



# Immunization Newsletter

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## Immunization Coverage Monitoring Chart: Innovative simplicity

The *Immunization Coverage Monitoring Chart* is an extremely simple yet effective tool. Developed by Mr. Henry Smith, the *Immunization Coverage Monitoring Chart* is one of the most user-friendly and low-tech tools available for the management of the immunization program in the world. Mr. Smith's ingenuity gave birth to this chart while he was working as an immunization advisor in the Caribbean in the early 1980s.

Mr. Smith's Monitoring Chart is used at all levels of the monitoring system of immunization programs. At the local level, it is used by health care workers, in paper form, to mark the monthly progress in the routine immunization coverage for their locality. Similarly, at the sub-national and national levels, it allows a quick visualization of aggregated coverage data. In its origins, the Monitoring Chart allowed the Immunization Unit at the Caribbean Epidemiology Centre (CAREC) to receive monthly coverage by country.

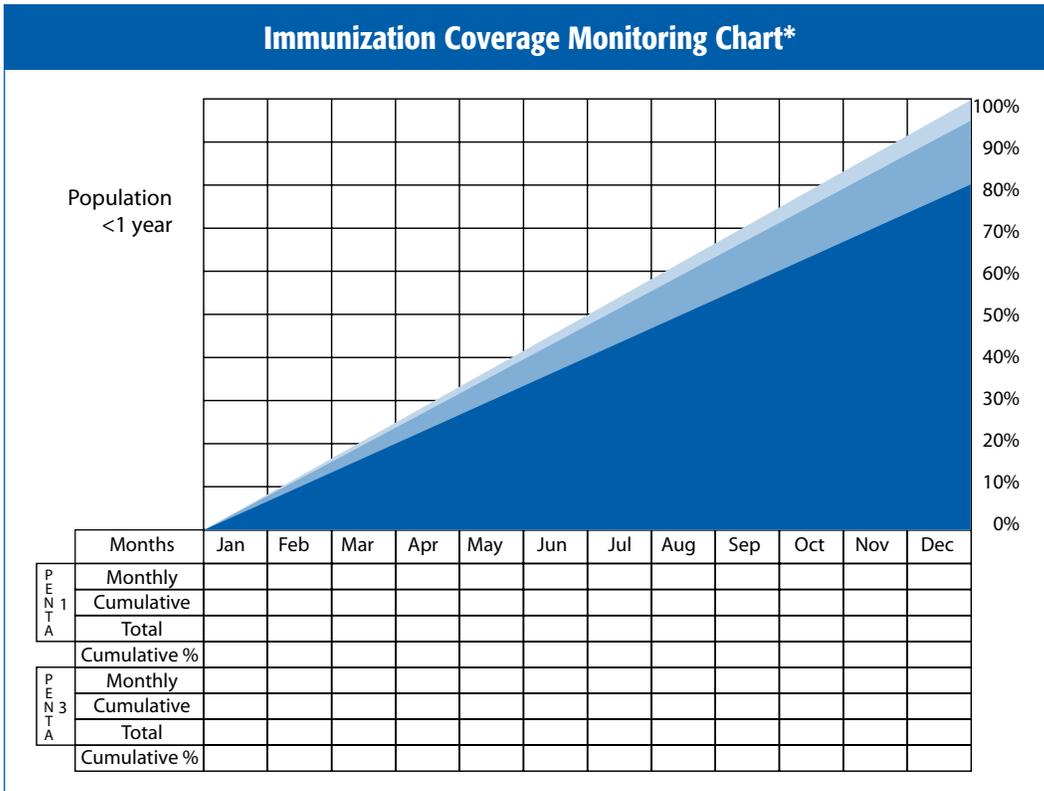
The *Immunization Coverage Monitoring Chart* is a data visualization tool that enables immunization program managers to: 1) set and evaluate monthly goals on a timely fashion, 2) compare performance and coverage over different time periods, 3) monitor each vaccine and dose, and 4) accurately reflect the situation of their locality.

Dr. Ciro deQuadros, Chief of PAHO's Immunization Program at the time approved and promoted the use of Mr. Smith's *Immunization Coverage Monitoring Chart* in the Americas. Later, the Chart was adopted by the WHO for worldwide use as a tool to monitor immunization coverage at health facilities, sub-national, and national levels.

## Vaccination Week in the Americas, 2011



The Pan American Health Organization's (PAHO) Vaccination Week in the Americas (VWA) was celebrated for the 9<sup>th</sup> consecutive year from 23 to 30 April 2011. VWA is a flexible initiative which seeks to advance equity and access to vaccination, while promoting cooperation between countries towards common health goals. Forty-three countries and territories carried out a diverse array of vaccination activities under the framework of VWA this year, vaccinating approximately 40 million individuals of all ages, and delivering integrated health interventions, social communication activities and educational efforts to promote vaccination. Dozens of VWA launching events were also celebrated, including national celebrations and events on bi-national and tri-national borders. More detailed information on selected VWA launching events can be found below.



\*This is an example of the current version in use.

See **CHART** on page 3

See **VWA** on page 2

VWA continued from page 1

**BOLIVIA-PERU BORDER:** PAHO's Regional Director, Dr. Mirta Roses, joined the Vice Minister of Health of Peru, Dr. Zarela Solís, and the Minister of Health and Sports of Bolivia, Dr. Nila Heredia, along with representatives from UNICEF<sup>1</sup>, UNOPS<sup>2</sup>, and UNDP<sup>3</sup>, health workers, community leaders and school children on 26 April for a VWA launching event. The event was held in the community of Kasani, on the two countries' shared border and at approximately 3,900 meters above sea level. During her speech at the event, Dr. Roses commented: "From here, facing Lake Titicaca, we have the potential to mobilize the entire world. This place is marvelous and very symbolic because it is the summit of our Americas. From here we make an appeal regarding the importance of continuing to vaccinate, for the health and lives of everyone."

**BRAZIL:** Participants in a VWA launching ceremony in Manaus on 30 April included Dr. Roses, the Minister of Health of Brazil Dr. Alexandre Padilha, representatives from UNAIDS<sup>4</sup>, UNICEF and CDC<sup>5</sup>, the governor of the state of Amazonas, Mr. Omar Azis, and the prefect of Manaus, Mr. Amazonino Mendes, as well as other national and local officials. Representatives from the WHO headquarters office and the Regional Office for South-East Asia also participated in the event as observers. Dr. Roses praised the "spirit of collaboration and Pan-Americanism" that has helped put immunization on countries' political agendas. Minister of Health Padilha noted that Brazil was also using the occasion to launch a national vaccination day against influenza. Governor Azis said his state had established 3,000 vaccination posts staffed by some 6,000 health workers and volunteers to serve approximately 450,000 people. Manaus, the capital of Amazonas state, was chosen for the VWA launch to highlight the importance of vaccination in indigenous communities and other at-risk populations in the Amazon Basin, as well as to strengthen international collaboration within the framework of the 1978 Amazon Cooperation Treaty.

**COLOMBIA:** Authorities from Colombia, Brazil and Peru joined PAHO/WHO<sup>6</sup> representatives on 25 April, for a launching event on the tri-national border between Leticia,

Colombia; Tabatinga, Brazil; and Santa Rosa, Peru. Participants included national, state and municipal authorities from all three countries as well as the popular *Plaza Sésamo*<sup>®</sup> (the Spanish version of *Sesame Street*<sup>®</sup>) TV characters Elmo<sup>®</sup>, Lucas<sup>®</sup> and Enrique<sup>®</sup>, who delighted children attending the event. Other "celebrity" participants included Gotinha, the Brazilian cartoon-character that represents a drop of polio vaccine, and Bambuco, the mascot of the FIFA Soccer World Cup Sub 20 team. Later in the afternoon, a launching event was held in the indigenous community of Tucuna, Brazil, where Dr. Gina Tambini, Manager of PAHO/WHO's Area of Community and Family Health, noted the Brazilian government's commitment to strengthening health services.

**EL SALVADOR:** The 9<sup>th</sup> VWA was launched in the locality of Dulce Nombre de María, Chalatenango on 6 May. Authorities of the Ministry of Health, PAHO, and local authorities inaugurated the VWA, which took place under the slogan: "Vaccinate your family, protect your community." The Ministry of Health provided all of the vaccines included in their routine immunization program, a program that includes vaccines for the entire family. In 2011, a special emphasis was given to vaccination against seasonal influenza, which included pandemic H1N1 influenza strain for the first time; the country acquired 668,000 doses for children aged 6 months to 5 years and 730,000 doses for adults aged >60 years. Pneumococcal vaccines were also included and made available to the population: 463,000 doses for children aged <24 months and 300,000 doses for adults aged >60 years.

**GUATEMALA:** The town of San Vicente, at the foot of Guatemala's Pacaya volcano, was the site for a 28 April VWA launching event, attended by PAHO Assistant Director, Dr. Socorro Gross, and Guatemalan Minister of Health, Dr. Ludwig Ovalle. School children marched in a parade to kick off the event, while some individuals dressed up as polio, measles, rotavirus and influenza viruses. Dr. Gross helped vaccinate members of the public, and was joined by PAHO/WHO Representative Dr. Pier Paolo Balladelli and Vice Minister of Health Dr. Silvia Palma. Among other activi-

ties which took place during VWA, Dr. Ovalle presented Guatemala's Congressional Health Commission with a proposed Vaccine Law that seeks to guarantee public funding for vaccines in order to ensure steady vaccine supply and support the introduction of new vaccines.

**PANAMA:** PAHO Champion of Health, singer Ricardo Montaner joined Panamanian Minister of Health Dr. Franklin Vergara, First Lady Marta Linares de Martinelli, and PAHO's Assistant Director Dr. Gross, for a VWA launching event at the Community Health Center of Veracruz, Panama on 25 April. Following the launch, Dr. Gross, Ricardo Montaner, and a group of national authorities visited the headquarters of the Panamanian Institute for Rehabilitation, where they delivered vaccines and inaugurated a new classroom for people with general development disorders.

**SURINAME:** During VWA 2011, Suriname continued its health collaboration with the French overseas department of French Guiana, marking another year of bi-Regional work between the Americas and Europe. On 28 April, French and Surinamese health authorities traveled by boat to VWA activities in the French village of Apatou and in the Surinamese village of Langa Tabiki. Both villages are along the Marowijne River, which divides Suriname from French Guiana. During the events health authorities released a new bilingual poster to promote vaccination services.

**US-MEXICO BORDER:** On 26 April, a launching event between the United States (US) and Mexico was held in Tucson, Arizona to celebrate VWA and the US National Infant Immunization Week. PAHO's Deputy Director, Dr. Jon Andrus participated in this event alongside high level Mexican and US health authorities. A wide variety of events and vaccination activities were carried out throughout in the border region in celebration of VWA/NIIW this year, supported by US/Mexico Border Health Commission, the US Department of Health and Human Services, the Secretariat of Health of Mexico, the PAHO/WHO US-Mexico Border Office, and 10 border-state health departments.

See [VWA](#) on page 8

1 UNICEF: United Nations Children's Fund.

2 UNOPS: United Nations Office for Project Services.

3 UNDP: United Nations Development Program.

4 UNAIDS: Joint United Nations Program on HIV/AIDS.

5 CDC: United States' Centers for Disease Control and Prevention.

6 PAHO/WHO: Pan American Health Organization/World Health Organization.

CHART continued from page 1

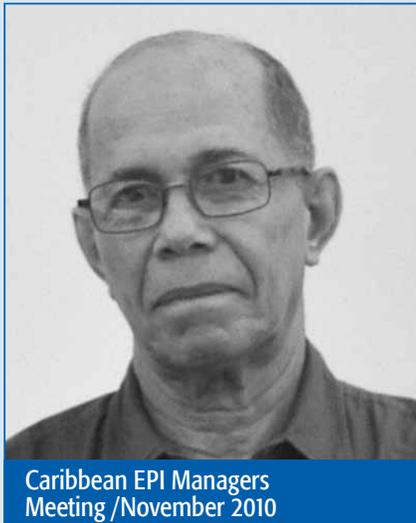
The *Immunization Coverage Monitoring Chart* has become a tool that is included in all training material for immunization program managers. It is also an integral part of the tools included in the Global Framework for

Immunization Monitoring and Surveillance, as it is instrumental to achieve Strategy 18 of WHO/UNICEF Global Immunization Vision and Strategy (GIVS) 2006-2015 "strengthen the management, analysis, interpretation, use

and exchange of data at all levels." Finally, the Monitoring Chart is one of the tools included in the RED (reach every district) strategy designed to increase immunization coverage from the local level up. ■

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## Henry Smith: a brief summary of his contributions to the field of Immunizations

Smallpox Eradication Program which successfully eliminated the disease in 1973. He was awarded for meritorious service by the Ministry of Health of Kenya and later, in 1979, a citation of appreciation from the WHO when it was certified that the disease was indeed eliminated from Kenya.

After his tours in Africa, Mr Smith served in Bangladesh and India from 1973-1977 with an international team of field epidemiologists where they successfully eliminated the last outbreaks of smallpox in Asia. That same year (1977) the last case of smallpox was eradicated from the world in Somalia, Africa. For this achievement Mr Smith was awarded the Order of the Bifurcated Needle as recognition of his participation in the great achievement of national and international health workers who shared privations and problems in a pursuit that

ultimately resulted in the global total eradication of smallpox. This honor was conferred on Henry Smith by Dr. Donald A Henderson, Chief of Global Eradication Smallpox Program, WHO, Geneva in 1976. In 1977, he began his work with PAHO as an immunization officer. He was made responsible for the organization and implementation of the expanded program on immunization of the nineteen CAREC member countries.

Currently, Mr. Smith is the Chairman/President of the Caribbean Commission of the documentation and verification of the elimination of measles, rubella and congenital rubella syndrome of the English and Dutch-speaking Caribbean sub-region of the Americas. Although Mr. Smith retired several years ago, he continues collaborating with PAHO in several immunization activities throughout the Region and in his home country of Belize. ■

In 1968, Mr. Smith was assigned to Nairobi, Kenya, East Africa where he was the sole WHO staff to assist the Ministry of Health organizing and implementing their

## Meeting of the Working Group on Mumps in the Region of the Americas, 2-3 June 2011

The Pan American Health Organization (PAHO) convened a meeting of the Working Group on Mumps in the Region of the Americas on 2-3 June 2011.

Using Elluminate conferencing software, this "virtual" event linked PAHO staff in Washington, D.C. with health authorities and vaccine experts from many countries of the Americas as well as with officials from the World Health Organization (WHO) and the United States' Centers for Disease Control and Prevention (CDC).

The goal of the Working Group was to assess the situation of mumps in the Region based on country experiences, and to propose practical recommendations to present to the PAHO Technical Advisory Group on Vaccine-preventable Diseases (TAG) for consideration at its meeting in Buenos Aires, Argentina on 6-8 July 2011. Two TAG members, Dr. José Ignacio Santos and Dr. Peter Figueroa, participated in the Working Group meeting.

The meeting had four objectives:

- To better understand the epidemiology of mumps in the Region.
- To identify best practices to control and respond to mumps outbreaks.

- To improve guidelines for the diagnostic testing of mumps in the Region.
- To propose recommendations for revised mumps strategies.

On the first day, the meeting began with a series of technical presentations, which were followed by periods for discussion and questions and answers. On the second day, two additional presentations were made, and participants discussed the recommendations that should be presented to TAG. Participants reached general consensus on recommendations concerning four primary areas: vaccination, surveillance, outbreaks, and laboratory diagnosis. A large amount of relevant and practical technical information was presented and reviewed by the Working Group. The most important conclusions include:

- 1) Following the recommendation of TAG in 1997, the introduction of the mumps vaccine has had a significant impact in the Americas, resulting in a substantial decline in the number of mumps cases.

- 2) In recent years, the leading cause of mumps outbreaks has been low vaccination coverage.
- 3) The vast majority of mumps outbreak cases occurred due to unvaccinated or under-vaccinated (one-dose) populations.
- 4) While the inter-epidemic interval before wide-scale mumps vaccination was previously considered to be three years, the interval is now approximately ten years.
- 5) Mumps outbreaks occasionally occur among persons who have received two vaccine doses. But these outbreaks are generally limited to older age groups and to high-density and high-contact populations, such as college students in dormitories or close-knit religious communities.
- 6) Countries using the measles-mumps-rubella (MMR) trivalent vaccine in campaigns have not found an increase in the expected rate of vaccine-related adverse events.

Based on the information presented and reviewed at the meeting, the Working Group submitted the following recommendations for consideration by TAG. See **MUMPS** page 4

MUMPS continued from page 3

## Recommendations

Overall/General Recommendations	<ul style="list-style-type: none"> <li>Given that the MMR vaccine is used in the Region of the Americas, strategies to control mumps should be closely integrated with existing goals of measles and rubella elimination.</li> </ul>
Recommendations for Vaccination	<ol style="list-style-type: none"> <li>Preventing mumps requires two doses of MMR vaccine in countries' national immunization programs, aiming at reaching coverage levels <math>\geq 95\%</math>, for all children and risk groups. The first dose should be given at 12 months of age as part of the routine immunization schedule. The second dose can be administered either through a campaign or through the routine immunization program and should be given at least one month after the first dose, optimally during the second year of life but no later than school entry.</li> <li>During all mumps vaccination activities, regardless of the vaccination strategy (routine or campaign) any of the WHO prequalified vaccines can be used, independent of the mumps strain. When responding to outbreaks, it is preferred that the Jeryl-Lynn strain (or Jeryl-Lynn-derived strains) be used among adolescents and adults.</li> <li>When using the MMR vaccine in campaigns, health authorities should monitor, investigate, and train health workers about possible vaccine-related adverse events for all vaccine components, including possible instances of aseptic meningitis (AM). Countries also need to use effective communication strategies to inform the general public about possible events supposedly attributable to vaccination or immunization (ESAVI), to maintain a high level of public trust in vaccines and vaccination programs.</li> <li>Future studies of the safety profile of the MMR vaccine in campaigns should be well designed to investigate the incidence of adverse events. Such research should use standardized case definitions and standardized quantitative indicators to assess the severity of adverse events.</li> <li>Vaccine effectiveness studies should take into consideration the thermostability of the mumps component of the MMR vaccine and evaluate practical issues, such as the need to ensure vaccine reconstitution using cold diluents.</li> </ol>
Recommendations for Surveillance	<ol style="list-style-type: none"> <li>Strengthened surveillance for mumps will be decisive in building the general knowledge base of mumps epidemiology in the Region of the Americas and in accelerating vaccination activities to prevent possible outbreaks and establish a disease control goal. Such surveillance efforts should evolve with the level of epidemiological control and should be adapted to each country to match regional and country-specific program goals and objectives. Surveillance should first focus on clusters of clinical cases to identify outbreaks of mumps. After an observed decline in the incidence of mumps cases, case-based surveillance should be implemented.</li> <li>All countries that have not yet made mumps a notifiable disease should do so. Countries should also strengthen their mumps surveillance systems to rapidly detect, investigate, and respond to mumps outbreaks.</li> <li>All the countries of the Region of the Americas should standardize mumps case definitions and surveillance indicators, using adequate data elements. PAHO will develop guidelines on mumps surveillance, outbreak response and investigation, as well as for laboratory diagnosis.</li> </ol>
Recommendations for Outbreaks	<ol style="list-style-type: none"> <li>Every suspected outbreak should be adequately investigated in order to identify the characteristics of the outbreak, select appropriate control measures, and determine why the outbreak occurred. While the single most important outbreak control measure is vaccination, these interventions should target only the affected populations. If the number of susceptible persons is high, a vaccination campaign should be conducted in order to increase coverage levels.</li> <li>During an outbreak, laboratory diagnosis should also be used to confirm the occurrence of a mumps outbreak and to establish causality of vaccine-related adverse events.</li> </ol>
Recommendations for the Laboratory	<ol style="list-style-type: none"> <li>Capacity for laboratory confirmation of mumps should be part of the Measles and Rubella Laboratory Network for the Region of the Americas. Building laboratory capacity will require development of standard protocols for laboratory testing, data management and quality control as well as training.</li> <li>Laboratory testing should be used to confirm suspected outbreaks of mumps, but not to confirm every suspected case. Samples should be collected for serologic and virological assays. Molecular characterization should be used to establish a genetic baseline for wild-type mumps.</li> <li>Laboratories with existing capacity for polymerase chain reaction (PCR) should consider establishing the mumps real time PCR (RT-PCR) assay as a diagnostic method. ■</li> </ol>

<sup>1</sup> High risk groups consist of people who live in areas that have low coverage levels or that have poor immunization program performance.

## Meeting of the Measles and Rubella Laboratory Network for the Region of the Americas

The annual Meeting of the Measles and Rubella Laboratory Network (LabNet) for the Region of the Americas was held at the United States' Centers for Disease Control and Prevention (CDC) Headquarters in Atlanta, GA, USA on 20-21 June 2011.

Representatives from the Regional Reference Laboratories (RRLs), the Global Specialized Laboratory (GSL), the World Health Organization (WHO), the Pan American Health Organization (PAHO), as well as representatives from 24 countries and the Caribbean Epidemiological Centre (CAREC) (in representation of the English-Speaking Caribbean), participated in this meeting. The meeting was co-chaired by Dr. Paul Rota (from the CDC) and Dr. Marilda Siqueira (from the Oswaldo Cruz Foundation, FIOCRUZ).

This meeting highlighted the achievements of the countries in the Region, addressed new challenges for diagnosing measles, rubella, and Congenital Rubella Syndrome (CRS), and challenges for the final classification of sporadic cases.

The objectives of this meeting were to:

- Review progress and identify the challenges in meeting laboratory-based requirements for documentation of regional elimination of measles, rubella, and CRS in 2011 and 2012.

- Gather information to help develop the laboratory training course on methods to achieve and maintain measles, rubella, and CRS elimination to be taught in FIOCRUZ in late August 2011.
- Facilitate, through presentations and discussions, the ability of participating national laboratories to support surveillance to monitor the maintenance of elimination of measles, rubella, and CRS beyond 2011.
- Review laboratory management and develop a plan for continued management of the laboratory network.
- Facilitate interactions between laboratories and with the RRLs: FIOCRUZ; CDC, and Canada; and the GSL and CDC on technical laboratory issues.
- Provide laboratories with updated information about laboratory methods and data reporting.
- Develop strategies to strengthen communication between the laboratory and public health epidemiologists.

The presentations and discussions included:

- Guidelines for laboratory testing with an emphasis on testing strategies to be used in low-disease incidence settings.
- Utility of additional laboratory tests/algorithms/guidelines in low-incidence settings (e.g. avidity testing).
- Turnaround time for various laboratory tests (for measles, rubella and CRS).
- Discussions of the importance of inclusion of both laboratory and epidemiologic/clinical/demographic data in final case classifications, especially in a low-incidence setting.
- Presentations/discussions on specific criterion for elimination of measles and rubella from the Americas.
- Small group discussions with RRLs, GSL and the World Health Organization's Headquarters (WHO/HQ) staff on technical issues.

### Draft recommendations

<p>Documentation of elimination of measles, rubella, and CRS in the Region of the Americas</p>	<ul style="list-style-type: none"> <li>• Laboratories should collect and evaluate laboratory data required for documentation and maintenance of national elimination goals for measles, rubella, and CRS.                         <ul style="list-style-type: none"> <li>◦ In the next 6-10 months, national laboratories should seek advice from RRLs and GSL on case classification when necessary and, after discussions with these laboratories, submit appropriate specimens to RRLs or other network laboratories for additional testing. This should include confirmation of positive Immunoglobulin G (IgM) results when necessary, and additional testing, such as real-time polymerase chain reaction (RT-PCR) and avidity, which may not be available in the national laboratory. Laboratories should use PAHO's Laboratory Guidelines<sup>1</sup> and the checklist for sporadic cases for guidance on determining the need for additional testing.</li> <li>◦ A plan of action for testing should be developed. This plan will be used to test samples for sporadic cases and outbreaks and monitor the maintenance of elimination. RRLs and the regional laboratory coordinator will develop a plan of action. It is anticipated that this plan will include establishing molecular diagnostics in most national laboratories and performing specialized testing in specific network laboratories through a defined referral system.</li> </ul> </li> <li>• Develop strategies to strengthen communication between the measles and rubella laboratory and public health epidemiology units. Laboratories should take appropriate steps to develop organizational arrangements necessary for the documentation and maintenance of national elimination goals for measles, rubella, and CRS. These include coordinated case classification using all available epidemiologic and laboratory data through direct discussions between epidemiology and laboratory teams regarding all available data. Laboratory and epidemiological staff should meet at least once a month to reconcile data, identify data omissions and decide on any further specimen collection and testing required for the classification of cases.</li> <li>• In order to verify measles, rubella and CRS elimination every laboratory in the network should monitor all the indicators referring to the laboratory as described in the components of the Plan of Action for the documentation and verification of the elimination.</li> </ul>
<p>Laboratory Management</p>	<ul style="list-style-type: none"> <li>• PAHO headquarters should work with RRLs and GSL to manage the laboratory network in the Americas. PAHO will continue to manage kit distribution and other essential organizational activities, and facilitate and support essential technical activities in RRLs and GSL such as accreditation of laboratories and development and evaluation of testing protocols.</li> <li>• Because of the demand for laboratory support for regional documentation and verification of measles, rubella and CRS, and because of the compressed timeline that network laboratories will require to receive the additional training and support needed to establish new testing procedures and strategies, PAHO should support a laboratory coordinator dedicated to measles, rubella and CRS for at least a period of 2 years.</li> <li>• PAHO, the GSL and RRLs should work to improve communications between the network laboratories and develop methods to rapidly disseminate information regarding new methods, recent outbreaks, and changes in testing procedures. PAHO should consider developing a newsletter that can be distributed to the laboratories. In addition, periodic Web-based meetings should be held with laboratory staff, epidemiologists, RRLs, CDC, and PAHO to discuss case classification. Ad hoc meetings should be also be considered for consultation on complex case classifications.</li> </ul>

<sup>1</sup> Guidelines available online, at: [www.paho.org/immunization/publications](http://www.paho.org/immunization/publications).

LABNET MEETING continued from page 5

**Draft recommendations (continued)**

Challenges for the diagnosis of measles, rubella, and CRS in low incidence settings	<ul style="list-style-type: none"> <li>• Laboratories should be aware of important information on case classification other than the results of laboratory testing, including timing of the use of various diagnostic tests and the effectiveness of diagnostic tests in specific situations (e.g. predictive positive value of 1 and multiple defect in suspect CRS cases). Laboratories should bring this type of information to discussions with epidemiologic teams concerning case classification.</li> <li>• Laboratories should achieve and maintain the level of technical expertise necessary to maintain laboratory surveillance capacity to monitor measles, rubella, and CRS elimination. This expertise should include molecular testing. To facilitate this, PAHO will support a regional laboratory training workshop at FIOCRUZ in August 2011 and another workshop at a location to be determined in the first quarter of 2012.</li> <li>• National laboratories with sufficient capacity are encouraged to use molecular tests, especially real-time polymerase chain reaction (RT-PCR) for measles and rubella to aid in case confirmation.</li> <li>• The validated avidity test for measles IgG that is performed at the CDC is not available in commercial format. Laboratories should send samples requiring measles avidity testing to CDC after consultation with PAHO and CDC. To facilitate this process, laboratories should use the checklist developed by CDC to help determine the need for avidity testing. The CDC avidity test will be transferred to other RRLs if there is an increased demand for testing or to improve turnaround time.</li> <li>• The avidity test for rubella IgG is commercially available, and PAHO, the RRLs and GSLs should conduct a workshop or meeting to standardize the methods and the interpretations of results and to develop a specimen referral protocol as well as a quality control program for the laboratories that are performing avidity testing.</li> <li>• Recognizing that laboratory confirmation of CRS cases requires an understanding of the timing of various diagnostic tests relative to the appearance of markers of disease; laboratories should become familiar with this timing and with managing receipt of specimens from sources outside the rash and fever surveillance network such as neonatologists and pediatricians. Laboratories need to report findings to the epidemiologic teams in the country.</li> </ul>
Molecular epidemiology	<ul style="list-style-type: none"> <li>• Laboratories should encourage collection of samples for virus detection in an attempt to obtain genetic information from at least 80% of confirmed outbreaks of measles and rubella.</li> <li>• Timely reporting of genotype information and sequence data are essential for rapid confirmation of viral importation. National laboratories (NLs) that are performing sequencing should report measles sequences to and rubella genotype information to the WHO database. RRLs performing sequence analysis for NLs should submit the sequence information to MeaNS<sup>2</sup> and the WHO database after obtaining permission from the NL. It is important that all relevant epidemiological data be included with the sequence information so that the submitting laboratory can submit complete reports. Laboratories are reminded of the need to share sequence data within at least 2 months of sample collection and that this performance indicator is monitored in the WHO accreditation process.</li> <li>• Future training workshops should include activities to increase the regional capacity for sequencing and sequence analysis in addition to molecular diagnostic techniques.</li> <li>• Molecular epidemiologic data are often limited for countries in the Region, especially for rubella viruses. Nevertheless, laboratories must seek to use such data to the extent possible in support of documentation of elimination of measles, rubella, and CRS as required by the Plan of Action.</li> </ul>
Quality Control	<ul style="list-style-type: none"> <li>• Laboratories should continue to perform quality control for serologic testing as required for WHO accreditation. National labs are strongly encouraged to provide a proficiency testing program for any sub national labs in their country.</li> <li>• The WHO accreditation process is an important component of the quality control process and laboratory results to support documentation of elimination must be provided by an accredited laboratory. Laboratories should be accredited on an annual basis either by paper accreditation or by a site visit. PAHO should conduct site visits to the NLs and RRLs on a rotating basis so that all laboratories are visited once every 3 years. A priority list of laboratories to be reviewed should be developed in consultation with PAHO, RRLs and GSLs. PAHO will conduct site visits in 4 countries by the end of 2011.</li> <li>• Sub-national laboratory (SNL) proficiency testing is a critical measure of the quality of the laboratory surveillance program in countries which have SNLs, but identifying sufficient volumes of IgM positive samples has been a challenge in many countries. Efforts should be made globally to collect large volumes of IgM positive measles and rubella serum for use in the SNL LabNet in the Region and support RRLs in the Region to produce a SNL proficiency testing panel.</li> <li>• In many countries, the SNLs perform a critical role in surveillance for measles and rubella by conducting a large volume of the primary serologic testing. However, successfully managing a network of SNLs requires a substantial effort from the NL. To document these management activities, the WHO accreditation checklist for NLs should be modified to include a summary of the performance of each SNL and a description of the management activities performed by the NL.</li> <li>• Laboratories in the PAHO network should work with the LabNet laboratories in other regions to develop a quality control program for molecular testing.</li> <li>• Laboratories are strongly encouraged to use the standard PCR controls and standardized kits provided by CDC for molecular testing and confirmation of viral isolation.</li> <li>• Laboratories should document any suspected problems with the performance of the Siemens kits for detection of IgM to measles and rubella. The laboratory coordinator, in consultation with the GSL and RRLs, will develop a protocol to assist laboratories with monitoring assays performance. Problems with assay performance should also be reported to WHO/HQ and CDC. ■</li> </ul>

<sup>2</sup> MeaNS: Measles Nucleoid Surveillance.

## Measles/Rubella/Congenital Rubella Syndrome Surveillance Data Final Classification, 2010

Country	Total Measles/ Rubella Suspect Cases Notified	Confirmed Measles			Confirmed Rubella			Congenital Rubella Syndrome (CRS)	
		Clinical	Laboratory	Total	Clinical	Laboratory	Total	Suspected	Confirmed
Anguilla	3	0	0	0	0	0	0	0	0
Antigua & Barbuda	0	0	0	0	0	0	0	0	0
Argentina	1174	0	17	17	0	0	0	5	0
Aruba	...	0	0	0	...	...	...	...	...
Bahamas	1	0	0	0	0	0	0	0	0
Barbados	14	0	0	0	0	0	0	0	0
Belize	56	0	0	0	0	0	0	...	...
Bermuda	0	0	0	0	0	0	0	...	...
Bolivia	120	0	0	0	0	0	0	...	...
Brazil	10304	0	68	68	0	0	0	...	...
Canada	...	...	99	99	...	12	12	...	...
Cayman Islands	1	0	0	0	0	0	0	0	0
Chile	205	0	0	0	0	0	0	180	0
Colombia	2802	0	0	0	0	0	0	201	0
Costa Rica	62	0	0	0	0	0	0	0	0
Cuba	775	0	0	0	0	0	0	0	0
Dominica	1	0	0	0	0	0	0	0	0
Dominican Republic	150	0	0	0	0	0	0	...	...
Ecuador	802	0	0	0	0	0	0	1	0
El Salvador	216	0	0	0	0	0	0	...	...
French Guiana	23	0	2	2	...	1	1	...	...
Grenada	2	0	0	0	0	0	0	0	0
Guadeloupe	...	0	0	0	...	...	...	...	...
Guatemala	329	0	0	0	0	0	0	5	0
Guyana	49	0	0	0	0	0	0	0	0
Haiti	24	0	0	0	0	0	0	0	0
Honduras	134	0	0	0	0	0	0	16	0
Jamaica	300	0	0	0	0	0	0	0	0
Martinique	...	0	0	0	...	...	...	...	...
Mexico	5147	0	0	0	0	0	0	1	0
Montserrat	0	0	0	0	0	0	0	0	0
Netherlands Antilles	...	0	0	0	...	...	...	...	...
Nicaragua	107	0	0	0	0	0	0	0	0
Panama	72	0	0	0	0	0	0	0	0
Paraguay	436	0	0	0	0	0	0	0	0
Peru	910	0	0	0	0	0	0	...	...
Puerto Rico	...	0	0	0	...	...	...	...	...
St. Kitts & Nevis	0	0	0	0	0	0	0	0	0
St. Lucia	1	0	0	0	0	0	0	0	0
St. Vincent & Grenadines	0	0	0	0	0	0	0	0	0
Suriname	3	0	0	0	0	0	0	0	0
Trinidad & Tobago	9	0	0	0	0	0	0	0	0
Turks & Caicos	0	0	0	0	0	0	0	0	0
United States	...	...	63	63	...	7	7	0	0
Uruguay	15	0	0	0	0	0	0	...	...
Venezuela	918	0	0	0	0	0	0	...	...
Virgin Islands (UK)	0	0	0	0	0	0	0	0	0
Virgin Islands (US)	...	...	...	...	...	...	...	...	...
<b>TOTAL</b>	<b>25165</b>	<b>0</b>	<b>249</b>	<b>249<sup>a</sup></b>	<b>0</b>	<b>20</b>	<b>20<sup>a</sup></b>	<b>409</b>	<b>0</b>

... No information provided

(a) No case is indigenous to the Americas.

Source: MESS/FCH-IM and country reports through the PAHO-WHO/UNICEF Joint Reporting Form (JRF), 2010.

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An electronic compilation of the *Newsletter*, "Thirty years of *Immunization Newsletter*: the History of the EPI in the Americas", is now available at: [www.paho.org/inb](http://www.paho.org/inb).

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**Editor: Carolina Danovaro**

**Associate Editors: Gabriela Félix and Cuauhtémoc Ruiz Matus**

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**Pan American  
Health  
Organization**

Regional Office of the  
World Health Organization

### Comprehensive Family Immunization Project

525 Twenty-third Street, N.W.  
Washington, D.C. 20037 U.S.A.  
<http://www.paho.org/immunization>

VWA from page 2

## Advances towards a World Immunization Week

VWA has become part of a growing global effort. In 2011, sister vaccination/immunization week initiatives were simultaneously conducted in four other Regions of the World Health Organization (African, established in 2011; Eastern Mediterranean, established in 2010; European, established in 2005; and Western Pacific, established in 2011). A delegation from the South-east Asian Region (SEARO) visited the Americas this year to take part in VWA activities and learn more about the planning and implementation of the effort at the regional level. In September 2011, during their Regional Committee meeting, the countries in the Region of South-East Asia (SEARO) formally committed to launch a vaccination week initiative in 2012. This development signifies the achievement of a World Immunization Week (WIW), ten years after VWA was first launched in the Americas. Advocacy efforts are now being undertaken to promote the inclusion of a WIW resolution during the 2012 World Health Assembly. WIW will not replace the unique Regional initiatives, but will instead serve as an overarching framework for all efforts.

In this photo, Dr. Genoveva Morales, president of El Salvador's National Commission for the documentation and verification of the measles, rubella and congenital rubella syndrome elimination, is seen receiving the influenza vaccine during the VWA launching act in Chalatenango. A single photo captures 3 important aspects of the current work undertaken by immunization programs in the Americas:

- 1) the expansion of the vaccination to cover all ages and include the use of underutilized vaccines, like the influenza vaccine was once considered;
- 2) the work under way to document and verify the elimination of the endemic circulation of measles and rubella viruses in the Western Hemisphere, which continues to put the American Region in the forefront of vaccine-preventable disease elimination, and
- 3) the VWA, launched in 2003 to provide a magnificent opportunity to close gaps with regard to vaccination, reduce inequities, and protect the achievements of the Region, while assisting countries in maintaining immunization on the political agenda. ■



Dr. Genoveva Morales at the VWA launch, El Salvador, 6 May 2011.

Picture by: Luis Cortéz, Communications, ISSS.