Third Meeting of the South-East Asia Regional Verification Commission for Measles Elimination and Rubella/Congenital Rubella Syndrome Control

New Delhi, India, 31 July–2 August 2018
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## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AFP</td>
<td>acute flaccid paralysis</td>
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<tr>
<td>CRS</td>
<td>congenital rubella syndrome</td>
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<tr>
<td>DQA</td>
<td>data quality assessment</td>
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<tr>
<td>EPI</td>
<td>Expanded Programme on Immunization</td>
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<tr>
<td>HQ</td>
<td>headquarters</td>
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<tr>
<td>MCV</td>
<td>measles-containing vaccine</td>
</tr>
<tr>
<td>MeaNS</td>
<td>measles nucleotide surveillance</td>
</tr>
<tr>
<td>MR</td>
<td>measles–rubella</td>
</tr>
<tr>
<td>MRCV</td>
<td>measles–rubella-containing vaccine</td>
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<td>NVC</td>
<td>National Verification Committee</td>
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<td>RCV</td>
<td>rubella-containing vaccine</td>
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<tr>
<td>RubeNS</td>
<td>rubella nucleotide surveillance</td>
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<tr>
<td>RVC</td>
<td>Regional Verification Commission</td>
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<tr>
<td>SEA</td>
<td>South-East Asia</td>
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<td>SEA-RVC</td>
<td>South-East Asia Regional Verification Commission</td>
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<tr>
<td>SIA</td>
<td>supplementary immunization activity</td>
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<tr>
<td>US CDC</td>
<td>United States Centers for Disease Control and Prevention</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children Fund</td>
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<tr>
<td>VPD</td>
<td>vaccine-preventable disease</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Executive summary

The Regional Verification Commission for Measles Elimination and Rubella/Congenital Rubella Syndrome Control for the South-East Asia Region (SEA-RVC) was established by the Regional Director in March 2016 to verify progress towards measles elimination and rubella/congenital rubella syndrome (CRS) control in the Region. The third meeting of the SEA-RVC was held in New Delhi, India from 31 July to 02 August 2018.

The key objective of the meeting was to review the country progress reports on measles elimination and rubella/CRS control submitted by national verification committees (NVCs) and verify progress towards measles elimination and rubella/CRS control.

The methodology for review of individual country progress reports was based on the guidelines for the verification of measles elimination and rubella/CRS control in the WHO South-East Asia (SEA) Region endorsed by the SEA-RVC during its first meeting in 2016.

Following an extensive review of evidence, the SEA-RVC verified the Democratic People’s Republic (DPR) of Korea and Timor-Leste as having eliminated endemic measles. The SEA-RVC also verified that Bhutan and Maldives had sustained their measles elimination status after being verified in 2017. Sri Lanka has interrupted transmission of endemic measles for more than 12 months but has not yet been verified. The SEA-RVC categorized the remaining countries in the Region as endemic for measles transmission.

In 2017, the SEA-RVC recommended an in-depth review of the Region’s progress towards rubella/CRS control. A working group on rubella and CRS, which included members from the SEA-RVC and subject matter experts, was formed to provide input on the status of progress towards control of rubella and CRS. The working group’s conclusions were presented at this meeting, and the SEA-RVC endorsed the findings, including verifying control of rubella and CRS in six countries (Bangladesh, Bhutan, Maldives, Nepal, Sri Lanka and Timor-Leste). The SEA-RVC also agreed to recommend proposing a resolution to eliminate rubella and CRS by 2022 in the 2019 Regional Committee meeting to the WHO South-East Asia Regional Office.
The SEA-RVC acknowledged the significant progress made by all countries in the Region towards measles elimination and rubella/CRS control. In addition, the SEA-RVC acknowledged the high-level commitment shown by governments, including Expanded Programmes on Immunization (EPIs) and surveillance programmes, and the measles–rubella laboratory network. The SEA-RVC also acknowledged the important role of stakeholders throughout the Region.

The SEA-RVC requested WHO, NVCs and Member States to provide some additional country-specific information at the next meeting to ensure better review of progress towards achieving the 2020 goal of measles elimination and rubella/CRS control in the South-East Asia Region.

During the meeting, the NVC shared the lessons learnt on the functioning of the NVCs, and the issues and challenges it faces as part of peer exchange.
1. **Background**

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 (SEA) Region by 2020. The Regional Director established an independent Regional Verification Commission for Measles Elimination and Rubella/Congenital Rubella Syndrome Control for South-East Asia Region (SEA-RVC) in March 2016 to monitor progress towards measles elimination and rubella/CRS control, as well as to verify countries that have stopped the transmission of measles and/or have controlled rubella/CRS. The first meeting held in August 2015 developed the framework for verification of measles elimination and rubella/CRS control, and templates for national verification committees (NVCs) of countries in the World Health Organization’s (WHO’s) SEA Region to report on the annual progress made towards achieving the goal of measles elimination and rubella/CRS control.

2. **Objectives of the meeting**

The objectives of the third meeting of the SEA-RVC were as follows:

1. to review and provide feedback and recommendations on progress reports submitted by the NVCs of all countries in the Region as per the template provided on progress made toward measles elimination and rubella/CRS control;

2. to conduct in-depth reviews of the progress reports submitted by the NVCs of the Democratic People’s Republic (DPR) of Korea and Timor-Leste to consider the verification of measles elimination and rubella/CRS control in these countries;

3. to review the findings of the working group on rubella/CRS in the SEA Region, including the status of prevention and control of rubella and CRS in the Region, and whether a rubella and CRS elimination target for the Region should be endorsed;

4. to plan activities of the SEA-RVC and NVCs for 2018–2019.
3. **Organization of the meeting**

On day 1, a preliminary meeting was held exclusively for SEA-RVC members. During this meeting, members discussed and agreed on the methodology to be adopted to review the progress reports and provide feedback and recommendations. The meeting was chaired by the Chairperson of the SEA-RVC and attended by 10 of the 12 members of the SEA-RVC.

For the remainder of day 1 and subsequent days, there was a joint meeting of SEA-RVC members and representatives of the NVCs. The Acting Director of Family Health, Gender and Life Course (FGL) of WHO’s Regional Office for SEA inaugurated the meeting on behalf of the Regional Director and read out the Regional Director’s remarks (Annex 2). The chairpersons or representatives of all 11 NVCs of the Region and representatives from WHO headquarters, the WHO Regional Office for the Western Pacific, and the United States Centers for Disease Control and Prevention (US CDC) participated in the meeting. The agenda of the meeting is available as Annex 1 and the list of participants as Annex 8.

Secretarial support was provided by the Regional Office for South-East Asia. Dr Sudhir Khanal and Dr Michelle Morales recorded the proceedings of the meeting. The secretariat also provided an update on the progress towards the recommendations made at the second meeting in Colombo, Sri Lanka in 2017 (Annex 6).

All sessions of the meeting were webcast live through WebEx; the links had been shared with all relevant partners and stakeholders before the meeting.
4. **Methodology of the review of country progress**

The review methodology of country progress was based on the guidelines on verification of measles elimination and rubella/CRS control endorsed by the SEA-RVC in 2016.

**Prior to the meeting**

1. Prior to the third meeting of the SEA-RVC, the annual reporting template on progress toward measles elimination and rubella/CRS control that had been finalized in the first SEA-RVC meeting held in 2016, was shared by the SEA-RVC Secretariat at the Regional Office with all the NVCs through the WHO country offices in December 2017.

2. The filled in and signed annual reports were submitted by all 11 NVCs to the SEA-RVC Secretariat at the Regional Office by June 2018.

3. Two SEA-RVC members were assigned as reviewers for each country report, with the exception of DPR Korea and Timor-Leste, for which three SEA-RVC members were assigned. This was done on 6 June 2018.

4. All SEA-RVC members were provided with a review checklist template to independently review the assigned country’s progress on measles elimination and rubella/CRS control against the five lines of evidence outlined in the guidelines on verification of measles elimination and rubella/CRS control for the WHO SEA Region. As DPR Korea and Timor-Leste made strong cases claiming interruption of transmission of endemic measles in their countries in their annual progress reports, field visits were conducted by SEA-RVC members to these two countries during January 2018. The field reports to these countries were archived by the SEA-RVC Secretariat and shared with all the SEA-RVC members for review.

5. A subgroup of SEA-RVC members and subject matter experts was formed in July 2018 to conduct an in-depth review of the progress towards rubella and CRS control in the Region. The
subgroup had two face-to-face meetings among themselves and many telephonic calls to discuss the review process and outcomes.

During the meeting

(1) Ten of the 12 SEA-RVC members attended the meeting. The SEA-RVC chairperson and members acknowledged the high level of commitment to measles elimination and rubella/CRS control by countries.

(2) Hard copies of the country progress reports and RVC reviews of the reports were provided to all the SEA-RVC members present at the meeting. Electronic versions were made available on the web and by email through the link provided in Annex 4.

(3) The reviews of the country reports written by the SEA-RVC members who were not present were read by the SEA-RVC Secretariat.

(4) Each NVC representative presented the country’s progress towards measles elimination and rubella/CRS control based on a template that had been provided to each NVC representative prior to the meeting by the SEA-RVC Secretariat. All presentations are available and uploaded on the website given in Annex 4.

(5) Each country presentation was given a time slot of 40 minutes – 20 minutes for presentation and 20 minutes for discussion and comments (except for DPR Korea and Timor-Leste, who were allotted 30 minutes for discussion and comments). The reviews by various participants were provided in the following order:

- dedicated reviewers of the country report,
- other RVC members,
- representatives of partner agencies.

(6) After the comments, the NVC chairpersons responded with additional information and clarifications.

(7) The working group on progress toward rubella and CRS control in the SEA Region was allotted one hour to present their findings.
to the NVC, including discussion and comments (Annex 5: Report of the Subgroup).

(8) Dedicated closed-door sessions were conducted exclusively by SEA-RVC members on days 2 and 3 after all the presentations of the NVCs had been made. These sessions were used to discuss and finalize the conclusions and recommendations of the meeting.

(9) A session exclusively on the lessons learnt from the experience of functioning of NVCs in the Region was conducted and the key findings of the session are presented in Annex 7.

(10) SEA-RVC members and the countries allocated to them for review of the annual progress reports are as follows:

<table>
<thead>
<tr>
<th>Country name</th>
<th>Reviewer-1</th>
<th>Reviewer-2</th>
<th>Reviewer-3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>Dr Natasha Crowcroft</td>
<td>Dr Rupa Singh</td>
<td></td>
</tr>
<tr>
<td>Bhutan</td>
<td>Prof Dr Shahina Tabassum</td>
<td>Dr B J C Perera</td>
<td></td>
</tr>
<tr>
<td>DPR Korea</td>
<td>Prof Soe Lwin Nyein</td>
<td>Dr Hiroshi Yoshikura</td>
<td>Dr Kumnuan Ungchusak</td>
</tr>
<tr>
<td>India</td>
<td>Dr B J C Perera</td>
<td>Dr Hiroshi Yoshikura</td>
<td></td>
</tr>
<tr>
<td>Indonesia</td>
<td>Dr Kinzang Tshering</td>
<td>Dr Jon Andrus</td>
<td></td>
</tr>
<tr>
<td>Maldives</td>
<td>Prof. Dr AP Dubey</td>
<td>Prof Soe Lwin Nyein</td>
<td></td>
</tr>
<tr>
<td>Myanmar</td>
<td>Dr Natasha Crowcroft</td>
<td>Prof Dr Shahina Tabassum</td>
<td></td>
</tr>
<tr>
<td>Nepal</td>
<td>Dr Kumnuan Ungchusak</td>
<td>Dr. Hinky Hindra Satari</td>
<td></td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>Prof Joe Icenogle</td>
<td>Prof. Dr AP Dubey</td>
<td></td>
</tr>
<tr>
<td>Thailand</td>
<td>Dr Jon Andrus</td>
<td>Dr Rupa Singh</td>
<td></td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>Prof Joe Icenogle</td>
<td>Dr Kinzang Tshering</td>
<td>Dr. Hinky Hindra Satari</td>
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5. Conclusions and Recommendations

The third meeting of the Regional Verification Commission was held from 31 July to 2 August 2018 in New Delhi, India following an extensive review of the reports from NVCs. Following a review of the report submitted by the subgroup of RVC members to assess the status of progress towards rubella and CRS control in the SEA Region and based on field observations of SEA-RVC members from their visits to DPR Korea and Timor-Leste, the SEA-RVC made the following recommendations (for endorsement of SEA-RVC members, see Annex 7):

1. The SEA-RVC categorized countries based on the framework for verification of measles elimination and rubella and congenital rubella syndrome control as follows:

<table>
<thead>
<tr>
<th>Country</th>
<th>Measles elimination</th>
<th>Rubella/CRS control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>Endemic</td>
<td>Controlled</td>
</tr>
<tr>
<td>Bhutan</td>
<td>Eliminated</td>
<td>Controlled</td>
</tr>
<tr>
<td>DPR Korea</td>
<td>Eliminated</td>
<td>Indeterminate</td>
</tr>
<tr>
<td>India</td>
<td>Endemic</td>
<td>Endemic</td>
</tr>
<tr>
<td>Indonesia</td>
<td>Endemic</td>
<td>Endemic</td>
</tr>
<tr>
<td>Maldives</td>
<td>Eliminated</td>
<td>Controlled</td>
</tr>
<tr>
<td>Myanmar</td>
<td>Endemic</td>
<td>Endemic</td>
</tr>
<tr>
<td>Nepal</td>
<td>Endemic</td>
<td>Controlled</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>Interrupted transmission</td>
<td>Controlled</td>
</tr>
<tr>
<td>Thailand</td>
<td>Endemic</td>
<td>Endemic</td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>Eliminated</td>
<td>Controlled</td>
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</table>
The SEA-RVC made the following recommendations to WHO and all Member States of the WHO SEA Region:

- The SEA Region should adopt the regional goal of interrupting endemic transmission of rubella and CRS by 2022.

- The SEA Region should realign the measles elimination target with that of rubella elimination, i.e. targeting the interruption of endemic transmission of measles by 2022. If successful, verification of elimination of each disease would take place three years later in 2025.

- The SEA-RVC endorses all the recommendations suggested by the respective NVCs of all the Member States. (These are available in the respective country presentations in Annex 3.)

- Achieving and sustaining high coverage through essential routine immunization services will be critical for achieving and maintaining these targets. To that end, all countries need to give urgent attention towards closing immunity gaps and achieving high routine immunization coverage with measles–rubella-containing vaccines (MRCVs), addressing high-risk communities, and conducting high-quality case-based active surveillance of cases with rash and fever. All countries should thus report on their efforts towards strengthening routine immunization at the next meeting.

- Among the many factors essential for achieving high-quality surveillance, special attention should be given to reaching the non-measles, non-rubella reporting rate of >2 per 100 000 population in every district and collecting specimens for virus characterization and sequencing from every chain of transmission. All countries are thus to report on the efforts towards acceleration of the transition to surveillance for fever and rash at the next meeting.

- Several countries have made progress in CRS surveillance, but more remains to be done to ensure that it is representative of the at-risk population. Medical schools participating in surveillance for acute flaccid paralysis (AFP) and currently existing platforms for monitoring birth defects need to be engaged in CRS surveillance efforts. The Rubella and CRS SEA-
RVC Working Group suggests that guidelines should include an indicator targeting at least one CRS sentinel surveillance site per second-level administrative unit (state or province) of the country.

➢ All measles–rubella (MR) campaigns should be conducted using a non-selective methodology, designed to reach every child, irrespective of their previous immunization status, with adequate attention to microplanning, and subsequent monitoring and supervision. All countries conducting MR supplementary immunization activities (SIAs) should report on the efforts made to ensure the quality of the MR SIAs at the next meeting.

➢ The Regional Office should develop additional templates to report outbreaks from countries in the NVC annual reporting template by the next 2–3 months and share this with RVC members.

➢ The Regional Office should develop a template specific for countries that have reached elimination to report on the efforts made to maintain the verification status, including detailed analysis of all reported cases/outbreaks and share it with RVC members for endorsement.

➢ The Regional Office should include additional information on rubella/CRS in the current template.

➢ The Regional Office should conduct one or more pre-meeting WebEx consultations with RVC members to review the objectives of and expectations from the next meeting.

➢ The Regional Office should conduct orientation activities for the NVC to ensure high-quality in-country review.

(3) **SEA-RVC requested the following additional information from countries, to be presented at the next meeting.**

**Bangladesh**

➢ Ensure strategies to achieve high coverage (>95%) of MRCV-1 and -2 and report to the RVC next year.
➢ Report on the budget for conducting SIA/outbreak response, especially among migrants.
➢ Report on how high-quality SIAs, including for migrants, were conducted.
➢ Report on laboratory strengthening activities, including human resources and genotyping information on measles and rubella.
➢ Report on the efforts to investigate the origin of measles cases (endemic/import/import-related/unknown).
➢ Report on the efforts made to ensure private sector involvement in MR surveillance.

**Bhutan**

➢ Report on the implementation of the post-elimination sustainability plan, including the outbreak preparedness and response plan.
➢ Report on the activities conducted to enhance capacity to strengthen outbreak investigation and response, including molecular epidemiology for measles and rubella.
➢ Describe new outbreaks (if any) in the year 2018.
➢ Report on the assessment of immunization coverage for measles and rubella at the national and subnational levels, including corrective action taken to close any identified immunization gaps.
➢ Report on the actions taken to strengthen the timelines for collection and testing of specimens for measles and rubella.

**DPR Korea**

➢ Report on the efforts made to protect the current achievements, given the circumstances, and to adopt elimination standards surveillance.
➢ Surveillance should be further reviewed in depth by the Commission within a year to ensure that surveillance of cases with fever and rash is on track and in elimination mode.

➢ Report on the implementation status of MR SIAs and introduction of the rubella-containing vaccine (RCV) in routine immunization.

➢ The Regional Office should provide information on rubella cases in countries bordering DPR Korea, including a risk assessment for importation of rubella to the country.

India

➢ Report on the quality of the MR SIA campaign conducted in the country.

➢ Report on the efforts to accelerate expansion of case-based surveillance (fever and rash).

➢ Report on the efforts made to evaluate routine immunization coverage/surveillance activities with granular coverage/surveillance data below second-level administrative units.

➢ Report on the involvement of the private sector in MR surveillance.

➢ Prepare a special report on the states of India that have conducted MR SIAs across a wide age range and switched to case-based surveillance.

➢ Report on the efforts to implement and strengthen CRS surveillance in the country.

Indonesia

➢ Report on the quality of the MR SIA campaign conducted in the country.

➢ Report on the efforts to accelerate expansion of case-based surveillance (fever and rash), including information on
genotyping and efforts to ensure testing of more specimens from persons with fever and rash.

➢ Report on the efforts made to evaluate routine immunization coverage/surveillance activities with granular coverage/surveillance data below second-level administrative units.

➢ Prepare a special report on the provinces that have conducted MR SIAs across a wide age range and switched to case-based surveillance.

➢ Report on the involvement of the private sector in MR surveillance.

➢ Report on the efforts made to successfully remove/reduce bottlenecks as presented in the current report for 2017.

➢ Report on the efforts made to implement and strengthen CRS surveillance in the country.

**Maldives**

➢ Report on the implementation of the post-elimination sustainability plan, including the outbreak preparedness and response plan.

➢ Report on the testing of selected vaccinated children from the population to ensure functioning of the surveillance and laboratory system.

**Myanmar**

➢ Report on the efforts made to strengthen case-based surveillance, genotyping, case investigation and case classification.

➢ Report on the implementation of strategies to address low coverage in high-risk areas, including closing immunity gaps in older age groups.

➢ Report on the evaluation of MCV-1 and MCV-2 coverage at subnational levels.
➢ Report on the root-cause analysis of unvaccinated cases of measles reported during outbreaks.

➢ Report on the efforts to implement CRS surveillance in the country.

➢ Report on the involvement of the private sector in MR surveillance.

**Nepal**

➢ Report on the impact of federalization on measles elimination and rubella/CRS control.

➢ Report on the efforts made to evaluate routine immunization coverage/surveillance activities with granular coverage/surveillance data below second-level administrative units.

➢ Report on the activities conducted to overcome issues with availability of the programme budget.

➢ Report on the efforts to strengthen MR laboratory services to attain full accreditation status, including genotyping.

➢ Report on the efforts to implement and strengthen CRS surveillance in the country.

➢ Report on the involvement of the private sector in MR surveillance.

**Sri Lanka**

➢ Report on the details of how sporadic cases were classified, including genotypic information.

➢ Report on the testing of selected vaccinated children from the population to ensure the functioning of the surveillance and laboratory systems.

➢ Report on the actions taken to ensure that genotyping data are shared with the measles nucleotide surveillance (MeaNS) and rubella nucleotide surveillance (RubNS) systems.
➢ Report on the efforts made to get retrospective baseline data on genotypes for both measles and rubella from historical samples (stored in some research/academic or other settings).

➢ Report on the actions taken to overcome issues related to procurement of serology kits, and measles and rubella specimen transportation.

Thailand

➢ Report back on how administrative bottlenecks for the MR programme have been resolved.

➢ Prepare a detailed report on the implementation of the proposed selective MR SIAs to close the immunity gap for measles and rubella.

➢ Report on any special study done to assess the CRS burden in the country.

➢ Report on the involvement of the private sector in MR surveillance.

➢ Report back on the streamlining of data recording and reporting from the subnational level as well as Bangkok metropolitan city for both immunization and surveillance.

➢ Report back on the implementation of elimination standard surveillance for measles and rubella, including genotyping information.

Timor-Leste

➢ Report on the implementation of the post-elimination sustainability plan, including the outbreak preparedness and response plan.

➢ Report on the activities conducted to enhance the capacity to strengthen outbreak investigation and response, including molecular epidemiology.

➢ Provide a complete report on the analysis of the July 2018 SIA coverage data.
➢ Report on the additional efforts made to strengthen routine immunization for measles-containing vaccine (MCV)-1 and MCV-2.

➢ Report back on the efforts made to build local capacity to strengthen surveillance for vaccine-preventable diseases (VPDs) with a focus on measles and rubella.

➢ Report back on the outcomes of the cross-border meeting with Indonesia.

➢ Report on the testing of selected vaccinated children from the population to ensure functioning of the surveillance and laboratory system.

➢ Report on the engagement of a virologist/microbiologist in the NVC to support the virologic aspects of laboratory component of MR surveillance.
### Annex 1

## Agenda

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<tr>
<th>Day and activity</th>
<th>Remarks</th>
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<td>Opening session</td>
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<tr>
<td>- Welcome by Ag. Director FGL</td>
<td>WHO-SEARO</td>
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<tr>
<td>- Opening address from RD presented by Ag. Director FGL</td>
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<tr>
<td>- Objectives of the meeting by Ag. Director FGL</td>
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<tr>
<td>- Administrative announcements</td>
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Presentation on the Status of measles, rubella and congenital rubella syndrome globally | WHO-HQ |

Presentation on the Status of measles, rubella and congenital rubella syndrome in the South-East Asia Region | WHO-SEARO |

Report on the mid-term review of the “Strategic Plan for Measles Elimination and Rubella/CRS Control in the WHO South-East Asia Region, 2014–2020” | MTR lead |

Western Pacific Regional Verification Commission – sharing of experience with review of country annual progress reports | WHO WPRO |

Presentation on the modus operandi of the third SEA-RVC meeting | Chair RVC |

Presentation of country progress reports by NVC chairs | NVC Chairs |

1. Bhutan |
2. Maldives |
3. Bangladesh |
<table>
<thead>
<tr>
<th>Day and activity</th>
<th>Remarks</th>
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Annex 2

Opening address by Dr Poonam Khetrapal Singh, Regional Director, WHO South-East Asia Region
(Delivered by Director a.i. FGL)

Members of the South-East Asia Region Verification Commission for Measles Elimination and Rubella/Congenital Rubella Syndrome Control, Chairpersons and representatives of the National Verification Committees from Member States, colleagues from WHO headquarters and representatives of partner agencies, ladies and gentlemen,

It is with great pleasure I welcome you to New Delhi and to the third meeting of the South-East Asia Regional Verification Commission for Measles Elimination and Rubella and Congenital Rubella Syndrome Control.

As many of you will recall, in September 2013, at the Sixty-sixth meeting of the Regional Committee, our Region’s Member States unanimously adopted the goal of eliminating measles and controlling rubella and congenital rubella syndrome by 2020. In 2014, I made achieving that goal one of our Flagship Priorities and a critical part of our quest to rid the Region of vaccine-preventable diseases.

We have gathered today with that goal and the vision it represents in mind – a vision that no child should suffer or die from a disease as easily prevented as measles; that no pregnant woman should lose her unborn baby due to a virus as avoidable as rubella; and that no neonate should be born with a heart ailment or loss of hearing owing to a tragedy as needless as in-utero rubella infection.

That is our vision and we know that by applying effective, evidence-based strategies we can achieve it. And, in fact, we are. As you have already verified, both Bhutan and Maldives are now free of endemic measles transmission.
But beyond simply verifying when a country has achieved our shared goal – indeed, our shared vision – I look upon the members of this Regional Verification Commission as my technical advisors – as advisors that review the progress Member States have made and then assess that progress with reference to the Region’s verification framework. Of course, the final part of the process – which, as you know, is also often the most taxing and rewarding – is verifying a country’s status based on the evidence provided by National Verification Committees.

Distinguished members of the Commission, participants and partners,

The goal and vision outlined at the Sixty-Sixth Regional Committee – to eliminate measles and control rubella and congenital rubella syndrome by 2020 – has gathered critical momentum. Indeed, the drive and energy to achieve it is palpable at both the subnational and local levels, whether talking to district-level administrators or volunteer immunizers. And it is also palpable at the highest levels of power and influence, whether engaging with ministers of health or political dignitaries from across the Region. It is clear each one of our Member States has made impressive efforts to implement our Region’s Strategic Plan and is making strong progress.

In 2016, for example, the Region recorded a 73% reduction in deaths due to measles compared to those at the turn of the millennium. That is a dramatic reduction, and one that has real consequences in the lives of real people. Notably, it is largely the result of remarkable improvements in routine immunization coverage, with the first and second doses of measles-containing vaccine now reaching 87% of the Region’s population.

Supplementary immunization activities with the measles and rubella vaccine are meanwhile being conducted to fill critical gaps where routine coverage is suboptimal. In the last four years these supplementary activities have vaccinated approximately 181 million children. By the end of 2019 we expect to vaccinate an additional 400 million children and young adolescents.

Nevertheless, even as together we forge ahead, we must be mindful of our vulnerabilities – by that I refer to gaps in both surveillance and coverage that continue to persist across our Region. Indeed, a mid-term progress review conducted in late 2017 concluded that although immunization systems in the Region are reasonably robust – with well-established supply,
logistics and effective human resources – and that although surveillance systems have been strengthened, their effectiveness would not allow us to achieve the 2020 goal. Indeed, it concluded that to do so, Member States would need to significantly up their game.

The challenges faced are particularly substantial for two of our Region’s largest Member States – India and Indonesia. Last January the Region’s six biggest countries, which together account for approximately 96% of the Region’s population, gathered here in New Delhi to discuss how the remaining immunity gaps for measles and rubella can be closed. I sincerely hope they will use the lessons learnt to accelerate progress towards achieving our shared goal – our shared vision.

Indeed, as I know you appreciate, measles moves fast. We need to move faster. Business as usual will not suffice. The policies, strategies and frameworks for success are in place. WHO’s technical documents and guidance are readily available. WHO South-East Asia is meanwhile all in when it comes to providing technical and operational support to Member States, including coordinating and mobilizing the resources required to fast-track progress. To that I give you my personal assurance.

Distinguished members of the Commission, partners and participants,

Need it be said: we can achieve our goal. We know that because despite all the doubters we have not had a single case of wild poliovirus in the Region for seven years. That includes in the Region’s biggest country, India. And we also know it because we are one of only two regions in the world to have eliminated maternal and neonatal tetanus. We must harness these remarkable achievements – both the infrastructure and inspiration they provide – to achieve the formidable task at hand, and which we are gathered today to discuss.

But allow me to leave you with one final thought. And that is my firm conviction that our success depends on expanding equitable access to vaccination for all people everywhere – to ensuring every newborn, child, adolescent and pregnant woman in our Region can avail themselves of the life-saving benefits vaccines provide.

But you needn’t take it from me: that conviction is also the conviction of the finest science and best evidence-based modelling we have. By
ensuring every newborn, child, adolescent and pregnant woman in our Region receives measles- and rubella-containing vaccine we can achieve our goals and avert almost half a million deaths Regionwide every year. The potential to have that kind of impact is rare. Let each of us use it wisely and leverage our talents as best we can.

I have no doubt that this eminent group of experts will examine the progress made with the same rigorous and meticulous approach demonstrated earlier, and that you will continue to provide actionable feedback and guidance on where progress can be made. I look forward to the report of your deliberations and the recommendations that come from this meeting.

I once again wish you productive deliberations and a very pleasant stay in New Delhi.

Thank you.
Annex 3

Endorsement of conclusions and recommendation

We, the Members of the South-East Asia Regional Verification Commission (SEA-RVC) for Measles Elimination and Rubella/Congenital Rubella Syndrome (CRS) Control, hereby endorse the conclusions and recommendations made by the Commission during its third meeting in New Delhi, India from 31 July-2 August 2018.

During the aforementioned meeting, the SEA-RVC for Measles Elimination and Rubella/CRS Control, conducted a detailed review of the country reports submitted by the National Verification Committees (NVCs) of all eleven countries of the Region, followed by an in-depth review of the measles and rubella surveillance and laboratory data of these countries. Based on this careful review and the follow-up discussions and interactions with representatives of the NVCs of all eleven countries as well as observations from field visits to DPR Korea and Timor-leste by select members of SEA-RVC, the Commission verified, on 2 August 2018, that DPR Korea and Timor-leste have eliminated endemic (indigenous) measles transmission and Bangladesh, Bhutan, Maldives, Nepal, Sri Lanka and Timor-leste have controlled rubella and CRS. Sri Lanka has been categorized as having interrupted endemic transmission of measles but yet to be verified by the RVC, while DPR Korea has been categorized as indeterminate for rubella/CRS. The remaining countries have been categorized as endemic for measles and rubella transmission. The Commission suggested a number of recommendations for all NVCs to report during the next meeting of the RVC to help achieve and maintain measles elimination and rubella/CRS control.
Annex 4

Presentations made at the SEA-RVC meeting

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

http://www.searo.who.int/immunization/meetings/RVC/en/
Annex 5

Report from the subgroup to review progress towards rubella/CRS control in the Region

Prevention and control of rubella and CRS in the SEA Region: report of the Rubella and CRS Working Group of the RVC

Members of the RVC Working Group on Rubella and CRS:

Jon Kim Andrus
Narendra Arora
Natasha Crowcroft
Joseph Icenogle
Michele Morales
Susan Reef

Background

In the WHO SEA Region, measles elimination has been targeted for 2020. However, for rubella and CRS, the Region has adopted only a control target for 2020. Political commitment to measles elimination in the Region remains high, coming on the heels of polio eradication. To that end, one recommendation of the recent Mid-term Review of Measles Elimination and Rubella Control in the SEA Region was that rubella elimination be included in the regional target.

Experience with rubella and CRS elimination from other countries and regions supports the position that rubella and CRS can be rapidly eliminated (Brazil broke a major epidemic and achieved sustainable rubella/CRS elimination primarily with a single nationwide campaign and routine immunization). WHO guidance no longer suggests reduction of measles to very low levels before starting a rubella/CRS programme. Specifically, for CRS, this allows early engagement of physicians who
already see suspected CRS cases. Documenting CRS elimination is very difficult if a notification system is attempted late in the programme. Laboratory testing for confirmation of CRS is not burdensome for the laboratory; the same tests are used as for postnatal rubella. Worldwide, the burden of CRS rests largely in the SEA Region, primarily because of the large country sizes.

The purpose of this note is to provide input on the status of prevention and control of rubella and CRS in the Region and whether the Region should endorse the inclusion of a rubella and CRS elimination target. To this end, various expert evaluations were assessed, and a critical review of available documents conducted.

**Key findings**

Substantial progress has been made towards measles elimination, which is important evidence of the robustness of immunization programmes and the capacity to address the challenges of rubella. Bhutan and Maldives were certified free of endemic measles transmission in 2017. Three other countries have nearly eliminated measles – DPR Korea, Sri Lanka and Timor-Leste. Bangladesh and Nepal are still endemic but have made substantial progress. Countries in the Region that remain endemic for measles are India, Indonesia, Myanmar and Thailand.

Despite having no rubella elimination target, six countries appear to have controlled rubella and/or CRS (Bangladesh, Bhutan, Maldives, Nepal, Timor-Leste and Sri Lanka). Bangladesh has exhibited exceptional leadership in strengthening their surveillance system for fever with rash. Non-measles non-rubella discard rates have substantially improved, but approximately 40% of districts still lag behind in discard rates and the Rohingya influx remains challenging. These countries are highly deserving of recognition. However, in the rest of the countries, surveillance for measles, rubella and CRS needs strengthening at all levels. For example, few countries have achieved a non-measles, non-rubella reporting rate of >2 per 100 000 population, performance of CRS surveillance is variable across the Region and genetic sequencing data remain a gap in most countries.
Routine immunization programmes in every country have benefited from the capacity development efforts of polio eradication and with the subsequent acceleration of measles elimination strategies. But more needs to be done. As noted in the Mid-term Review, decreased polio funding in the five Member States supported by the Global Polio Eradication Initiative (GPEI) in the Region (Bangladesh, India, Indonesia, Myanmar and Nepal) is a threat to the MR surveillance and elimination platform. High levels of immunization with MRCV-1 and -2 have yet to be consistently achieved in India, Indonesia, Myanmar and Nepal. We know that even in countries with reported high levels of coverage, clusters of unimmunized or partially immunized children remain, and importations are likely to spread rapidly. Countries with a high coverage of immunization will continue to have measles outbreaks, only spaced further apart. In other regions, even in countries with overall good control, low vaccine coverage in adult populations has led to significant measles, rubella and CRS outbreaks. Elimination of measles, rubella and CRS requires a strong routine programme, and cannot be achieved and sustained through campaigns. However, because rubella is less infectious than measles and rubella vaccine is more effective than measles vaccine, lower coverage is needed to achieve rubella elimination compared to measles. This explains why coverage that is not quite sufficient to prevent measles outbreaks may achieve rubella and CRS control and even elimination.

By 2019, it is anticipated that all 11 Member States will have introduced RCV into their national immunization programmes. Of the eight Member States that introduced RCV before 2017, six introduced RCV through campaigns across a wide age range. Non-selective MR catch-up campaigns using MRC vaccines have either been conducted or planned for in the near future in Bangladesh (2014), Bhutan (2006), India (2017–2019), Indonesia (2017–2018), Myanmar (2015), Maldives (2006, 2017), Nepal (catch-up 2012–2013 and follow up 2015–2016), Timor-Leste (2015) and Sri Lanka (2004). Thailand is planning a selective catch-up campaign in 2019. Both Thailand and Sri Lanka have had well-established rubella programmes before 2000. The last countries to introduce RCV have done so through a catch-up SIA, which can bring about elimination much quicker. In India, a phased wide age-range MR catch-up campaign is ongoing since 2017. To maintain herd immunity in areas already covered by the campaign, MRCV is being introduced in routine immunization in covered areas immediately following the campaign. Rubella and CRS elimination efforts are therefore also strengthening the routine
immunization system, even during large-scale SIAs. However, despite the critical importance of SIAs for bringing about elimination much quicker, immunity gaps exist in every country for both measles and rubella.

**Discussion**

Efforts to eliminate measles would benefit greatly if the SEA Region was to adopt a rubella and CRS elimination target, as demonstrated in the Region of the Americas. The two antigens (measles and rubella) are included in the same vaccine and have similar vaccination and surveillance strategies. Measles vaccine is one of the most cost-effective public health interventions, and a combined MR vaccine makes this even more cost effective. Many studies have shown CRS elimination to be cost-saving. As mentioned, great progress has been achieved in measles elimination. However, it is not likely that these efforts will be sufficient to reach the target on time, unless other measures are taken. One opportunity would be to also take advantage of the political commitment required to eliminate rubella and the consequences of CRS. As noted, several countries have already controlled rubella and/or CRS. This control status is a tremendous boost to the likelihood of countries successfully achieving a rubella elimination target. By 2019, it is anticipated that all Member States of the Region will have introduced the MRC vaccine. With this, the elimination goal will be within reach. In the Americas, rubella elimination was verified more than a year before measles elimination, and this provided a boost to the morale and political will. Furthermore, through strengthening surveillance for CRS, countries can often uncover a previously unrecognized burden of disease. Most medical schools in the Region are part of the AFP surveillance platform; this can be used to strengthen CRS surveillance by engaging departments beyond pediatrics (e.g., ophthalmology). Such support can also help to galvanize key champions such as pediatricians and bring a virtuous cycle of quality improvement in immunization programmes.

Aside from the benefit to measles elimination efforts, there are several other arguments in favor of the SEA Region adopting a rubella and CRS elimination target. The capacity in the Region to eliminate measles is rapidly growing and it would be a tremendous missed opportunity to not include rubella, especially the opportunity to document the elimination of a leading infectious cause of birth defects. The programme is expected to be
stronger by having multiple imperatives woven together. Such an approach takes advantage of the differences in the two diseases and their consequences, particularly CRS. The epidemiology of rubella and measles and dynamics of CRS are different. Addressing these differences in the beginning will form an overall stronger joint programme and mutually benefit the likelihood of achieving multiple goals. From a humanitarian standpoint, if not included, deaths due to and sequelae of CRS would continue, despite it being a totally preventable disease.

As borne out by several studies, CRS comes at a great health and financial cost. In addition, the financial and health system opportunity costs of outbreaks of measles, rubella and CRS are substantial. As mentioned above, the elimination of CRS in countries will result in significant cost savings. Consequently, for many national ministers of finance, the elimination of CRS then comes as a “no brainer” in terms of allocating the necessary resources to achieve the target. National health security would benefit from eliminating all three diseases. Including rubella now would be cost-saving, and also result in much more efficient use of resources. The progress achieved in the SEA Region towards measles elimination indicates that including rubella and CRS in elimination efforts is achievable and sustainable if the rest of the world remains committed.

Although all 11 Member States of the SEA Region report that they are conducting CRS surveillance, gaps remain in the extent and quality. For example, in India, there are only six sentinel sites, with plans to include only nine more. The current approaches to controlling CRS are insufficient to adequately motivate the community to achieve elimination of MR. Strong CRS surveillance will benefit women’s health and prevent and control other causes of birth defects.

If the Region decides to include the elimination of rubella and CRS as part of their measles elimination efforts, the Regional Committee could adopt such a resolution in 2019 at the earliest, because the 2018 Regional Committee is only a few months away, with insufficient time to make such an important proposal this year. Given this situation, the 2019 resolution could conceivably propose an elimination target three year after the resolution, by 2022, with subsequent verification of elimination three years later, in 2025. To ensure the best utilization of resources and efficiency in the verification process, it would be preferable for the measles elimination target to be synchronized with the rubella proposal.
Recommendations

After considering the current state of rubella and CRS control in Member States of the SEA Region and all the evidence, the Review Group makes the following recommendations:

➢ The SEA Region should adopt the regional goal of interrupting endemic transmission of rubella and CRS by 2022.

➢ The SEA Region should realign the measles elimination target with that for rubella, i.e. targeting the interruption of endemic transmission of measles by 2022. If successful, the verification of each would take place three years later in 2025.

➢ Achieving and sustaining high coverage through essential routine immunization services will be critical for achieving these targets.

➢ This Working Group, after reviewing the data, recognizes that rubella control standards have been achieved in Bangladesh, Bhutan, Maldives, Nepal, Sri Lanka and Timor-Leste. It congratulates these countries. DPR Korea, India, Indonesia, Myanmar and Thailand will need to substantially accelerate their efforts to prevent rubella and CRS.

➢ To that end, all Member States, even the successful ones, need to give urgent attention to closing the gaps in achieving high-quality routine immunization coverage and SIAs with MRC vaccines, paying attention to high-risk communities, and conducting high-quality case-based active surveillance of illness with rash and fever.

➢ Among the many factors essential for achieving high-quality surveillance, special attention should be given to reaching the non-measles, non-rubella reporting rate of >2 per 100 000 population in every district and collecting specimens for virus characterization and sequencing from every chain of transmission.

➢ Several countries have made progress in CRS surveillance, but more remains to be done to ensure that it is representative of the at-risk population. Medical schools participating in AFP surveillance and currently existing platforms for monitoring birth
defects need to be engaged in CRS surveillance efforts. The Rubella and CRS SEA Region/RVC Working Group suggests that guidelines include an indicator targeting at least one CRS sentinel surveillance site per second-level administrative unit (state or province) of the country.

➢ All MR campaigns should be conducted using a non-selective methodology, designed to reach every child irrespective of their previous immunization status, with adequate attention to microplanning, and subsequent monitoring and supervision.
Annex 6

Progress towards the key recommendations made at the second SEA-RVC meeting in 2017

The progress against each recommendation is indicated at the end of each recommendation in bold font.

**Overall Recommendations**

1. A mid-term review of the South-East Asia Regional Strategy for Measles Elimination and Rubella/CRS Control for 2014–2020 should be completed by 2017. **Completed and report disseminated at the 9th Immunization Technical Advisory Group (ITAG) and 3rd RVC meeting**

2. Countries should ensure adequate laboratory capacity to conduct serology, virology and genotyping for measles and rubella diagnostics with well-defined mechanisms for quality assurance as well as reporting and coordination. Additional laboratories in countries of the Region, with capacity to undertake this work, should be considered for inclusion in the measles–rubella laboratory network. **Accreditation and on-site coaching done, on-site coaching conducted for laboratories and 10 new laboratories added in the network.**

3. NVCs should continue to provide high-quality reports annually on the progress made towards measles elimination and rubella/CRS control. **Ongoing**

4. NVCs should review and monitor national plans and milestones for measles elimination and rubella/CRS control in their respective countries through a minimum of two meetings per year and field visits as and when required. The meetings of the NVCs should be documented and the NVCs should review updated surveillance data during these meetings. **Ongoing**
(5) NVCs should continue to emphasize with the national immunization programmes the need to conduct subnational risk assessments and translate the findings of these assessments into action plans at the subnational level. Partially on track

(6) To the extent possible, countries should carefully plan polio transition to ensure that resources are available to reach the measles/rubella/CRS targets while maintaining preparedness against possible reintroduction of wild-type poliovirus and/or outbreaks of vaccine-derived poliovirus. Draft polio transition plan developed in all five priority countries

(7) The WHO SEA Regional Office should work with partners and donors to mobilize additional resources for measles elimination and rubella/CRS control programme activities in the Region. Ongoing

(8) The SEA-RVC also made country-specific recommendations for individual countries.

Bangladesh

➢ Efforts should be made to further improve the coverage of vaccines administered through the routine immunization system. Ongoing

➢ The national VPD surveillance programme should ensure that molecular epidemiology/virologic surveillance is included as part of the case investigation for fever and rash. Yet to be initiated

➢ Data quality assessment (DQA) from immunization and surveillance for measles and rubella should be conducted periodically and recommendations from the DQA implemented as a priority. Ongoing

Bhutan

➢ The SEA-RVC requested that Bhutan submit a summary on the lines of evidence for interruption of endemic transmission, incorporating the comments of the second SEA-RVC meeting, by July 2017. Done
➢ A post-elimination plan should be developed. *Draft under discussion*

➢ Routine immunization is strengthened, especially in pockets of low immunity, and micro plans are developed for coverage improvement in urban areas. *Done*

➢ Data management and DQAs should be done to ensure high-quality surveillance data. *Planned*

➢ Laboratory-supported case-based surveillance should be strengthened through training and orientation of health workers and periodic monitoring and feedback mechanisms with a focus on districts that have low discard rates for non-measles non-rubella cases. *Ongoing*

**DPR Korea**

➢ RCV should be introduced in the routine immunization programme as a priority. *Preparations ongoing, GAVI proposal approved*

➢ A seroprevalence study should be conducted to evaluate the status of population immunity for measles and rubella. *Planned with hepatitis B serosurvey*

➢ Joint field visits by SEA-RVC members and NVC members should be organized to various subnational units to assess the progress towards measles elimination and rubella control. *Completed and report of field visit shared with SEA-RVC*

➢ Clinically compatible measles cases should be reviewed rather than excluded from analysis. Standard algorithms should be followed to classify these cases. *Done*

**India**

➢ A subnational plan, risk assessment and monitoring of progress in each state should be undertaken along with efforts to intensify routine immunization through approaches such as “Mission Indradhanush”. *Ongoing*
➢ The Government should endorse the draft national plan and budget lines outlined. Progress in implementing the plan should be tracked regularly. **Ongoing**

➢ The NVC should encourage the programme to achieve high coverage during the upcoming SIA through pre-campaign readiness assessments and rigorous intracampaign monitoring. **Ongoing; readiness assessment conducted effectively and corrective actions taken**

➢ The NVC should advocate for technical and financial resources so that modified case-based surveillance can be rapidly rolled out and coordinated with the phased roll-out of SIAs in the country. **Ongoing**

**Indonesia**

➢ High coverage should be achieved during the August 2017 SIA in Indonesia through pre-campaign readiness assessments and rigorous intra-campaign monitoring. **Done**

➢ The NVC should advocate for mobilization of additional resources to expand case-based surveillance for measles and rubella in the entire country by 2018. **Ongoing**

➢ The NVC should advocate for subnational risk assessments to be conducted, and subnational plans developed and implemented based on these assessments. **Risk assessment available**

**Maldives**

None

**Myanmar**

➢ High coverage should be achieved during the 2017 outbreak response in Yangon and SIAs planned with adequate pre-campaign readiness assessments. **Planning in process**

➢ The national EPI should support strengthening of the case-based surveillance system. **Work in progress**
➢ The national EPI should include other formal and non-formal health sectors to support MR surveillance. **Planned**

➢ A root-cause analysis of the Naga region outbreak that occurred in 2016 should be undertaken and the lessons learnt disseminated to every level in the country. **Done as part of overall health systems assessment for Naga region.**

**Nepal**

➢ The coverage evaluation survey should be completed immediately, and plans made to close any immunity gaps, if found. **Done**

➢ Case-based surveillance reporting sites should be expanded from the current AFP sites to all health facilities in the country, and mechanisms strengthened for sample collection for serology and virology. **Discussion ongoing**

➢ Alternative sample collection methods such as dried blood spots should be explored in areas where there are difficulties with sample collection and transportation. **Discussion ongoing**

**Sri Lanka**

➢ Continued efforts should be made to strengthen surveillance to ensure that the indicators meet recommended standards. **Ongoing**

➢ Adequate support should be made available to laboratories to enhance laboratory testing capacity and quality for both serology and virology. **Ongoing**

**Thailand**

➢ A zero-reporting system should be started for integrated measles and rubella surveillance all over the country. Reporting and data flow mechanisms should be strengthened from the subnational to the national level. **Ongoing**

➢ Routine immunization coverage should be strengthened and SIAs conducted in areas where measles vaccination coverage is
low as well as in areas where outbreaks of measles have been recently reported, notably in the southern provinces. **Work in progress**

- A communication strategy should be developed and implemented to address vaccine hesitancy in population groups where this is a problem. **Ongoing**

- In view of the progress of measles elimination programme in this country, the use of the Guidelines’ definition of “measles outbreak” should be considered, which is “a single laboratory-confirmed case of measles”. **Ongoing**

- As large measles outbreaks may occur in hospitals, training campuses, prisons, schools, appropriate guidelines/policies should be established and implemented. **Ongoing**

**Timor-Leste**

- A nationwide MR SIA should be conducted in 2018 to close any immunity gaps. **Completed**

- Case-based surveillance reporting for fever and rash should be expanded to all Sucks (subdistrict level). **Done**

- Case investigations should be complemented with molecular epidemiology to get information on the origin of the measles and rubella viruses being detected. **Ongoing**

- A detailed outbreak response plan should be developed. **Ongoing**
Annex 7

Lessons learnt from the experience of the national verification committees

On the third day of the meeting, the chairpersons and members of the NVCs of all the 11 Member States had a dedicated session to discuss the key lessons learnt and share these lessons as a part of peer exchange. The following three areas emerged from the meeting:

1. **Challenges in the functioning of the National Verification Committee**

Some of the challenges outlined by the NVCs in their day-to-day functioning were as follows:

- Membership
  - building new members’ institutional memory
  - few experts in the country, so difficult to get experienced personalities as members.

- Secretariat support for the NVC may be ad hoc at times and NVCs are thus limited to conducting meetings as required.

- No mechanism exists by which the information received by the programmes can be regularly shared with the NVC except when the NVC proactively requests the same.

- Dedicated resources are not allocated to ensure smooth functioning of NVCs.

- NVC recommendations should be translated into action by the programmes.

2. **Recommendations from the NVC**

The NVCs, after a thorough deliberation, came up with the following recommendations:
➢ The RVC should request the NVC to descriptively summarize the activities and functioning of the NVC in their annual report and recommend minimum indicators for functioning such as number of annual meetings.

➢ The presence of strong secretariat support for the NVC is critical for its effectiveness and thus the respective WHO country office and Ministry of Health, where applicable, are requested to ensure such support.

➢ NVC membership should be stable.

➢ In Member States where there are member rotations, this should be done such that institutional memory is preserved by ensuring overlap between new and experienced members.

➢ Peer-to-peer sharing of experiences of NVCs should be considered through exchange visits. The RVC secretariat should recommend and facilitate such sharing of experiences.

➢ The visibility of the NVC should be increased with the Ministry of Health and other stakeholders.

➢ National programme managers should attend meetings with the NVC and RVC to increase advocacy.

➢ Recommendations made by the RVC should be shared directly by the secretariat with the Ministry of Health.

➢ There should be a mechanism to ensure that feedback from the government on the response to the NVC recommendations are received by NVCs and shared with the RVC.

3. Other observations

➢ Clarity is needed from the RVC on the criteria for “high-quality surveillance for measles/rubella/CRS”.

➢ Community-level participation should be strengthened (midwives, village health workers), including recognition of community-level reporters.

➢ How to engage/incentivize clinicians/health-care providers in reporting needs to be better understood.
### Annex 8

**List of participants**

**RVC members**

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<tr>
<td>Professor Dr Shahina Tabassum</td>
<td>Chairperson SEA-RVC, Professor and Chairman, Department of Virology, Bangabandhu Sheikh Mujib Medical University (BSMMU), Bangladesh</td>
</tr>
<tr>
<td>Dr Kinzang P. Tshering</td>
<td>President, Khesar Gyalpo University of Medical Sciences of Bhutan, Post Box: 0446, Thimphu, Bhutan</td>
</tr>
<tr>
<td>Professor Dr A.P. Dubey</td>
<td>Director-Professor, Department of Pediatrics, Maulana Azad Medical College, New Delhi 110002, India</td>
</tr>
<tr>
<td>Dr Hinky Hindra Irawan Satari</td>
<td>Division of Infectious Diseases and Tropical Pediatrics, Department of Child Health, Fakultas Kedokteran Universitas Indonesia, Jl. Salemba 6, Jakarta 10430, Indonesia</td>
</tr>
<tr>
<td>Professor Soe Lwin Nyein</td>
<td>Public Health Expert and Advisor, Ministry of Health and Sports Building (A-441), Mya Thitsa Street, Htantapin-Shwekyapin Quarter, Zabuthiri Township, Nay Pyi Taw, Myanmar</td>
</tr>
<tr>
<td>Dr Rupa Rajbhandari Singh</td>
<td>Professor and Chair, Division of Neonatology, Department of Pediatrics, B.P. Koirala Institute of Health Sciences, Dharan, Nepal</td>
</tr>
<tr>
<td>Dr Kumnuan Ungchusak</td>
<td>Advisor, Department of Disease Control, Ministry of Public Health, Nonthaburi, Thailand</td>
</tr>
<tr>
<td>Dr Jon Kim Andrus</td>
<td>Adjunct Professor and Senior Investigator, Center for Global Health, University of Colorado, Washington, DC, USA</td>
</tr>
<tr>
<td>Dr Joseph Parker Icenogle</td>
<td>Virologist/Public Health Scientist, Team Leader, Rubella Virus Laboratory, Centers for Disease Control and Prevention (CDC), USA</td>
</tr>
<tr>
<td>Dr Natasha Sarah Crowcroft</td>
<td>Professor, Laboratory Medicine and Pathobiology and Dalla Lana School of Public Health, University of Toronto, Ontario, Canada</td>
</tr>
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</table>

**National Verification Committees for Measles Elimination and Rubella/CRS Control (NVC)**

<table>
<thead>
<tr>
<th>Name</th>
<th>Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professor Mahmudur Rahman</td>
<td>Member, NVC, Bangladesh</td>
</tr>
<tr>
<td>Dr Sonam Wangchuk</td>
<td>Member, NVC, Bhutan</td>
</tr>
<tr>
<td>Dr Sun Gwang Hong</td>
<td>Chair, NVC, Democratic People’s Republic of Korea</td>
</tr>
</tbody>
</table>
Dr Nam Chol Ro
Member, NVC
Pyongyang
Democratic People’s Republic of Korea

Dr Narendra Arora
Chair, NVC
New Delhi, India

Professor Elisabeth S. Herini
Chair, NVC
Yogyakarta 55284
Indonesia

Dr Nazla Mustafa Luthfee
Member, NVC
Maldives

Dr Ye Hla
Chair, NVC
Myanmar

Dr Kedar Prasad Baral
Member, NVC
Nepal

Professor Lalitha Mendis
Chair, NVC
Sri Lanka

Dr Supachai Rerk-Ngarm
Chairperson
National Verification Committee for Polio Eradication and Measles Elimination and Rubella Control (NVC)
Thailand

Dr Virna Martins-Sam
Chair NVC and NITAG
Democratic Republic of Timor-Leste

Dr Aniceto Cardoso Barreto
Member NVC
Democratic Republic of Timor-Leste

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Dr Michelle Morales
Medical Officer
Global Immunization Division
CDC, Atlanta, USA

**WHO headquarters**

Dr Arunmozhi Balajee
Associate Director of Global Health
Division of Viral Diseases
CDC, Atlanta, USA

**WHO Regional Office for the Western Pacific**

Dr Katrina Kretsinger
Focal Point for Measles & Rubella
Expanded Programme on Immunization Plus
Geneva, Switzerland

Dr Mick Mulders
Global Measles Rubella Laboratory Network Coordinator
Expanded Programme on Immunization Plus
Geneva, Switzerland

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

Dr. Neena Raina
Director a.i.
Department of Family Health, Gender and Life Course

Dr Sunil Kumar Bahl
Team Leader
Immunization and Vaccine Development
Department of Family Health, Gender and Life Course

Dr Sudhir Khanal
Medical Officer, Measles
Immunization and Vaccine Development
Department of Family Health, Gender and Life Course

Mr Md Sharfuzzaman
Data Management Officer
Immunization and Vaccine Development
Department of Family Health, Gender and Life Course