, products or services. The use of the WHO logo is not permitted. If you adapt the work, then you must license your work under the same or equivalent Creative Commons licence. If you create a translation of this work, you should add the following disclaimer along with the suggested citation: “This translation was not created by the World Health Organization (WHO). WHO is not responsible for the content or accuracy of this translation. The original English edition shall be the binding and authentic edition”.

Any mediation relating to disputes arising under the licence shall be conducted in accordance with the mediation rules of the World Intellectual Property Organization.

Suggested citation. Lessons from the Big Six – closing the immunity gap for measles elimination and rubella/CRS control [New Delhi]: World Health Organization, Regional Office for South-East Asia; 2018. Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at http://apps.who.int/iris.

Sales, rights and licensing. To purchase WHO publications, see http://apps.who.int/bookorders. To submit requests for commercial use and queries on rights and licensing, see http://www.who.int/about/licensing.

Third-party materials. If you wish to reuse material from this work that is attributed to a third party, such as tables, figures or images, it is your responsibility to determine whether permission is needed for that reuse and to obtain permission from the copyright holder. The risk of claims resulting from infringement of any third-party-owned component in the work rests solely with the user.

General disclaimers. The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate borderlines for which there may not yet be full agreement. The mention of specific companies or of certain manufacturers’ products does not imply that they are endorsed or recommended by WHO in preference to others of a similar nature that are not mentioned. Errors and omissions accepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by WHO to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall WHO be liable for damages arising from its use.
Contents

Acronyms
Executive summary
Introduction
Objectives of the meeting
Meeting proceedings
Deliberations
Country plans to close immunity gaps for measles and rubella in 2018–2019
Bangladesh
India
Indonesia
Myanmar
Nepal
Thailand
WHO Regional Office for South-East Asia
Annexures
Annex 1 – Agenda of the meeting
Annex 2 – Speech by the Regional Director
Annex 3 – Presentations and discussion files
Annex 4 – List of participants
Annex 5 – Evaluation of meeting by participants
Acronyms

AEFI  adverse event following immunization
BCC  behaviour change communication
CDC  Centers for Disease Control and Prevention
CES  coverage evaluation survey
CRS  congenital rubella syndrome
CSO  civil society organization
DBS  dried blood spot
DGHS  Directorate General of Health Services
DQS  data quality self-assessment
EPI  Expanded Programme on Immunization
Gavi  Gavi, the Vaccine Alliance
IDSP  Integrated Disease Surveillance Programme
IEC  information, education and communication
IPC  interpersonal communication
IPH  Institute of Public Health
JE  Japanese encephalitis
KAP  knowledge, attitudes and practice
MCV  measles-containing vaccine
MoH  Ministry of Health
MR  measles–rubella
NIP  National Immunization Programme
RI  routine immunization
SIA  supplementary immunization activity
SOP  standard operating procedure
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>TIP</td>
<td>tailoring immunization programmes</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>VPD</td>
<td>vaccine preventable disease</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
Executive summary

In September 2013, the Sixty-sixth Session of the Regional Committee for South-East Asia (SEA/RC66/R5) adopted the goal of measles elimination and rubella/congenital rubella syndrome (CRS) control in the WHO South-East Asia Region by 2020. The big six countries in the WHO South-East Asia Region, viz. Bangladesh, India, Indonesia, Myanmar, Nepal and Thailand constitute 95% of the population of the WHO South-East Asia Region and 98% of the unvaccinated population and contribute to 99% of all reported measles cases in the Region. These countries have unique challenges with closing the immunity gap for measles and rubella and accelerating progress towards measles elimination and rubella/CRS control.

A meeting was conducted on sharing of lessons from countries to help these countries to close the immunity gap on measles and rubella.

Apart from extensively sharing of lessons, the meeting discussed the issues, challenges and way forward under the following four thematic areas:

- Pre-campaign readiness assessment
- Tackling challenges with supplementary immunization activities implementation
- Using data to strengthen the programme
- Implementing TIP (Tailoring immunization programmes) approach

Following the discussions, the meeting came up with key conclusions and action plans to close the immunity gap for measles and rubella in these countries. These action plans will be closely monitored by WHO Regional Office for South-East Asia and technical support provided as appropriate. Based on the discussions and the lessons learnt, the Regional Office will develop an appropriate field guide to support Member States to use supplementary immunization activities (SIAs) as opportunity to strengthen routine immunization programme and adapt the field guide on “Planning and Implementing High-Quality Supplementary Immunization Activities for Injectable Vaccines” to the Regional context.
Introduction

In September 2013, the Sixty-sixth Session of the Regional Committee for South-East Asia (SEA/RC66/R5) adopted the goal of measles elimination and rubella/congenital rubella syndrome (CRS) control in the South-East Asia Region by 2020. The Strategic Plan for Measles Elimination and Rubella/CRS Control in the WHO South-East Asia Region recommended the following strategies:

- achieving ≥95% coverage with two doses of measles and rubella containing vaccine in each district through routine immunization (RI) and/or supplementary immunization activities (SIAs);
- developing and sustaining a sensitive and timely case-based measles surveillance system that meets recommended performance indicators;
- developing and maintaining an accredited measles laboratory network; and
- establishing linkages with other child health initiatives to achieve the above three strategic objectives.

The big six countries in the WHO South-East Asia Region, viz. Bangladesh, India, Indonesia, Myanmar, Nepal and Thailand constitute 95% of the population and contribute to 99% of all reported measles cases in the Region. These countries have unique challenges with closing the immunity gap for measles and rubella and accelerating progress towards measles elimination and rubella/CRS control. Achieving more than 95% coverage with two doses of measles-containing vaccine (MCV) at national and subnational level is the key to measles elimination. This has remained a huge challenge for most countries. More than 4.3 million children do not receive MCV through the annual RI programme. SIAs have been planned to close the immunity gap due to suboptimal RI coverage. A number of lessons have been learnt from the SIAs from some countries in the Region that can be applied to achieve high coverage with measles and rubella containing vaccine in all countries of the Region. Nearly 500 million children are targeted for vaccination through the measles–rubella (MR) SIAs during the next 2 years.

A lesson sharing workshop on closing the immunity gap for measles and rubella was organized as part of south-south and triangular cooperation.

Objectives of the meeting

The general objective of the meeting was to share lessons learnt by the big six countries of the Region on closing the immunity gap for measles and rubella to accelerate progress towards measles elimination.

The specific objectives were:

- sharing key lessons learnt on strengthening RI to close the immunity gap for measles and rubella;
- sharing lessons learnt on planning and preparedness assessment for supplementary (operations and communication) immunization activities for measles and rubella; and
Meeting proceedings

The meeting started with the remarks of the Regional Director, WHO South-East Asia Region, delivered by the Director of Programme Management, WHO South-East Asia Region (Annex 1).

The first half of Day 1 of the meeting was dedicated to global and Regional updates on the status of measles, rubella and CRS and the key actions that have been taken at global and Regional level. The second half of Day 1 focused on country presentations and the discussions on progress towards measles elimination and rubella control in the six big countries.

The last part of Day 1 and the entire Day 2 were dedicated to discussions on lessons learnt on the following thematic areas by countries:

- pre-campaign readiness assessment – MR SIA (India and Indonesia)
- SIA implementation and implications for RI strengthening
- data for action – use of data to strengthen the programme
- promoting demand for vaccination.

A group work was organized based on the above thematic areas at the end of Day 2 and presented during the plenary the next day. The second half of Day 3 was dedicated to country-specific group work to develop action plans to close the immunity gap for measles and rubella in respective countries.

A total of eight sessions were conducted, each chaired in rotation by a representative from the Ministry of Health (MoH), co-chaired by a partner agency representative. A dedicated rapporteur for each session was identified from among the partner agencies.

The agenda for the meeting is available at Annex 2. All presentations made during the meeting are available in the meeting website (Annex 3) and the list of participants is at Annex 4. Secretarial support to the meeting was provided by Immunizations and Vaccine Development (IVD) team of WHO Regional Office for South-East Asia.

Deliberations

The key highlights of the discussions during the meeting are enumerated below:

- A mid-term review of the Strategic Plan for Measles Elimination and Rubella/CRS Control in the South-East Asia Region 2014–2020 has highlighted that the basic strategies articulated in the Strategic Plan are sound. The programme has gathered significant momentum. However, neither is measles elimination nor rubella control on track to achieve the ambitious goals by 2020. WHO and Member States must significantly shift gears (across the specific domains and activities) to achieve the
measles elimination and rubella/CRS control goals. The challenge is particularly substantial for two of the largest Member States – India and Indonesia. In fact, the burden of measles and rubella in these countries is still not accurately known. Achieving MR targets in the Region is severely limited by financing inadequacies. Dwindling polio assets pose an additional and serious threat of losing the momentum in five Global Polio Eradication Initiative (GPEI) supported countries, including India and Indonesia.

- Sharing of the lessons learnt on the use of the SIA readiness assessment tool highlighted that SIA readiness assessment should be part of the SIA planning, and that adequate budget for this should be incorporated in the plans. Global guidelines for SIA readiness exist, but countries need to adapt these based on the local context and SIA operational guide of the particular country, ensuring that all the fundamental components in the tool remain. The readiness assessment should expand beyond the health sector to schools and the community and at least two assessments should be conducted prior to the campaign. A “go–delayed go” policy should be applied rather than a “go–no go” policy, and such policy should be based on both qualitative and quantitative analysis rather than putting a cut-off point for “go” or “delayed go”. Such a “go–delayed go” policy should be applied after the last assessment, preferably 7–10 days prior to the campaign. The pre-campaign readiness assessment should involve a wide range of stakeholders as assessors, including civil society organizations (CSOs) like Lions Clubs International, after adequate capacity building. The findings of such assessments should be shared at all levels to ensure timely corrective actions.

- Sharing of lessons learnt on implementing SIAs highlighted the need for a robust micro-plan with well-defined population groups, the need to ensure preparedness for adverse event following immunization (AEFI) management, the importance of monitoring and use of real-time data for corrective actions during campaigns and the need to proactively initiate positive messaging to parents, communities as well as private practitioners through social media. Several lessons learnt on implementation of a high-quality campaign were discussed (details available through link provided in Annex 3). Opportunities for RI strengthening using SIA as a platform were highlighted.

- Sharing of lessons on using data to strengthen the immunization programme highlighted that data has not been adequately prioritized and that there is a need to build capacity at all levels to handle data including analysis of data. This will make the data available to programme managers on time in a user-friendly manner so that corrective action can be taken. The discussion also highlighted the importance of triangulation of data from various sources and the need for regular validation of data. The discussion highlighted the importance of technology to provide real-time data to the programme managers so that timely actions can be initiated. Examples of electronic databases like eVIN were shared in which data can be visualized as per the need of the programme implementers. The discussion also emphasized that data collection and reporting requirements should be kept as simple as possible and that data quality assessment should be part of regular monitoring and supervision.

- The discussion on surveillance highlighted that surveillance was the key to identify gaps in immunization coverage. Any outbreak should be used as an opportunity to
diagnose the gaps in the immunization system and take corrective actions to close these.

- The discussion on tailoring immunization practices highlighted that country context is important, and plans to address hesitancy should target specific population groups. The discussion also highlighted the need to consider the risks and threats to the programme, e.g. anti-vaccination groups, etc. and emphasized the importance of getting ahead of the curve and knowing “the enemy” and their tactics by monitoring negative sentiment and determining directions of influence, as well as by gathering data on all programme areas including media monitoring. The discussion also dwelt on the need to build the support of programme stakeholders, which includes building political will at national and local levels, identifying and strengthening immunization champions at all levels and engaging civil society. The discussion ended with a note to “expect the unexpected and not to forget history”. Examples from Nepal and deep south Thailand were shared on how the programmes were tailored to local needs with strong local level engagement.

**Country plans to close immunity gaps for measles and rubella in 2018–2019**

Following a group discussion, respective country groups came up with several action points to be completed at the earliest. These action points are summarized below.

**Bangladesh**

*RI strengthening*

- MoH should finalize the immunization policy and urban strategy.
- Review and finalize micro-plans for all districts, with special emphasis on low-performing divisions (Sylhet and Chittagong). The process should be expedited to cover the entire country by the end of the year.
- Finalize the annual work plan for the National Immunization Programme by 20 February 2018 with wide participation of planning units from MoH, Directorate General of Health Services (DGHS) and partners (UNICEF, WHO, BRAC, USAID and others). The plan will ensure effective implementation of comprehensive multi-year plans of action at national and sub-national levels.
- Regular capacity building training on immunization system strengthening to be conducted at the sub-district level. This includes mid-level manager training and refresher training to the Expanded Programme on Immunization (EPI) programme managers and officers at upazila level.
- Mapping of the vacant posts of vaccinators followed by recruitment and replacement of vaccinators to be done at the earliest possible.
- Establish regional cold-chain warehouses in 12 districts and increase capacity of the central warehouse.
Supplementary immunization activities

- Plan for a follow-up sub-national MR SIA in Q1 of 2019. The proposal has been already submitted to Gavi and will be revised based on feedback from technical mission that is planned later in the year.
- Identify low performing divisions for initial phases of MR SIA based on risk assessment and available data.

Surveillance

- Maintain high quality surveillance through continued orientation of health staff and periodic review and sharing of feedback down to lower levels.
- Use any outbreak as an opportunity to explore systems issues and help fix them to prevent outbreaks. There is a need to conduct a more in-depth systems assessment following large measles and rubella outbreaks, in line with the GRIP guidance on the 10 transformative changes for immunization systems strengthening.
- Streamline the vaccine preventable disease (VPD) surveillance data set with the District Health Information System (DHIS) 2 platform.
- Strengthen laboratory testing capacity for VPDs in the country, e.g. Institute of Epidemiology, Disease Control and Research (IEDCR) for Japanese encephalitis (JE), diphtheria and other VPDs; Institute of Public Health (IPH) National Polio and Measles Laboratory (NPML) for measles, rubella and polio.
- Renewal of laboratories as per the need assessment.

Data

- Enhance data quality through:
  o review of data quality through regular field visits by a team of supervisors (MoH, WHO and UNICEF) and desk review;
  o developing a data improvement plan which is endorsed by all partners and stakeholders;
  o training on data quality strengthening to EPI staff and partners;
  o review of DHIS 2 data visualization platform on a regular basis and provide feedback to all levels, as appropriate.
- Build capacity of EPI staff at district, city corporation and sub-district level to review immunization data (training and computers).
- Initiate online information management on cold chain and vaccine management.
- Conduct regular review of data and feedback at all levels.
- Data quality self-assessment (DQS) – at least one/surveillance and immunization medical officer (SIMO)/month will be conducted.
- Coverage evaluation survey (CES) will be conducted.

Innovative approaches

- Use of mobile technology to inform mothers and track defaulters on a pilot basis
- Population-based registration to start in five districts
- Weekly video conference with Civil Surgeon by DGHS and Programme Focal Person
- Multipurpose health volunteers will be in place to support immunization and other primary health-care services – five volunteers will be positioned in each community clinic as a pilot in 20 districts.

**Sustainable financing for measles and rubella**

Costed comprehensive multi-year plan (cMYP) and measles, rubella and CRS elimination strategy plan should be available to guide the programme. The *Fourth Health, Population and Nutrition Sector Development Programme (HPNSP) (2017–2021)* has allocated funds for vaccine and operation costs for RI. MR 1 vaccine has been procured by the Government and MR 2 vaccine has been co-financed with Gavi for RI.

**India**

**RI strengthening**

- High level commitment for RI strengthening to be maintained through:
  - monitoring of RI performance through the Prime Minister’s Office, involving chief ministers of states;
  - strengthening of intersectoral coordination and accountability framework at district level and close oversight by states.
- Increase RI monitoring by national and state level EPI teams in all districts for identifying the gaps in service delivery/community participation and taking corrective actions as required. This will be followed by periodic assessment in the states by national level teams. District task forces will act on the gaps found.
- Integrate Intensified Mission Indradhanush (IMI) sessions into RI sessions and transfer the lessons learnt from IMI to other districts for scale-up.
- Utilize MR SIA as a platform for strengthening RI based on lessons learnt from Phases 1, 2 and 3 of the MR SIA campaign.
- Develop sub-national annual plans and closely monitor implementation of the following:
  - states and districts to develop a vision document and roadmap for strengthening RI. The district plans to be consolidated into the vision document;
  - annual RI plans to be developed and budgeted under programme implementation plans in National Health Mission funding;
  - need-based human resources to be enhanced;
  - concurrent monitoring with adequate sampling;
standardizing the RI micro-plans and coverage improvement plans at the planning units;
- communication plans.

**Supplementary immunization activities**
- Ensure high coverage in the planned MR SIA all over the country. Context specific and need-based multi-dimensional approach will be adopted for achieving high quality SIAs.
- Lessons from previous phases will be incorporated to upgrade and help tailor the campaign for the next phase (operations and communications).
- Media mix method will be followed, that will encompass the following:
  - be pro-active with messaging;
  - use mass media, mid media, Interpersonal Communications (IPC) and Behaviour Change Communications (BCC);
  - high level of engagement and involvement of the private sector.
- Geo-context specific communication plans to be made, e.g. underserved strategy for polio. Social media needs to be developed based on local consultations.
- Crisis communication plan to be put in place, including media scanning and interventions.

**Surveillance**
- Expansion of a high quality, sensitive, elimination standard case-based surveillance across the country by 2019;
- Broadening of case definition to fever and maculopapular rashes, starting from selected states to scale-up all over the country based on the lessons learnt from implementation in selected states;
- Gradual expansion of the MR lab network along with strengthening of internal and external quality assurance and gradual integration with the Integrated Disease Surveillance Programme (IDS);  
- Promoting domestic production of MR IgM ELISA kits;
- Generating state/district specific molecular epidemiology of circulating measles virus and tracking the transmission pattern;
- Modelling exercises to be done in partnership with experts to identify susceptible cohorts and interval between the campaigns for measles and rubella;
- Expansion of sentinel sites CRS surveillance to cover the entire country in partnership with Indian Council of Medical Research (ICMR) and monitor the CRS trend.

**Data**
- Monitor the measles-rubella-containing vaccine (MRCV) 1 and 2 coverage at national and sub-national level and flag areas that will require augmentation of RI.
- Enhance the use of technology to strengthen data availability and utilization and triangulate data from various sources for action:
  o Health Management Information System (HMIS)
  o Reproductive child health (RCH) portal – name-based tracking
  o ANM Online (ANMOL)
  o Electronic Vaccine Intelligence Network (eVIN)
  o National Cold Chain Management Information System (NCCMIS)
  o concurrent monitoring
  o periodic surveys
  o Vaccine Adverse Events Information Management System (VAEIMS).

**Innovative approaches**
- Conduct assessment of RI systems in the selected states by national teams.
- Conduct sero-prevalence surveys for measles and rubella.
- Explore the feasibility of point-of-care testing devices, dried blood spot (DBS) and oro-crevicular fluid testing for measles and rubella diagnostics.

**Sustainable financing for measles and rubella**
The immunization programme in the country is being supported by the Government and is an ongoing process. While the financing from the Government is sustainable and predictable, partners’ support and technical assistance will have to be coupled to achieve maximum benefits of immunization.

**Indonesia**

**RI strengthening**
- Strengthen sub-national annual plans and micro-plans by:
  o including high-risk populations into the micro-plans;
  o meaningful engagement with local religious leaders;
  o meaningful engagement with medical students, professional health organizations (IDI, IDAI, IBI, PPNI), private sector, etc.
  o engage with local nongovernmental organizations (NGOs) and community health volunteers
  o developing an accountability framework for village heads.

**Supplementary immunization activities**
Complete Phase 2 MR SIA by September 2018 and ensure high quality MR SIA for Phase 2 by the following actions:

- revision of the national MR implementation guideline based on lessons learnt from Phase 1;
- identification of high-risk areas and high-risk populations for inclusion in the micro-plan;
- recruitment, training and deployment of national and international consultants in high-risk pockets (3-2-1 strategy). Employ approximately 50 additional staff for 6–9 months to ensure effective planning and implementation of the micro-plans;
- use the SIA readiness assessment tool, depending on the risk assessment – select high-risk areas and ensure timely corrective actions as required;
- deployment of independent technical experts from partners to pockets of high-risk areas (microplanning, capacity strengthening, on-the-job training, etc.) for effective monitoring, planning and local capacity building to effectively implement MR SIA;
- training of regional AEFI committees in batches at regional level during May–July;
- map the issues related to communication and plan for local context-specific interventions;
- address the issues (inter-sectoral approach, involving local communities):
  o tailor the information, education and communication (IEC) materials according to local needs
  o engage the local authorities appropriately
  o update the existing communication plan accordingly;
- engage media to positively reinforce and promote public awareness on the importance of immunization and risk of not being immunized.

**Surveillance**

- Revision of VPD surveillance module and training as per the regional guide. Based on the revised VPD surveillance guide, ensure the following:
  o develop handout on VPD surveillance standard operating procedure (SOP)
  o e-learning portal to be used as applicable
  o training on outbreak investigation and response as well as data analysis to be done in all provinces and cascaded to districts
  o short message/video on VPD surveillance to be disseminated through social media.
- Increase the sensitivity of surveillance by engaging professionals and the private sector to promote reporting of suspected measles cases and expansion of reporting units.
- Increase laboratory capacity on serology and virologic testing of samples from suspected cases by introduction of a new approach of sample collection (dried blood test) in hard-to-reach areas.
- Improve data quality:
  o develop and expand the VPD web-based system, with a linkage to reporting laboratory unit;
  o periodic data validation in areas with lower reporting rate and silent areas.

**Data**

- Undertake capacity strengthening of district staff on data analysis (data for action) of immunization and surveillance data and monitor trends to identify issues and take timely corrective actions.
- Link data of EPI and surveillance and implement integrated web-based data recording (immunization–surveillance).
- Use MR SIA’s school data to update the denominator of the school based immunization programme.

**Innovative approaches**

- Ensure school entry checks are carried out.
- Expedite the process of development of a legal framework to screen for vaccination status of the child during school admission, followed by the development of its implementation plan with aggressive monitoring of the implementation. Coordinate with Ministry of Education and Ministry of Religious Affairs.
- Ensure regular and proactive engagement with parent–teacher associations to promote routine as well as supplementary vaccination.
- Open vial policy and its compliance study to be completed and findings used for any course correction required.
- Extensive use of real-time data monitoring, RapidPro.

**Sustainability**

- Ensuring budget availability of MR SIA in the comprehensive multi-year plan (cMYP) 2020–2024;
- Advocacy to parliament highlighting regional and country goals of measles elimination and rubella control;
- Inclusion of RI performance indicators as part of the Minimum Service Standard to measure performance of local government bodies at sub-national level;
- Strengthening Bio Farma capacity for vaccine self-sufficiency through timely technology transfer;
- Sub-national/island advocacy missions to be conducted jointly by MoH, WHO and UNICEF.

**Myanmar**

**Strengthening RI**

- Strengthening of sub-national plans, annual plans and micro-plans.
  - Micro-plans from the lowest implementing level to be compiled as costed annual plan of each township, region, state and finally the country as a whole. This will be clearly linked with the Annual Operation Plan of the National Health Plan.
  - GIS mapping to be used during development of micro-planning at each level to identify fixed posts, outreach sessions and crash immunization activities. Based on the mapping, and considering the cold-chain needs, travel times
and the number of fixed sites, outreach sessions and crash immunization activities can be decided in a more efficient and cost-effective manner.

- Demand generation activities through tailored approach to be done using the Gavi HSS support.

**Geographically hard-to-reach areas**

- Improved micro-planning (as mentioned earlier)
- Crash immunization (three times/year) using catch-up strategy
- Expansion of cold chain beyond township HF as per the effective vaccine management (EVM) assessment and recommendation
- Long-term costed plan.

**Conflict-affected areas**

- Volunteers from ethnic health organizations (EHOs) to be identified and mobilized as vaccinators for both oral and injectable routine vaccination.
- Volunteers from local community will be mobilized as social mobilizers and polio vaccinators (Rakhine state).

**Urban poor and migrants**

- Expansion of fixed immunization posts to peri-urban areas
- Establishment of immunization clinics at the earliest at tertiary and township hospitals for increased services availability
- Additional vaccinators’ support in urban health centres
- CSOs’ engagement in social mobilization.

Some of the above strategies are already being implemented and scaled up during implementation of the JE Campaign and are planned to be continued with Gavi HSS support.

**Supplementary immunization activities**

The country plans to conduct MR SIA in 2019 and thus will be applying to Gavi in the May 2018 window for funding support. Lessons learnt from countries will be incorporated and SIA will be used as an opportunity to strengthen RI.

**Tailoring immunization programmes (TIP)**

Considering the changing context of Myanmar, influence of social media, diverse ethnic groups and dialects (>100), a knowledge, attitudes and practices (KAP) study is planned in 2018 using health systems strengthening (HSS) support from Gavi. Following this, tailored approaches like onsite production of IEC materials for specific communities and other proactive approaches (preparation for crisis conditions) will be designed.
**Surveillance**

Case definition of suspected cases has been changed in 2016 to fever and maculopapular rash. In view of this, the following activities will be conducted to increase the sensitivity of surveillance.

- Ensure effective implementation of fever and rash surveillance all over the country through regular monitoring, review and feedback.
- Increase private sector involvement in surveillance for fever and maculopapular rashes, for which following activities will be conducted:
  - advocacy meetings/orientation training to all clinicians;
  - developing a policy on mandatory reporting of VPDs as a requirement in the registration process of private sector providers to get more cases reported and specimens collected;
  - outsourcing for specimen transport – private providers in urban areas.
- Alternate sampling techniques such as DBS to be considered for specimen collection or serology for measles and rubella in hard-to-reach areas where there is a challenge with collection of samples through venipuncture.
- Genotyping for each chain of transmission of measles and rubella will be strengthened along with ensuring adequate provision of specimen collection kits and transportation costs.

**Data**

- Triangulation of data will be conducted – denominators, numerators, coverage vs cases distribution, and corrective actions conducted as per the need to streamline each data set;
- Data improvement plan, for which budget has already been secured;
- Capacity building will be done at all levels on data quality

**Innovative approaches**

- School entry check for immunization status against MR and catch-up vaccination for missed children.
- Reach every child (REC) strategy implemented for monastic schools and orphanages.
- Vaccination against MR among health-care workers and students from medical universities and institutes will be conducted on a regular basis and expanded to other institutions/factories. This includes new job entry check for immunization status against MR and mandatory MR vaccination at their own expense.
- Develop research agenda on EPI & VPD surveillance (measles and rubella/CRS).

**Sustainable financing**

- **Vaccine costs**

  MR vaccines requirement for RI, catch-up and small-scale outbreak response immunization (ORI) have been projected and cost estimated and planned up to
2021 as part of the vaccine independence initiative for the next 5 years. There is a commitment from the Government for all 11 EPI antigens.

- **Operational costs**
  - Future costs (cold chain and travel cost) for RI outreach sessions and crash immunization will be supported by the Government after the end of Gavi HSS support.
  - Gavi support for vaccine and operational support is expected for MR SIA in 2019; thereafter, for SIAs the cost will be shared by the Government.

**Nepal**

**RI strengthening**

- Intensification of micro-plan – in the federalized context, focusing on low-performing municipalities and councils.
- MCV 2 will be used as an indicator for both protection from vaccine and marker of “fully immunized district” declaration.
- Formation of immunization core group (MoH/WHO/UNICEF) at the Central level that meets monthly, reviews data, identifies the gaps at different administrative levels, makes recommendations which reaches appropriate local bodies and ensures corrective actions are taken.
- Districts will be classified into: high MCV1/low MCV2 and low MCV1/MCV2, etc.

**SIA**

- Nepal plans to conduct MR SIA in Q1 of 2019 and will develop a proposal for submission to Gavi in the May 2018 window. The target age group will be decided based on local epidemiology and modelling data. The SIA proposal will include:
  - ways to reach children missed during RI
  - SIA will be used as an opportunity to strengthen the RI
  - details of Government support to RI/SIA
  - importance of the SIA to close the immunity gap.

**Surveillance**

Districts will be reviewed for their non-measles–non-rubella case rates for fever and rash. For districts with a rate of less than 2 per 100,000 population, the following activities will be conducted:

- female community health worker (FCHV) support for referral of suspected cases to the nearby health facility;
- active case search in the community by government staff/SMOs;
- contact assessment in selected districts;
- DBS test in remote areas where collection of samples for serology is difficult.
**Funds**

Gavi HSS and TCA funds will be used to provide technical assistance to help strengthen RI and implementation of SIA over and above the support from MoH for the National Immunization Programme.

**Thailand**

**Strengthening RI**

- Advocacy to include measles elimination into the larger health agenda at the provincial and regional level and identify local and national champions for the same.
- Plans to strengthen vaccine coverage data through strengthening the electronic database of the health data center.
- Programme plans to conduct coverage evaluation survey every 5 years.
- Implementation of tailored approach in high-risk populations, e.g. migrant, underserved population and high-risk areas – deep south, border areas and urban areas with pockets of underserved population.
- For pockets of vulnerable population, key activities proposed to ensure high vaccination coverage are:
  - mop-up vaccination in underserved populations and ensuring barriers such as language barrier are addressed to achieve high coverage;
  - catch-up vaccination in high-risk areas;
  - engage other line ministries and civil society to identify innovative approaches to provide immunization for these vulnerable populations;
  - closing knowledge gaps on the changing perception on vaccination through positive messaging using various channels;
  - policy decision is required to include registered migrant workers for vaccination.

- To strengthen immunization systems, activities proposed are:
  - capacity building of staff at all levels for immunization programme management, including monitoring and reviews;
  - site visits and supervision of national/subnational staff to the local health facilities to provide timely and constructive feedback;
  - engage local administrative officers in immunization activities;
  - improve the school entry database system and ensure school vaccination has high coverage.
**Surveillance**

- Integration of the currently existing two MR surveillance and immunization reporting systems into one database;
- Engage stakeholders from the private sector to report cases of fever and rashes through periodic orientation and capacity building and development of accountability framework;
- Initiate CRS surveillance;
- Revision of the VPD surveillance guide in line with the Regional standards.

**Data**

- Develop a data visualization platform to demonstrate vaccine coverage and surveillance data and make it more user-friendly and usable.
- Strengthen data monitoring systems at all levels by integrating this into the monthly meetings at provincial level as well as build local capacity to analyze data.
- Regular meeting of stakeholders to provide feedback to the local level.

**Innovation**

- Develop a communication strategy to reach high-risk populations.
- Carry out research on sensitivity/specificity of rapid test to ensure early detection in high-risk/underserved populations.

**Sustainability**

- Develop budget plans to ensure investigation of all suspected cases with fever and rash.
- In case of emergency and large-scale outbreak, additional lab supplies will be required including support for outbreak response. It is proposed to have a stockpile of vaccines with WHO/UNICEF for large outbreaks.

**WHO Regional Office for South-East Asia**

- Ensure that a high level of commitment is maintained by Member States. WHO Regional Office to facilitate a joint letter from WHO HQ/Regional Office and UNICEF HQ/Regional Office to Member States to reiterate commitment on measles elimination and rubella/CRS control.
- Ensure that the revised surveillance guidelines for measles, rubella and CRS are released at the earliest.
- Provide technical guidelines on strengthening of RI using SIA as an opportunity and Regional adaptation of the document *Planning and Implementing High Quality Supplementary Immunization Activities for Injectable Vaccines.*
- Conduct periodic follow-up on the key action points and provide necessary technical support as and when required.
- Document the lessons learnt shared in the meeting on various topics in the form of a coffee table book and share the same with all stakeholders.
## Annexures

### Annex 1 – Agenda of the meeting

<table>
<thead>
<tr>
<th>Day 1</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Opening session</strong>&lt;br&gt;- Opening remarks by Regional Director, South-East Asia Region&lt;br&gt;- Objectives of the meeting and housekeeping announcement</td>
<td>WHO Regional Office for South-East Asia</td>
</tr>
<tr>
<td><strong>Session 1 – Updates on measles, rubella and congenital rubella syndrome</strong>&lt;br&gt;- Global updates (15 mins)&lt;br&gt;- Regional update from Regional Office for South-East Asia (15 mins)&lt;br&gt;- Findings from the Midterm Programme Review (20 mins)&lt;br&gt;- Modelling data on population–immunity gap in South-East Asia Region</td>
<td>WHO HQ&lt;br&gt;WHO SEARO&lt;br&gt;MTR Team&lt;br&gt;BMSGF</td>
</tr>
<tr>
<td><strong>Session 2 – Country updates – progress towards measles elimination and rubella/CRS control</strong>&lt;br&gt;- Bangladesh, India, Indonesia, Myanmar, Nepal, Thailand</td>
<td>Respective MOHs</td>
</tr>
<tr>
<td><strong>Session 3 – Lessons from the pre-campaign readiness assessment – measles–rubella SIA in India and Indonesia</strong>&lt;br&gt;- Background information (20 mins)&lt;br&gt;- India (30 mins)&lt;br&gt;- Indonesia (30 mins)</td>
<td>IVD /SEARO&lt;br&gt;MOH India&lt;br&gt;MOH Indonesia</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Day 2</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Session 4 – Lessons learned on SIA implementation and implications for RI strengthening</strong>&lt;br&gt;- India (30 mins)&lt;br&gt;- Indonesia (30 mins)</td>
<td>MOH India&lt;br&gt;MOH Indonesia</td>
</tr>
<tr>
<td><strong>Session 5 – Data for action – use of data to strengthen programme</strong>&lt;br&gt;- Bangladesh – on MR surveillance (30 mins)&lt;br&gt;- Myanmar – on immunization (30 mins)</td>
<td>MOH Bangladesh&lt;br&gt;MOH Myanmar</td>
</tr>
<tr>
<td><strong>Session 6 – Promoting demand for vaccination (each presentation of 30 mins)</strong>&lt;br&gt;- WHO HQ – Overview of tailoring immunization programme (TIP)&lt;br&gt;- Nepal – Fully immunized village/district initiative&lt;br&gt;- Thailand – Lessons from deep south on vaccine</td>
<td>WHO HQ&lt;br&gt;MOH Nepal&lt;br&gt;MOH Thailand</td>
</tr>
</tbody>
</table>
hesitancy

**Group work A – Introduction to group work (four groups):**
- Pre-campaign readiness assessment
- Tackling challenges with SIA implementation
- Using data to strengthen programme
- Implementing TIP

<table>
<thead>
<tr>
<th>Day 3</th>
<th>Responsibility</th>
</tr>
</thead>
</table>
| Session 7 – Plenary – presentations of Group work A  
- 15 mins per group (four groups)  
- Discussion – 30 mins | Respective groups |
| Group work B – Country action plans development  
(Facilitated by WHO, UNICEF and Gavi) | All |
| Session 8 – Plenary: presentations of Group work B  
- 10 mins per country (6 countries)  
- Discussion – 30 mins | Respective country groups |
| Closing session  
- Conclusion and action points  
- Remarks by UNICEF HQ, WHO HQ, US CDC, and MoH participants | UNICEF HQ, WHO HQ, US CDC, MoH |
Annex 2 – Speech by the Regional Director

Representatives of the national immunization and surveillance programmes from Bangladesh, India, Indonesia, Myanmar, Nepal and Thailand, WHO colleagues from Headquarters and country offices, representatives of UNICEF, US CDC, Gavi and other partner agencies, ladies and gentlemen:

It is with great pleasure that I welcome you to New Delhi for this unique opportunity – one I know you are looking forward to.

I share your anticipation and sense of occasion. Our quest to eliminate measles and control rubella and congenital rubella syndrome – or CRS – by 2020 is inspiring. Indeed, it is central to what our Region is about and what we are striving to achieve.

That begins with human impact at the grassroots. Eliminating measles means saving half a million lives in our Region every year. Lives of the young. Lives of the elderly. And lives of the immune-compromised. Controlling rubella and CRS would meanwhile promote the health of pregnant women and the infants they give life to.

Our mission is advanced by a deep and abiding commitment to health equity. Eliminating measles and controlling rubella means extending the benefits of vaccine technology to all people everywhere. That includes communities in hard-to-reach or remote areas. It also includes communities that are underserved, neglected or marginalized for reasons we must better understand, challenge and overcome.

And our struggle is carried forward by the strength of our enduring yet flexible partnerships. The leadership provided by national immunization programmes has been remarkable. So too has the drive and commitment of the many partners gathered today. Our ability to eliminate measles and control rubella and CRS rests on our shared vision and the effective pursuit of south–south and triangular cooperation.

Distinguished representatives, colleagues and friends, beyond the significance measles elimination and rubella control has within our Regional agenda, there is another reason why I am especially buoyed by this occasion. That reason is the opportunity to listen to six of the Region’s largest countries and gain insights into how they are closing immunity gaps and working towards our common 2020 vision.

As I know you appreciate, in recent years these countries, and the South-East Asia Region more generally, has made stunning progress in preventing, controlling and eliminating vaccine-preventable diseases – progress that has been noted the world over.

Last year India and Indonesia targeted 70 million and 35 million children, respectively in supplementary immunization campaigns. Both have strengthened routine immunization systems, including by adding key vaccines to their schedules. Bangladesh has implemented an urban immunization strategy, harnessing networks of volunteers to broaden coverage and leave no child behind. Last November, Myanmar protected around 14 million children against Japanese encephalitis. Nepal has pioneered an incentive scheme to recognize and
celebrate villages and districts that are fully immunized. Thailand has demonstrated to the world the impact surveillance can have via its unique “data for action” model.

So we have a lot to learn here in New Delhi, far though it may be from Geneva or New York. Indeed, this dynamism and positive exchange is at the very core of south–south and triangular cooperation, and is sure to make the coming sessions immensely engaging and productive.

Distinguished representatives and participants, before we move to the Member States’ presentations, and then on to the global view from our colleagues at HQ, I want to briefly look at the Regional picture, especially as it relates to our founding strategy.

Of the 38 million children born in our Region every year, approximately 87% receive the first dose of measles-containing vaccine. Though that represents a dramatic increase over previous levels, it still means around 4.8 million children are deprived of the most basic protection against measles each year. Importantly, although the recommended two doses of MCV have been introduced in each of the Region’s countries, only five of them have achieved 95% coverage of both doses – the level needed for herd immunity.

To be sure, each country is unique in terms of its progress, challenges and the specific interventions that can help them achieve the 2020 goal. That is certain to come out in country presentations. We must appreciate these nuances and be agile in our thinking. But like all good planners, we must also hold fast to the fundamentals of strategy and recognize the cross-cutting challenges our Region faces. In that regard, our Regional Strategic Plan for measles elimination and rubella and CRS control is a good place to turn to.

The Strategic Plan highlights how routine immunization can be strengthened and all people everywhere reached. It details how supplementary campaigns can be harnessed and accelerated progress achieved. It outlines why community mobilization is needed, and how vaccine hesitancy can be overcome. And it emphasizes the importance of hard data and why effective surveillance is so critical to our mission.

Indeed, it highlights these points among many, many others that are crucial to achieving our goals, both at the country and Regional level. As we engage with one another in coming days, I urge you to come back to, and reflect on, these principles and how they can best be leveraged. After all, we know by experience they work. As you may be aware, Bhutan and Maldives have already achieved the 2020 target. They have both eliminated measles.

Distinguished representatives, colleagues, friends, in grasping the significance of the moment, I urge you to look around – to consider the company you are in. You are surrounded by people with the strongest experience in battling vaccine-preventable diseases, whether at the country, regional or global level. You are joined by professionals with the finest expertise in immunization, whether in micro-planning, cold-chain management or community mobilization. And you are connected to a range of global health advocates advancing an agenda that promises to bring health and well-being to all by 2030.
Every one of these people is here to make a difference – to make a meaningful contribution to our quest to eliminate measles and control rubella by 2020. This is indeed a special moment. We have a rare opportunity. Let us make full use of it by listening to one another, learning from one another, and reflecting on how together we can close the gap and drive life-changing progress across the South-East Asia Region.

Thank you very much.

(Dr Poonam Khetrapal Singh)

**Annex 3 – Presentations and discussion files**

All presentations made in the meeting are available in the following link in the order of presentations made as per the agenda:


To access the meeting documents please use the following:

User name – bigsixguest

Password – who@2018
Annex 4 – List of participants

National EPI Programme

Bangladesh

Dr Md. Jahangir Alam Sarker
Director Health and Line Director
MNC&AH
Directorate General of Health Services
Mohakhali, Dhaka

Dr Md. Altaf Hossain
Programme Manager, EPI
Directorate General of Health Services
Mohakhali, Dhaka

India

Dr Pradeep Haldar
Deputy Commissioner (Immunization)
Ministry of Health & Family Welfare
Nirman Bhavan, Maulana Azad Road
New Delhi

Dr M.K. Agarwal
Deputy Commissioner (UIP)
Ministry of Health & Family Welfare
Nirman Bhavan, Maulana Azad Road
New Delhi

Dr Sudheera Gamalla
State EPI Officer
O/o Commissioner of Health & Family Welfare
DM & HS Campus
Sultan Bazar, Kothi, Hyderabad – 500 095

Indonesia

Dr Made Yosi Purbadi W, MKM
Head of Basic Immunization Section
Directorate of Surveillance and Health Quarantine
Ministry of Health
Republic of Indonesia
Jakarta

Dr Siska Hidayani, MKes
Head of Section of Surveillance and Immunization
Riau Provincial Health Office
Pekanbaru, Indonesia

Drg. Yus Ruseno, MScPH
Head of Section of Surveillance and Immunization
West Java Provincial Health Office
Bandung, Indonesia

Mr Subur Hadi Marhaento, SKM, MKes
Head of Section of Surveillance and Immunization
Central Java Provincial Health Office
Semarang, Indonesia

Myanmar

Dr Htar Htar Lin
Deputy Director (EPI)
Department of Public Health
Ministry of Health and Sports
Naypyitaw, Myanmar

Dr Aye Mya Chan Thar
Assistant Director (EPI)
Department of Public Health
Ministry of Health and Sports
Myanmar

Dr Danny Linn
Team Leader
State Public Health Department
Ministry of Health and Sports
Shan State, Lashio
Naypyitaw, Myanmar
Nepal

Mr Krishna Bahadur Chand
Chief, Expanded Programme on Immunization
Senior Public Health Administrator
Child Health Division
Department of Health Services
Teku, Kathmandu, Nepal

Mr Badri Raj Acharya
Immunization Supervisor
Western Regional Health Directorate
Pokhara, Kaski, Nepal

Thailand

Dr Suwich Thammapalo
Director, Office of Disease Prevention and Control 12
Department of Disease Control
Ministry of Public Health
Nonthaburi 11000, Thailand

Dr Pawinee Doung-Ngern
Medical Officer, Professional Level
Bureau of Epidemiology
Department of Disease Control
Ministry of Public Health
Nonthaburi 11000, Thailand

Dr Chaninan Sonthichai
Medical Officer, Professional Level
Chief, Basic Immunization Program Development Section
Department of Disease Control
Ministry of Public Health
Nonthaburi 11000, Thailand

EPI focal points from WCOs

Bangladesh

Dr Rajendra Bohara
Team Leader - IVD

India

Dr Pauline Harvey
Team Leader (NPSP)

Dr Pankaj Bhatnagar
NPO-Deputy Team Leader (NPSP)

Dr Balwinder Singh Chawla
National Professional Officer (Immunization)
NPSP

Dr Mohammad Samiuddin
Monitoring and Evaluation Officer, NPSP

Dr Danish Ahmed
Focal Person- Underserved Strategy, NPSP

Dr Satyabrata Routray
Measles Focal Point, NPSP

Dr Asish Satapathy
Regional Team Leader- South, NPSP

Dr B.P. Subramanya
Regional Team Leader- Central, NPSP

Dr Prashanta Kumar Roy
Regional Team Leader- North, NPSP

Dr Madhup Bajpai
Regional Team Leader- Uttar Pradesh, NPSP

Dr M. Ratnesh
Sub-regional Team Leader, Chennai, NPSP

Dr Puttaraju
Sub-regional Team Leader, Hyderabad, NPSP

Dr Vikas Kokare
Sub-regional team leader, Gujarat, NPSP
**Indonesia**

Dr Vinod Bura  
Technical Officer-EPI

Ms Niprida Mardin  
National Professional Officer

Dr Fina Tams  
National Professional Officer

**Myanmar**

Dr Tin Tin Aye  
National Professional Officer, (VPD Surveillance)

**Nepal**

Dr Anindya Bose  
Medical Officer-EPI

Dr Binod Sah  
National Professional Officer

**Thailand**

Ms Aree Moungsookjareoun  
National Professional Officer

**WHO HQ**

Dr Katrina Kretsinger  
Medical Officer

Ms Lisa Menning  
Technical Officer

Ms Carole Tevi Benissan  
Technical Officer

**UNICEF ROSA**

Dr Paul Rutter  
Regional Adviser-MNCH

**UNICEF EAPRO**

Dr Saadia Farrukh  
Regional Immunization Specialist

**UNICEF HQ**

Dr Xiaojun Wang  
Immunization Specialist, Health Young Child Survival and Development  
UNICEF’s East Asia and Pacific Regional Office Bangkok, Thailand

Dr Robin Nandy  
Principal Advisor and Chief of Immunization

Dr Richard Duncan  
Senior Immunization Specialist

**UNICEF – Bangladesh**

Ms Jucy Merina Adhikari  
Immunization Specialist

**UNICEF India**

Dr Satish Gupta  
Health Specialist

**UNICEF Indonesia**

Dr Wei Xia  
Immunization Specialist

Dr Kenny Peetosutan  
Health Specialist-Immunization

**UNICEF Myanmar**

Dr Daniel Ngemera  
Immunization Specialist

**UNICEF Nepal**

Dr Ashish KC  
Health Specialist (Immunization)
Gavi, the Vaccine Alliance

Ms Carol Szeto
Senior Country Manager, India
Gavi Alliance Secretariat

Mr Dirk Gehl
Senior Country Manager, Bangladesh & Myanmar
Gavi Alliance Secretariat

Dr Peter Strebel
Senior Specialist
Gavi Alliance Secretariat

Special invitee

Dr N.K. Arora
Mid Term Review Lead
Mid-term review of the Strategic Plan for Measles Elimination and Rubella/CRS Control
INCLEN Executive Office
F-1/5, Okhla Industrial Area, Phase-I
New Delhi - 110020

WHO Regional Office for South-East Asia

Dr Neena Raina
Ag. Director
Department of Family Health, Gender and Life Course
WHO Regional Office for South-East Asia
New Delhi, India

Dr Sunil Bahl
Team Leader
Immunization and Vaccine Development
WHO Regional Office for South-East Asia
New Delhi, India

Dr Jayantha Liyanage
Regional Adviser - Immunization Systems Strengthening (ISS)
Immunization and Vaccine Development
WHO Regional Office for South-East Asia, New Delhi, India

Mr Stephane Guichard
Regional Adviser - VQM
Immunization and Vaccine Development
WHO Regional Office for South-East Asia, New Delhi, India

Ms Sirima Pattamadilok
Scientist
Immunization and Vaccine Development
WHO Regional Office for South-East Asia, New Delhi, India

Dr Sudhir Khanal
Medical Officer
Immunization and Vaccine Development
WHO Regional Office for South-East Asia, New Delhi, India

Ms Uttara Aggarwal
Technical Officer
Immunization and Vaccine
WHO Regional Office for South-East Asia, New Delhi, India

Ms Malu Adlakha
Supply Assistant
Immunization and Vaccine Development
WHO Regional Office for South-East Asia
New Delhi, India
## Annex 5 – Evaluation of meeting by participants

<table>
<thead>
<tr>
<th>Pre-conference arrangements (Rating: Poor – 1; Excellent – 10)</th>
<th>Average score (Max 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timely receipt and clarity of administrative information</td>
<td>8.4</td>
</tr>
<tr>
<td>Travel authorization/arrangements for WHO-sponsored attendees</td>
<td>8.9</td>
</tr>
<tr>
<td>Response time for pre-conference clarifications</td>
<td>8.85</td>
</tr>
</tbody>
</table>

### Conference arrangements

<table>
<thead>
<tr>
<th>Item</th>
<th>Average score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airport pick-up</td>
<td>7.3</td>
</tr>
<tr>
<td>Reception and check-in efficiency of the hotel</td>
<td>8.2</td>
</tr>
<tr>
<td>Registration process</td>
<td>8.7</td>
</tr>
<tr>
<td>Quality of conference kit</td>
<td>8.4</td>
</tr>
<tr>
<td>Hotel rooms and service</td>
<td>7.4</td>
</tr>
<tr>
<td>Meeting room(s) – set-up and ambience</td>
<td>8.9</td>
</tr>
<tr>
<td>Group work facilities/allocation</td>
<td>8.6</td>
</tr>
<tr>
<td>Quality of audio-visual systems</td>
<td>9.0</td>
</tr>
<tr>
<td>Food and beverage – quality and service</td>
<td>8.3</td>
</tr>
<tr>
<td>Facilities at, and efficiency of, Meeting Secretariat</td>
<td>8.9</td>
</tr>
<tr>
<td><strong>Overall rating</strong> (Number of respondents – 23)</td>
<td>8.8</td>
</tr>
<tr>
<td><strong>Technical quality of the meeting</strong> (Rating: Poor – 1; Excellent – 5)</td>
<td><strong>Average score</strong></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>To what extent were the objectives of the meeting accomplished?</td>
<td>4.1</td>
</tr>
<tr>
<td>Was the agenda of the meeting relevant to achieve the desired objectives?</td>
<td>4.4</td>
</tr>
<tr>
<td>Were outcomes of the meeting relevant to the needs of your country?</td>
<td>4.3</td>
</tr>
<tr>
<td>Were working papers presented substantive to the meeting?</td>
<td>4.1</td>
</tr>
<tr>
<td>Are you in a position to integrate the outcome of this meeting to your national work plan?</td>
<td>4.1</td>
</tr>
<tr>
<td>Which sessions did you find most useful and why?</td>
<td>Group works and lessons sharing</td>
</tr>
<tr>
<td>What could have been improved to meet the objectives?</td>
<td>More time for group work</td>
</tr>
<tr>
<td>What additional topics should have been covered?</td>
<td>Microplanning, surveillance, modelling</td>
</tr>
<tr>
<td>What topics should be covered next year?</td>
<td>M&amp;E framework, surveillance</td>
</tr>
</tbody>
</table>
Lessons from the Big Six-Closing the Immunity Gap for Measles Elimination and Rubella/CRS Control

WHO/SEARO, New Delhi, India, 31 January 2018 to 2 February 2018