



**World Health
Organization**

REGIONAL OFFICE FOR

Europe

Extraordinary meeting
of the European
Technical Advisory
Group of Experts on
Immunization (ETAGE)

30 January 2015
Copenhagen, Denmark



**World Health
Organization**

REGIONAL OFFICE FOR **Europe**

Extraordinary meeting of the European
Technical Advisory Group of Experts on
Immunization (ETAGE)

30 January 2015
Copenhagen, Denmark

ABSTRACT

The European Technical Advisory Group of Experts on Immunization (ETAGE) met on 30 January 2015 to review and discuss measles and rubella elimination in the WHO European Region and to be briefed and provide input on the advocacy plan for the European Vaccine Action Plan (EVAP).

Representatives of the European Regional Verification Commission (RVC) participated at the meeting, to report on their November 2014 review of regional measles and rubella elimination progress as reported by Member States for 2013.

Keywords

DISEASE ELIMINATION
IMMUNIZATION
IMMUNIZATION PROGRAMS
MEASLES
RUBELLA

Address requests about publications of the WHO Regional Office for Europe to:

Publications
WHO Regional Office for Europe
UN City, Marmorvej 51
DK-2100 Copenhagen Ø, Denmark

Alternatively, complete an online request form for documentation, health information, or for permission to quote or translate, on the Regional Office website (<http://www.euro.who.int/pubrequest>).

© World Health Organization 2015

All rights reserved. The Regional Office for Europe of the World Health Organization welcomes requests for permission to reproduce or translate its publications, in part or in full.

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 the World Health Organization 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 lines on maps represent approximate border lines 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 the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either express or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use. The views expressed by authors, editors, or expert groups do not necessarily represent the decisions or the stated policy of the World Health Organization.

CONTENTS

	<i>Page</i>
Introduction.....	1
Opening remarks	1
Measles and rubella elimination: regional verification status, 2013 reports, conclusions and follow-up action	1
Discussion	3
Measles and rubella elimination: epidemiology, operationalization of modified verification process, VPI mobilization plan for 2015	3
Measles and rubella epidemiology in 2014.....	3
Operationalization of modified verification process	3
VPI mobilization plan for 2015	4
Population immunity profiles	5
Discussion	6
Measles and rubella elimination goal, 2015: communications, advocacy and reputational risk management issues.....	7
Discussion	8
EVAP Advocacy Plan: channels, messaging and audiences	8
Discussion	9
Closing discussions	10
Draft conclusions and recommendations.....	10
Recommendations	11
Annex 1. List of participants	12

Introduction

The European Technical Advisory Group of Experts on Immunization (ETAGE) meets annually to review the progress of the Vaccine-preventable Diseases and Immunization Programme (VPI) towards the European Region's disease prevention goals. ETAGE usually meets on an annual basis, during the third quarter of the year. At its 14th meeting, conducted 8–9 October 2014, ETAGE supported several changes to the verification process for the elimination of measles, related to reporting at country level and the categorizing of Member States according to their elimination status. Recognizing the need for further discussion and development of indicators, ETAGE called for an extraordinary meeting: to consider more complete data on the status of regional measles and rubella elimination (based on the outcomes of the RVC meeting to be held November 2014); to develop specific recommendations for furthering the verification initiative; and to provide input related to advocacy of the European Vaccine Action Plan (EVAP). The extraordinary meeting was conducted on 30 January 2015 at the WHO Regional Office for Europe (Regional Office), Copenhagen, Denmark.

Representatives of the RVC participated in the extraordinary meeting, to report on their November 2014 review of regional measles and rubella elimination progress as reported by Member States for 2013.

Opening remarks

Mr Robb Butler, acting Programme Manager of the Vaccine-preventable Diseases and Immunization Programme (VPI), welcomed participants on behalf of the WHO Regional Director and provided an overview of the scope and purpose of the meeting. Professor Pierre Van Damme welcomed participants on behalf of ETAGE and expressed appreciation for the opportunity to bring together members of ETAGE and the European Regional Verification Commission (RVC) to review the current status of measles and rubella elimination in the Region and discuss possible changes to the verification process.

Measles and rubella elimination: regional verification status, 2013 reports, conclusions and follow-up action

Dr Susana Esposito, RVC Chair

The RVC met for the third time on 10–12 November 2014 in Copenhagen, Denmark when the 8-member panel evaluated a total of 59 country reports. These included Annual Status Updates (ASU) for 2013 and late-submitted Elimination Status Reports (ESR) for 2010–2012.

Member States are required to form a National Verification Committee (NVC) for measles and rubella elimination. To date, 50 out of 53 Member States have established an NVC, and of these, 46 submitted ASUs for 2013.

Criteria for documenting the verification of interruption of endemic measles and rubella transmission include the absence of endemic measles and rubella cases in the presence of a high-quality surveillance system, supported by genotyping data on measles and rubella virus isolates. Supporting evidence submitted by the NVC to the RVC includes the epidemiology of measles, rubella and congenital rubella syndrome (CRS), molecular epidemiology of measles and rubella

viruses, performance of measles, rubella and CRS surveillance systems and population immunity against measles and rubella, including data from vaccination coverage surveys, vaccine registries and serosurveys.

In reviewing the 2013 reports, the RVC encountered similar issues and deficiencies to those encountered with the ESR 2010-2012 submission: incomplete information, particularly regarding laboratory activities, misinterpretation of data requested and inappropriate use of denominators for the estimation of vaccination coverage. Miscalculations and the inadequate presentation of data, particularly with regard to surveillance indicators, were also common. Completeness of the ASUs was generally high, although some countries omitted important information or details. It appears that a significant minority of countries did not completely understand the requirements or lacked the resources to provide all of the requested data.

For several countries, information on the quality of surveillance indicators was either absent, incomplete or not submitted correctly. Confusion continues on the part of some Member States over the definition and method of calculation of the sensitivity of surveillance. Sensitive surveillance is defined as the detection of >2 suspected cases per 100 000 population. In the absence of confirmed cases, a sensitive surveillance system is expected to document 2 or more discarded cases per 100 000 population (the 'discard rate'). Of the 35 countries reporting a discard rate, only 11 reported a rate of >2 per 100 000 population.

Ten Member States did not have a status report reviewed by the RVC, including 7 that failed to submit any report and 3 that have been requested to revise and resubmit their reports due to missing information.

Several Member States lack the capacity to document virus transmission pathways, due to the absence of sufficient genomic sequence data and failure to effectively implement surveillance by linking clinical, epidemiological and laboratory data. As the Region moves towards the measles and rubella elimination goal it is essential that all Member States report genomic sequence data on viruses isolated or detected and that the capacity to integrate these data unequivocally to the surveillance case records is significantly strengthened.

Every Member State should establish a National Plan of Action for measles and rubella elimination and should report details of this Plan to the RVC. As of the end of 2014, 27 countries had a current Plan of Action; 3 countries had plans that were time-expired; 4 had plans in development; and 19 Member States failed to report on the status of their plans.

With regard to measles, the RVC concluded that 22 Member States had interrupted endemic transmission in 2013, 7 of which were at risk of re-establishing transmission due to suboptimal population immunity, and that 13 countries remained endemic. Measles elimination status was inconclusive for 8 countries due to insufficient evidence being provided; and the status of 10 countries was not reviewed due to lack of adequate reports. For rubella, the RVC concluded that 24 Member States had interrupted endemic transmission in 2013, 7 of which were at risk of re-establishing transmission, and that 9 countries remained endemic. Rubella elimination status was inconclusive for 10 countries, and the status of a further 10 countries was not reviewed. Overall, the status of measles and rubella elimination in the Region in 2013 was very similar to that seen in 2012.

Discussion

While the number of countries in the Region that have interrupted transmission is relatively high (22 for measles and 24 for rubella), this encompasses many of the small- to medium-sized countries. The countries with the largest populations remain endemic for either measles or rubella, or both. It would be helpful if the tables showing the grouping of countries by level of achievement could include an indication of the total population represented at each level.

WHO headquarters provides general guidance and standards for its regional offices to follow, but the individual regions are free to develop their own strategies and systems for validation of elimination. Of issue for the RVC is the apparent lack of pressure placed on Member States to comply with regional verification requirements, as witnessed by the lack of reports from several countries. It is possible that greater political commitment could be generated among Member States if WHO headquarters played a more prominent role in pushing countries towards measles and rubella elimination.

There is an increasingly urgent need for the regional programme to demonstrate that progress is being made towards measles and rubella elimination in some Member States, and also to encourage more action among those that are not showing sufficient progress towards the elimination goals.

Measles and rubella elimination: epidemiology, operationalization of modified verification process, VPI mobilization plan for 2015

Dr Abigail Shefer, WHO Regional Office for Europe

Measles and rubella epidemiology in 2014

Data for 2014 suggest that there may have been a substantial reduction in the number of measles cases in the Region compared with 2013 (provisionally 15 445 in 2014 against 32 171 in 2013). Most of the reported cases in 2014 occurred in Bosnia and Herzegovina, Georgia, Italy, Russian Federation and Ukraine. The regional total of rubella cases in 2014 also appears to be a reduction over 2013 (provisionally 6 257 in 2014 against 39 562 in 2013), with very large outbreaks, primarily in Romania and Poland through 2012 and 2013, now showing signs of dying out. As of November 2014, Poland has reported approximately 90% of all cases in the Region in 2014.

In several Member States many adults continue to be infected, with 41% of regionally reported measles cases being ≥ 20 years of age. A number of countries (Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, Turkey and United Kingdom) have, or will very shortly, conduct supplementary immunization activities (SIAs) in response to outbreaks of measles. There are recognized ongoing measles outbreaks in Bosnia and Herzegovina, Kazakhstan and Kyrgyzstan.

Operationalization of modified verification process

It has been proposed that a system of grouping Member States according to level of achievement be adopted. The advantages of categorizing countries in this way include providing a mechanism for prioritizing countries according to need for support and introducing an element of competition between countries to achieve elimination status. This should make it easier to highlight those countries considered to be better performers and those considered to be at risk. It may also make it easier for RVC members to work with a group of countries that have the same status and similar circumstances.

Proposed achievement categories:

- countries with interrupted transmission ≥ 36 months (verified as having achieved elimination);
- countries with interrupted transmission < 36 months;
- countries with endemic transmission (re-established);
- countries with endemic transmission (never interrupted);
- inconclusive (e.g. due to poor quality, inconsistent or incomplete data);
- not reviewed by the RVC (due to lack of or insufficient reporting).

This categorization can be linked to a colour system, indicating which countries have moved up the scale in the past year, those that have not been reviewed in the past year and those that have moved down the scale.

The second proposed change to the verification process is to verify elimination of measles and rubella at country level, rather than only at regional level. This strategy has been adopted by the WHO Western Pacific Region and there is an opportunity to learn from experience gained there.

VPI mobilization plan for 2015

Building on the Package for Accelerated Action: 2013-2015, VPI developed a proposed measles and rubella mobilization plan encompassing measles and rubella elimination activities for 2015. The plan focuses on specific actions to build the capacities of Member States to address remaining challenges. The primary goals are:

- to improve Member States' understanding of the verification process and thereby improve the quality of reporting;
- to address country-specific challenges through country support missions; and
- to increase impact through categorization of countries and consistent messaging.

Planned activities to improve the quality of reporting by NVCs include the staging of a series of intercountry workshops planned for March to May 2015 to include all Member States in the Region. The first workshop is intended for Member States of the European Union and European Economic Area (EU/EEA) (24–25 March), the second for selected newly independent states (NIS), and the third for non-NIS, non-EU/EAA countries. NVC chairpersons together with national surveillance technical experts will be invited to these meetings and the focus will be on the challenges encountered in surveillance and data management. The meetings will include practical sessions on the updated reporting forms and technical support will be provided in understanding and completing the forms. Depending on needs and capacities, VPI will consider country missions as an alternative for some Member States.

VPI also proposed that a pre-review process be introduced for all country annual reports prior to the formal RVC review. The pre-review would be conducted by members of the RVC and WHO Secretariat to identify reports that require clarification, additional information or correction before they are formally submitted for RVC analysis. This will require submission of annual update reports early enough in the year to allow for this extra step.

To address country-specific challenges through country support missions, Member States have been classified according to priority for support. Eleven countries have been classified as being of high priority for support missions, and these will be visited or will have a visit date scheduled during the first quarter of 2015. Fifteen countries are considered to be of medium priority and

plans are being developed to visit these by the end of the second quarter of 2015. It is expected that a further 11 countries, considered to be of lower priority, will be visited before the end of 2015. The goal of country support missions is to address political, technical or high-level advocacy needs and the mission team composition will reflect the type of support required. There are currently 10 missions planned for the first quarter of 2015, 5 planned for the second quarter, 5 for the third quarter and 6 for the fourth quarter of 2015. In addition to these missions, high-level advocacy missions are planned for Austria, France, Italy, Poland, Romania and Ukraine.

Population immunity profiles

Dr Sebastian Funk, London School of Hygiene and Tropical Medicine

A project conducted by the London School of Hygiene and Tropical Medicine in coordination with the Regional Office is attempting to determine if the annual data reported to WHO through the WHO/UNICEF Joint Reporting Form (JRF) and other data sources can be used to estimate immunity gaps at population level. The number of people in a population that are susceptible to a disease depends primarily on the number of people that have already contracted the disease and the number that have been vaccinated. This information has been reported at country level, and collected at international level, since 1980, potentially allowing estimates of population immunity in any given age cohort for each country reporting data.

Plotting reported vaccination coverage against age cohort does permit detection of potential immunity gaps in a number of countries, however, the data sets are not complete for all countries for all years, and methods used for estimating vaccination coverage are not the same in all countries. To estimate population immunity the history of disease incidence also needs to be considered and this data has also been reported through the JRF. Review of available data, however, suggests that historically there has been considerable underreporting of disease. In addition, the age distribution of cases is not reported through the JRF, and in order to make use of the data, estimated age distributions were used based on known patterns of age distributions of cases.

Using available data on vaccination coverage (from routine as well as supplementary immunization activities) and disease incidence, national susceptibility profiles can be developed, and, if the data are reliable, these demonstrate which countries have significant susceptible populations and which age cohorts represent the greatest risk. Predicted immunity gaps can potentially be validated by assessing which age groups are infected during an outbreak. However, it appears that for a variety of reasons the number of individuals infected in the youngest or oldest age cohorts may generally be underestimated. Another method for validating predicted immunity gaps is to make a comparison with available serological surveillance data, although the utility of this approach may be questionable given the difficulties of using historical data to determine the fraction of individuals in previous cohorts who were infected.

Another source of data to consider is the European Sero-Epidemiology Network (ESEN2), which was established in 2001 with the aim of standardizing the serological surveillance of 8 vaccine-preventable diseases in 22 European countries. Serological data generated through ESEN2 for the years 2002 and 2003 were compared with the predicted immunity profiles generated from the JRF data, and used to estimate the extent of disease underreporting. Using this method it appears that underreporting was minimal in several countries, but that many countries failed to report a

significant proportion of cases ranging from less than 10 to several hundreds of cases for every reported case.

In comparison with the immunity gaps identified through the RVC review process, this analysis found an additional 8 countries with potential gaps in immunity (i.e. with the RVC conclusion of interrupted transmission but not at risk). The limitations in interpreting these analyses remain significant due to missing and poor-quality data, particularly for adult populations.

Discussion

Improving the quality of reporting has been a goal for several years now, and a significant level of activity has taken place to attain this goal. However, even if can be attained high quality current reporting, it is still could not possible to demonstrate how many susceptibles there are in a country, and to which age groups they belong, as the historical case data are usually subject to significant and unknown levels of underreporting. While it is clearly essential to improve the quality, there were significant questions regarding what evidence, in addition to vaccination coverage and surveillance data, could be collected in order to accurately assess the status of a country's elimination status. While country support missions are clearly necessary, it is possible that, due to lack of good-quality data, the real problems faced by a country are not being exposed and cannot, therefore, be addressed. ETAGE was concerned that some level of re-thinking of the process for acquiring accurate and relevant information on the status of measles and rubella elimination in countries is required.

The importance and relevance of serological assessments in determining susceptibility to measles was discussed at length. While vaccine coverage estimates provide a measure of the level of susceptibility of vaccine-receiving younger age cohorts, they provide no information on susceptibility of older age cohorts, including adults, who did not receive vaccines through routine immunization. The only way to demonstrate susceptibility gaps in these age groups is to conduct appropriate serosurveys. Although serosurveillance data are relatively easy to obtain and interpret in some countries, there remain considerable difficulties in both obtaining and interpreting serological data in many countries, including some of those considered to be of highest priority. Regional guidance on serosurveys was published last year and new global guidelines on conducting serosurveys and use of serosurveillance data are being prepared by WHO. A draft will be available for comments very soon. Assessment of available serosurveillance data should be included in the country review process and used to support countries in strengthening their immunization programmes. ETAGE proposed that standardized serosurveys should be established across Europe, following in from the ESEN2 Project, to identify measles and rubella susceptibility pockets.

It was generally accepted that there has been lack of progress in the Region toward achieving its 2015 measles and rubella elimination goal, and questions were raised over the reasons for this. One contributing factor to the lack of progress in some countries may be the lack of a clear understanding of the respective roles of WHO and the Member States in setting and achieving the goal. The 2015 elimination goal was set by the Member States, and commitment for achieving the goal must come from them. The role of WHO is to support Member States in realizing the goal, by providing technical support and high-level advocacy. Use of experts from successful countries to share experiences with less successful countries may provide encouragement for improved commitment and performance.

Measles and rubella elimination goal, 2015: communications, advocacy and reputational risk management issues

Mr Robb Butler, WHO Regional Office for Europe

The 2010 regional goal for measles and rubella elimination passed without attracting a great deal of attention. It is now generally considered that the 2015 regional elimination goal will also not be met, but there is a determination within WHO that failure to meet the 2015 goal will not be allowed to pass without a significant effort to strengthen programme performance and make elimination a realistic short-term goal. The communications activity around the 2010 goal was probably insufficient to raise the necessary prioritization of measles and rubella in Member States, and to establish the ownership required to achieve the goal. Since then communications and advocacy activities have progressively been strengthened. A new package of accelerated action prompts have been provided since 2012, including ongoing development of resource mobilization guidelines and advocacy tools, region-wide European Immunization Week activities, risk and crisis communications support and capacity building, a scale-up of the social media platform, a number of country-level immunization communications reviews and the development of guidelines for these.

The goal of communications and advocacy now is to maintain and accelerate commitment and action for elimination from Member States through 2015 and beyond. To achieve this will require a change in the emphasis of communications activities, towards more effective highlighting of the requirements and expectations placed on Member States. New strategies and guidance on communications and advocacy are being developed that are evidence based and reflect experience gained over the past few years. New partners in measles and rubella elimination have been engaged, and the verification process has been developed and strengthened, providing new platforms from which communications can be launched.

With respect to the measles and rubella mobilization plan goal of increasing impact through effective and consistent messaging, emphasis will be placed on the progress that has been made and how close the Region now is to achieving elimination. Countries will be encouraged to maintain or improve their verification status by grouping them according to progress, publicizing their status and applauding countries that have successfully interrupted transmission of either or both diseases. A European parliamentary roundtable event, planned for 22 April 2015 during European Immunization Week, will advocate for greater attention and commitment by decision-makers in high- and medium-priority countries.

WHO continues to introduce advocacy tools and provide training on immunization resource mobilization, advice on ring-fencing immunization budgets and advocacy for additional funding. The Regional Office also continues to offer technical assistance on communications, advocacy and capacity building and will coordinate measles and rubella messaging through European Immunization Week 2015.

The 2015 elimination goal remains achievable, but it is probably not realistic to assume it will be met. Confirmation of success or failure will not be available until the RVC has reviewed available evidence in November 2016, and the Regional Committee will not formally review the RVC decision until September 2017. This extended timeframe makes communications and advocacy requirements difficult and complex, and requires careful and thorough planning and preparation. This will require a more detailed understanding of the target audience for

communications and advocacy and greater emphasis on targeting communications to high-level decision-makers in Member States.

Discussion

The need to target specific audiences was discussed as an essential component of communications policy. The need to avoid a repeat of the experience of 2010 in allowing the missed elimination goal to pass without significant comment or action was emphasized and supported.

EVAP Advocacy Plan: channels, messaging and audiences

Katrine Habersaat, WHO Regional Office for Europe

The European Vaccine Action Plan (EVAP) plots a course towards a Region free of vaccine-preventable diseases and as such, it is essential that the Plan is both known about and understood by Member States and all who champion and promote it, and that stakeholders feel commitment and ownership to the goals set. Much of the work that needs to be done to implement the EVAP is conducted by the immunization programmes and managers, but they cannot function without a range of political decision-makers, national immunization partners and regulatory bodies, international (professional) organizations and international and regional advisory bodies and working groups, including ETAGE and the RVC. In addition to a vision, EVAP defines specific goals and objectives including disease elimination, disease control, strengthening immunization programmes and improving equitable access to vaccines. To achieve these goals and objectives it is important to promote more specific messages on the actions required or changes necessary to realize the EVAP vision.

It has been proposed that the key action points for EVAP implementation at present include the following.

- Improving data information systems. Strong and reliable monitoring and surveillance through improved quality of valid and accurate data and the use of new information technologies for collection, transmission and analysis of immunization data.
- Developing tailored and innovative strategies. Research methods and improved immunization data to monitor perceptions, knowledge and attitudes towards immunization in all population groups and, based on that, tailored and innovative strategies ensuring equitable extension of services, demand in all population groups and impactful plans for vaccine safety-related events and introduction of new vaccines.
- Establishing and strengthening independent national advisory bodies. Establishing evidence-based decision-making on immunization and providing justification for greater investment, including on new vaccines, through independent National Advisory Bodies (NITAGs).
- Increased political commitment and domestic funding. Advocacy and resource mobilization activities ensuring that national decision-makers are aware that by adopting the EVAP in 2014, Member States made an unprecedented commitment to immunization as a priority, pledging to ensure political commitment and sustainable and predictable investment in immunization.
- Strengthening regulation and procurement mechanisms. A fully functional NRA as a strong regulatory mechanism to ensure access to and use of quality-assured vaccines at

affordable prices – and an efficient procurement system with predictable, transparent pricing and innovative procurement mechanisms to alleviate funding pressure.

- Improving monitoring and surveillance systems. Case-based surveillance and Adverse Events following Immunization (AEFI) surveillance systems, a strong expert review committee assessing causality for AEFIs and sustained access to WHO-accredited polio and measles-rubella laboratories.

Five platforms for advocacy have been identified: WHO activities, i.e. provision of knowledge and technical support to Member States in implementing the Plan; national EPI programmes and managers who advocate on behalf of immunization at national level; WHO communication channels, including websites and social media; external communication channels, including peer-reviewed publications, partner publications and other health or immunization-related publications; and partners, including international organizations and international and regional advisory bodies and working groups. ETAGE members in particular are seen as a potentially very valuable group of advocates.

ETAGE members can potentially advocate for EVAP by integrating the Plan into their work, presentations, teaching and workshops; developing professional relationships with national stakeholders; providing technical support documents; demonstrating good practice; engaging in social media activities; and using every opportunity to promote and advocate on behalf of the EVAP. ETAGE members were asked to discuss how VPI could best support them in promoting and advocating for EVAP, e.g. by providing standard and up to date presentation materials; and providing technical documents with messages, guidance and appropriate infographics.

Discussion

ETAGE noted and approved of more recent Regional Office undertakings to actively engage its members over the past few years and encouraged the Secretariat to consider increased involvement of ETAGE in support of Member States. Provision of updated presentation materials has been very useful at national and professional level, particularly for meetings with NITAGs, in promoting and advocating for EVAP, and the Secretariat was encouraged to continue to provide and update these materials. There is a professional interest within the Region in receiving current information on the vaccine-preventable diseases programme, and ETAGE can play a role in providing this information through scientific meetings and seminars. ETAGE members can also play an important role in advocating for immunization during missions to countries, not only with the technical authorities and bodies but also with high-level political decision-makers.

The WHO Regional Office and its programmes tend to have low visibility for journalists and the general media. Greater efforts should be made to describe and promote the activities conducted and achievements made within the Region. ETAGE members are often highly visible within their own countries, and generate interviews and talks describing their own work. With little additional effort these opportunities could include some elements of advocacy for EVAP and promotion of regional plans and achievements. More effective use could also be made of existing infographics by putting together a package of materials for journalists to explain and promote EVAP.

Further discussions are required on the nature and format of materials required for more effective promotion of WHO and regional programme activities. Other WHO regions, PAHO for example, have been addressing this issue for some time and may be able to offer advice based on their

experiences. It may be possible to include this topic on the agenda of the next post-SAGE meeting for TAG members.

Closing discussions

ETAGE has greatly appreciated the opportunity to hold the extraordinary meeting, permitting consideration of aspects of the measles and rubella elimination programme in greater detail than is usually possible in the annual ETAGE meetings. ETAGE also appreciates VPI's efforts to generate a better overview of immunity gaps in the Region, particularly the development of diseases-susceptible adult cohorts as immunization has been introduced over the years. This information is highly valuable for Member States to identify at risk populations.

This has been a very good opportunity for ETAGE to meet with members of the RVC and to gain a better understanding of the role played by the RVC. Further efforts are clearly necessary to improve the quality of data being submitted to the RVC. ETAGE supports proposals to develop further tools and strategies to encourage provision of accurate and reliable information on the status of measles and rubella elimination. ETAGE strongly recommends the use of additional information, such as the results from serosurveys, to support vaccine coverage and disease surveillance data in establishing the risk of outbreaks occurring in a particular country. The added value of categorizing countries into groups dependent on the level of achievement has been discussed at an earlier meeting and the proposal has now been further developed. Further development should take into account assessment of additional information provided by countries, including seroepidemiological data if this is available.

The relative roles and responsibilities of the WHO Regional Office and WHO headquarters, with regard to establishing plans and developing strategies, are not clearly understood by ETAGE and further explanation would be helpful. What was clear to ETAGE is that the elimination goal supported by WHO is a goal of the Member States, not a goal of WHO. Member States should be made more aware of their roles and responsibilities in achieving the goals they have agreed to and that the role of WHO is to support Member States in achieving their goals.

ETAGE noted and approves of the markedly increased activity in advocacy and communications activities and tools developed by the Regional Office in the past 5 years. The entire communications landscape has changed dramatically over the past 5 to 10 years and WHO has invested heavily in the development of new tools of communication and developing new partnerships in communications and advocacy. Communications on maintaining the 2015 deadline for regional measles and rubella elimination presents a complex and difficult challenge that will need to be addressed to take advantage of all of the gains made by the end of 2015 if elimination is not achieved. ETAGE has an important role to play in advocacy and communications and ETAGE members can play a more active part in promoting the programme.

Draft conclusions and recommendations

ETAGE greatly appreciated the opportunity to hold the extraordinary meeting and the opportunity to become better acquainted with the objectives, activities and members of the RVC. It also appreciated the opportunity to gain a better understanding of the importance of determining measles and rubella susceptibility profiles in populations with established immunization programmes, particularly on the generation of disease-susceptible age cohorts.

ETAGE fully supports VPI's mobilization plan for 2015 and agrees with the proposed activities and timeline for implementation. Further efforts are clearly necessary to improve the quality of data being submitted to the RVC, and ETAGE supports proposals to develop further tools and strategies to encourage provision of accurate and reliable country information.

ETAGE suggests that consideration be given to implementation of a standardized serosurvey process in the Region, such as ESEN3. Further discussion is recommended to weigh the benefits and resources needed to implement such an initiative.

ETAGE supports increasing advocacy activities to ensure that national decision-makers are fully aware that by adopting the measles and rubella elimination goal Member States made a commitment to ensure political commitment and investment to achieve the goal.

ETAGE noted and approves of the markedly increased activity in advocacy and communications activities and tools developed by the Regional Office in the past 5 years. As the communications landscape has changed over the past 5 to 10 years WHO has invested heavily in the development of new tools of communication and new partnerships in communications and advocacy.

Recommendations

- Member States should be reminded that the regional measles and rubella elimination goal belongs to the Member States, not to WHO. All Member States should ensure they have the political commitment required to prioritize measles and rubella elimination and achieve the goal.
- Use should be made of additional country information, such as the results from serosurveys, to support vaccine coverage and disease surveillance data in establishing the risk of outbreaks in a particular country due to immunity gaps. Recognizing that due to poor historical data on cases the only effective way to do this is to implement a standardized process for conducting serosurveys across the Region (e.g., ESEN3).
- As also noted in the 2014 meeting report, ETAGE agrees with and recognizes the added value of categorizing countries into groups dependent on the level of achievement towards elimination status and verifying elimination at the country level.
- Further refinement and development of this approach should take into account the assessment of additional information provided by countries, including seroepidemiological data if this is available.
- Recognizing the important role ETAGE can play in advocacy and communications and in promoting programme goals, further detailed discussion is required on the potential roles and inputs of ETAGE, beyond the technical inputs to programme development.

Annex 1. List of participants

ETAGE

Professor Pierre Van Damme (Chair)
European Technical Advisory Group of Experts on Immunization (ETAGE)
University of Antwerp
Belgium

Professor Christian Perronne (Vice-chair)
Hopital Raymond Poincaré
France

Dr Cornelia Betsch
University of Erfurt
Germany

Professor Paolo Bonanni
University of Florence
Italy

Dr Vladimir Chulanov
Central Research Institute of Epidemiology
Russian Federation

Dr John Edmunds
London School of Hygiene and Tropical Medicine
United Kingdom

Dr Hans Houweling
Health Council of the Netherlands
Netherlands

Regional Verification Commission

Professor Susanna Esposito (Chair)
Università degli Studi di Milano
Italy

Dr Andrei Lobanov
Russian Federation

Dr Günter M. Pfaff
Baden-Württemberg State Health Office
Germany

WHO headquarters

Dr Alya Dabbagh
Expanded Programme on Immunization (EPI)
Switzerland

Regional Office for Europe

Dr Guenaël Rodier, Director
Division of Communicable Diseases, Health Security, and Environment

Vaccine-preventable Diseases and Immunization Programme

Mr Robb Butler, Programme Manager a.i.
Ms Malika Abdusalyamova
Dr Myriam Ben Mamou
Dr Oleg Benes
Dr Niyazi Cakmak
Dr Sergei Deshevoi
Ms Katrine Habersaat
Dr Dragan Jankovic
Dr Liudmila Mosina
Dr Mark Muscat
Dr Abigail Shefer
Dr Annemarie Wasley

Temporary advisors

Dr Sebastian Funk
London School of Hygiene and Tropical Medicine
United Kingdom

Mr Jan-Marcus Hellström
Finland

Rapporteur

Dr Raymond Sanders
United Kingdom

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

Member States

Albania
Andorra
Armenia
Austria
Azerbaijan
Belarus
Belgium
Bosnia and Herzegovina
Bulgaria
Croatia
Cyprus
Czech Republic
Denmark
Estonia
Finland
France
Georgia
Germany
Greece
Hungary
Iceland
Ireland
Israel
Italy
Kazakhstan
Kyrgyzstan
Latvia
Lithuania
Luxembourg
Malta
Monaco
Montenegro
Netherlands
Norway
Poland
Portugal
Republic of Moldova
Romania
Russian Federation
San Marino
Serbia
Slovakia
Slovenia
Spain
Sweden
Switzerland
Tajikistan
The former Yugoslav Republic of Macedonia
Turkey
Turkmenistan
Ukraine
United Kingdom
Uzbekistan

World Health Organization Regional Office for Europe

UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark
Tel.: +45 45 33 70 00 Fax: +45 45 33 70 01 Email: contact@euro.who.int
Website: www.euro.who.int