Targeted and selective strategies for measles and rubella (MR) vaccination campaigns

Interim guidance

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Targeted and selective strategies in measles and rubella vaccination campaigns: interim guidance

Agenda

1. **Welcome, introductions and housekeeping**
2. **Overview of the interim guidance for targeted and selective strategies in Measles and Rubella (MR) Vaccination Campaigns**
3. **Teaser Questions**
4. **Panel Discussions on the interim guidance on targeted and selective strategies in MR vaccination campaigns**
5. **Discussions**
6. **Closing**

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Welcome, Introductions & Housekeeping

1. Warm welcome, thank you for your participation in this webinar
2. Please introduce yourself using the comment chatbox – name, designation, organization, country
3. Please mute your mic
4. Interpretation services from English to French are provided
5. Kindly use the Q&A to post questions and comments during the course of the webinar
6. During the discussions section, raise your hands to be given an opportunity to share your comments or questions
7. Enjoy the discussions!!!!

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Overview of the interim guidance for targeted and selective strategies in Measles and Rubella (MR) Vaccination Campaigns

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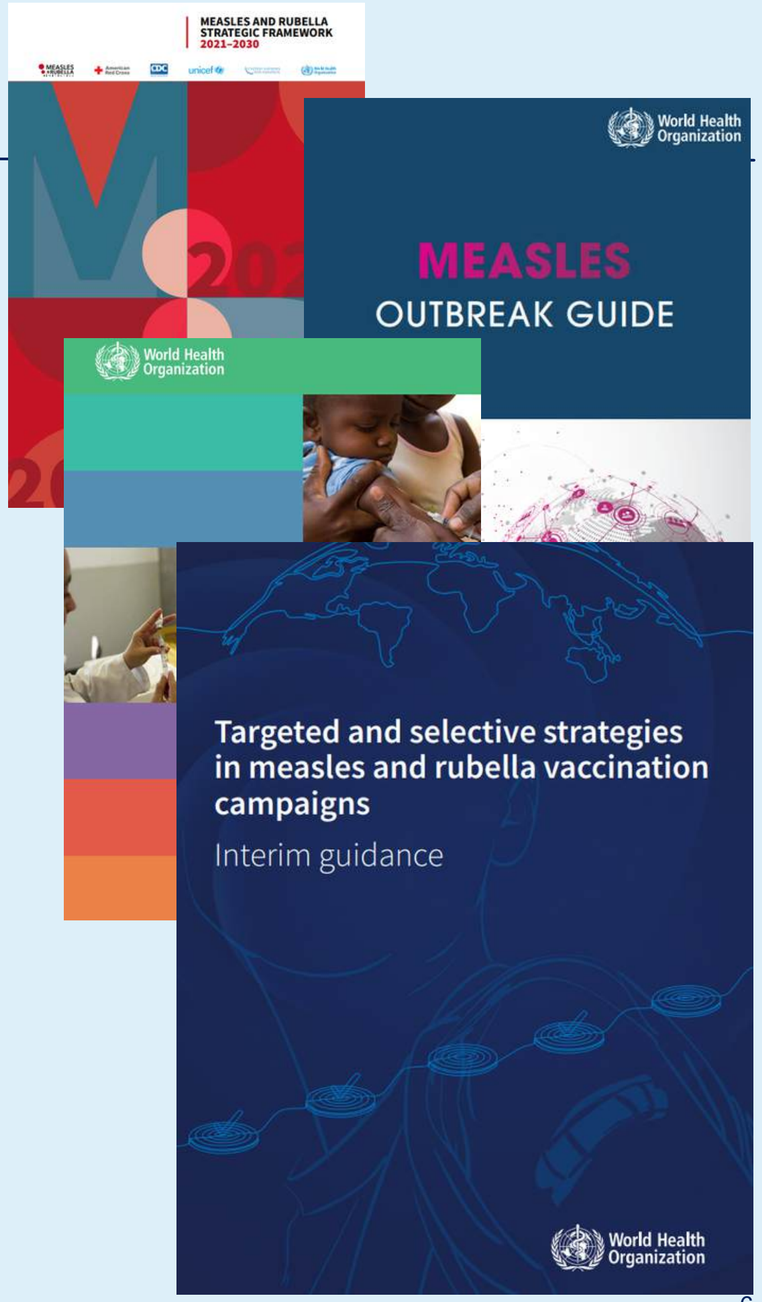
Presentation Outline

- **Interim guidance**
  - Objectives
- **Definitions of targeted and selective strategies**
- **Steps in planning targeted and selective strategies in MR campaigns-**
  - Step 1: Gather and **assess available data**
  - Step 2: Determining the '**age-range**'
  - Step 3: Considerations for targeted strategies to '**geographical areas** ' or '**high-risk**' groups.
  - Step 4: Considerations for '**selective**' strategies.
- **Conclusions**

Objectives of the guidance

- **The main objective of the guidance** is to support decision-making processes for M/MR vaccination campaigns, including helping when considering alternatives to nationwide non-selective campaigns
- **The guidance complements and does not replace other resources**, including WHO's *Planning and implementing high-quality supplementary immunization activities for injectable vaccines using an example of measles and rubella vaccines: field guide* (WHO SIA Field Guide)
- Note this **does not address planning of Periodic Intensification of Routine Immunization nor of Outbreak Immunization responses.**



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WHO interim guidance on targeted and selective campaigns

***Targeted* campaign strategies:** Vaccination campaigns customized to vaccinate eligible individuals at the **national or subnational levels.**

Where subnational data are of sufficient quality, exclude **low-risk areas or groups** from MCV/MRCV campaigns.

Use evidence to select the **age range** rather than default to 9–59 months.

***Selective* campaign strategies:** Vaccination campaigns customized where documentation is available to vaccinate eligible persons on the basis of their individual previous **vaccination status**.

A threshold of 90% availability of suitable documentation is required unless vaccination is part of an integrated campaign.

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Steps in planning targeted and/or selective strategies in an MCV/MRCV campaign

Step 1

*Campaign **or** routine immunization strengthening:*

Is an MCV/MRCV campaign necessary to bridge an immunity gap?

Step 2

Targeting optimal age group:

Which age groups should be included in the campaign?

Step 3

*Targeting certain location/groups **or** nation-wide:*

Are information/data available to decide that areas can be excluded from the campaign?

Step 4

*Selective **or** non-selective vaccination:*

Is vaccination status documented* for 90% of those to be vaccinated?

* E.g. home-based records, immunization registries (either paper or electronic)

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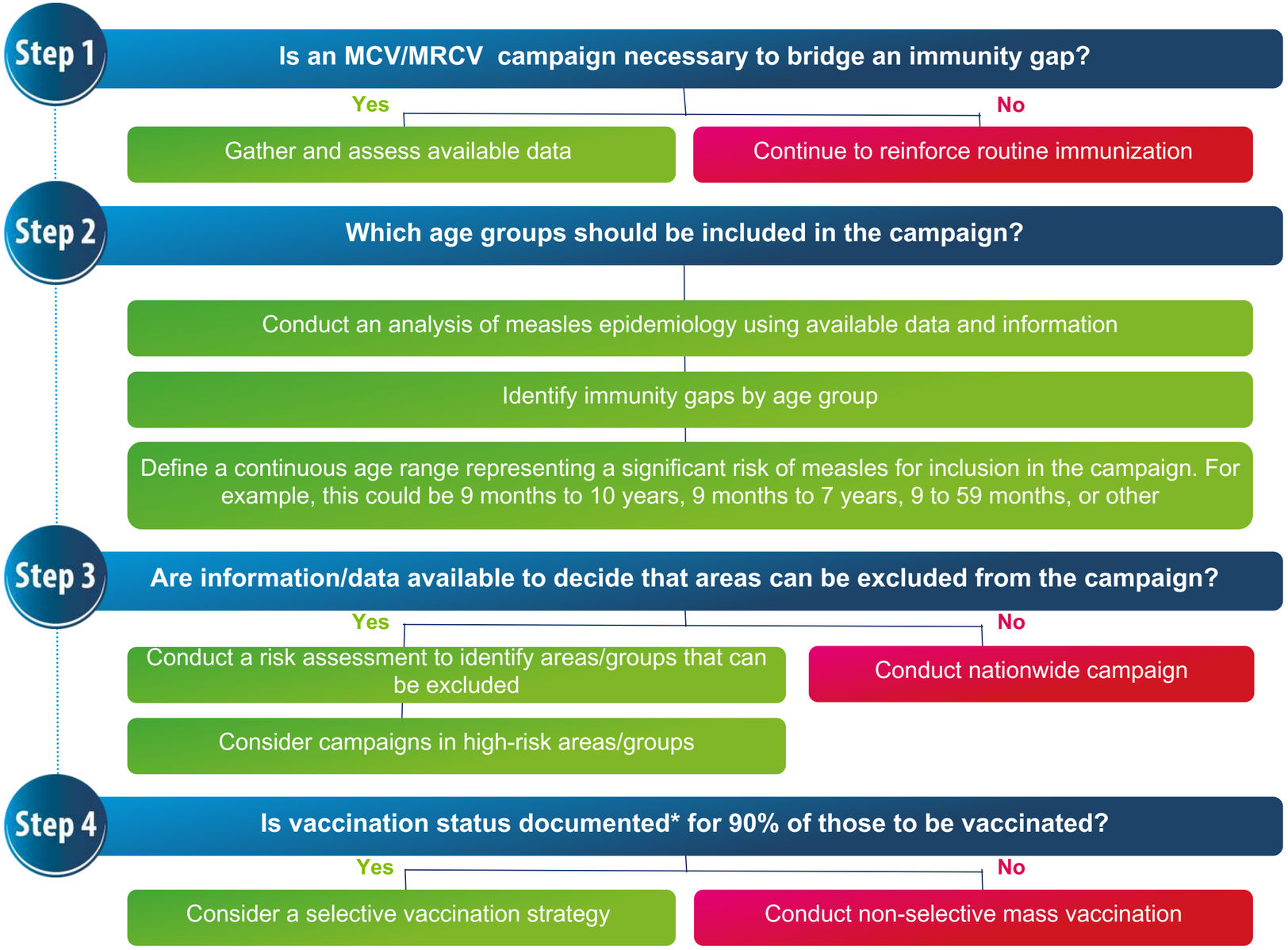
Steps in planning targeted and/or selective strategies in an MCV/MRCV campaign



* E.g. home-based records, immunization registries (either paper or electronic)

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Step 1: Gather and assess available data

Sources:

- Measles-rubella vaccination coverage by age group
- Measles disease surveillance data
- Estimation of immunity profiles
- Migration patterns and population mobility
- Demographic data
- Other information from modelling, serosurveys and identification of zero-dose or missed communities
- Assessments of local programme and service delivery readiness
- Qualitative information
- Information regarding security concerns and external factors
- Information available from nongovernmental actors

Assess data with tools and methods – including triangulation, data quality assessment and surveillance system assessment:

Handbook on the use, collection and improvement of immunization data. Geneva: World Health Organization; 2020 (https://www.technet-21.org/en/resources/guidance/who-handbook-on-the-use-collection-and-improvement-of-immunization-data).

Data quality assurance: module 1: framework and metrics. Geneva: World Health Organization; 2023 (https://www.who.int/publications/i/item/9789240047365). Licence: CC BY-NC-SA 3.0 IGO.

Triangulation [online resource]. TechNet-21. Geneva and New York (NY): World Health Organization and United Nations Childrens' Fund (https://www.technet-21.org/en/tags/triangulation).

Measles: vaccine-preventable disease surveillance standards. Geneva: World Health Organization; 2018 (https://www.who.int/publications/m/item/vaccine-preventable-diseases-surveillance-standards-measles). Licence: CC BY-NC-SA 3.0 IGO.

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Step 2: Determine the age range for an MCV/MRCV campaign

- Age range is one of the first decision to be made about a vaccination campaign.
- Ensure that the campaign age range forms a continuous group (e.g., 9mnths-10 years, 9mnths-7 years...)

Source 1: By year of most recent non-selective MCV/MRCV campaign-

- include all birth cohorts from that year forward.
- specify campaign eligibility based on year of birth.
- Best practice to include the youngest cohort, as only a portion of this cohort would have been eligible.

Source 2: By immunity gaps at subnational level

- Triangulate multiple data sources to ensure accuracy because the data quality.
  - If data quality is sub-optimal, surveillance data on age-specific incidence, case distribution by age group and vaccination coverage surveys may be used.
- Consider local context that could contribute to immunity gaps in certain age groups (e.g., supply interruptions, humanitarian emergencies, displaced populations).

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Step 2: Determine the age range for an MCV/MRCV campaign

Source 3: Using measles immunity profiles to determine susceptible proportion in each birth cohort.

- Use these estimates with inclusion of birth cohorts with ≥10% measles-susceptibility.
- Create continuous age range for the campaign age group from youngest to the oldest.

Source 4: Using surveillance data to assess the proportion of cases by year of age and location.

- Include annual birth cohorts in the campaign age range if they represent more than 20% of confirmed (lab and epi-linked confirmed) cases in the previous 12 months.
- Analysis by single birth year is preferable.

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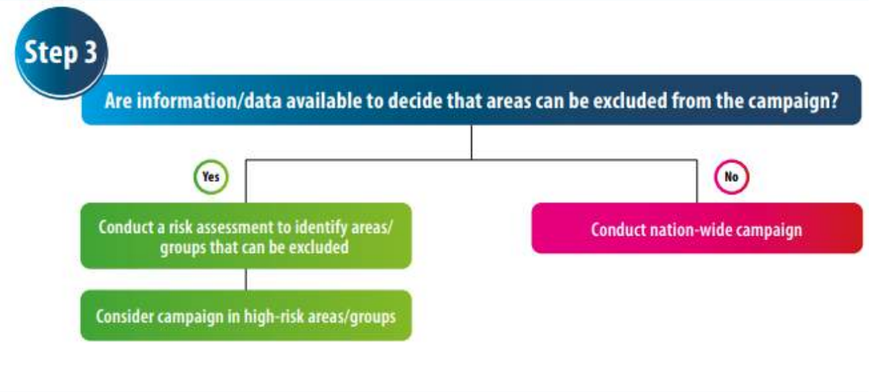
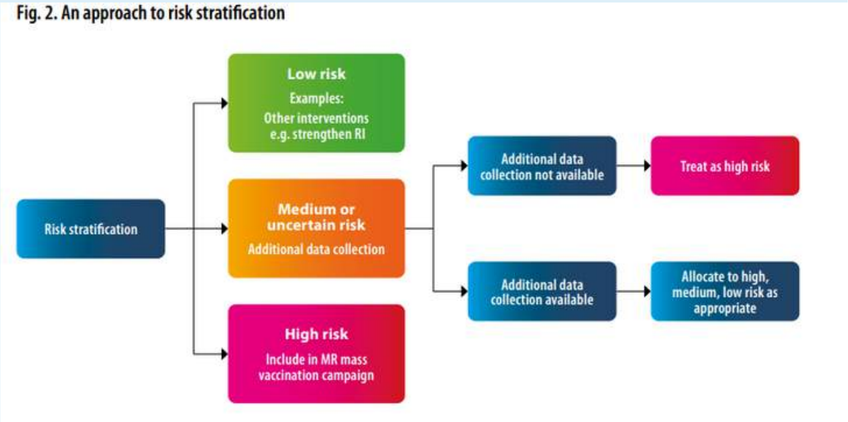
Step 3: Targeted strategies to geographical areas or high-risk groups





- The decision to use a targeted strategy should be guided by an assessment of the availability and **quality of data**.
- Where subnational data are of sufficient quality, exclude **low-risk areas or groups** from campaign
- Other considerations:
  - Integration with other programmes and how would targeted or selective strategies affect integration?
  - Could non-campaign strategies more effectively and efficiently reach unvaccinated and under vaccinated children and missed communities?
  - Might exclusion raise concerns about fairness and equity?
  - Does the local health system have capacity?

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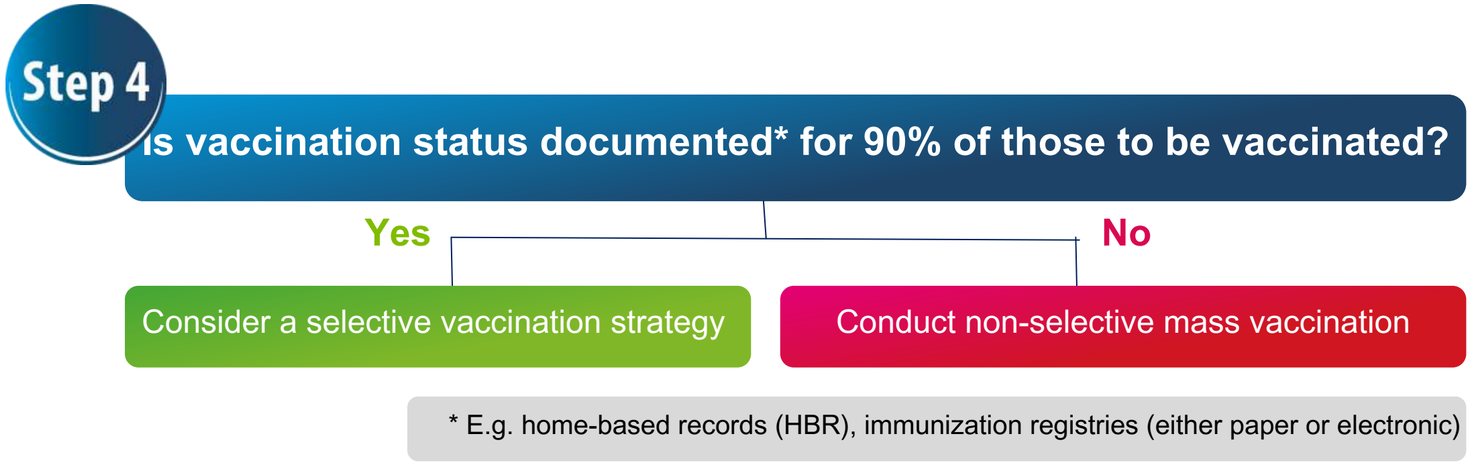
Step 4: Selective strategies where documentation is available

- Only vaccinate individuals without documentation of previous vaccination.
- Threshold of 90% availability unless part of an integrated campaign.
  - As all individuals eligible for any of the interventions to be offered (e.g. OPV, nutrition supplementation or screening, bednet distribution) will participate, the desired effectiveness may be achieved regardless of the prevalence of documentation of vaccination history.



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Selective strategy, implementation

A

Convene all families with children in the **targeted age group to vaccination posts** and screen them there. Sufficient qualified staff should be on hand to ensure accurate screening as well as vaccination.

- If the campaign is to provide only M/MRCV, this model risks disappointing the families of fully vaccinated children as they will receive no intervention. This risk is lower in integrated campaigns.

B

A **pre-campaign house-to-house screening** can give appointments to children who have missed doses. The operational costs of this model are the highest.

C

House-to-house vaccination and screening of children at home has been used but raises safety concerns; house-to-house channeling could be an alternative.

D

Prescreening can be based on clinic records. Only children missing 1–2 doses of M/MRCV are invited for vaccination during the campaign. There should be special provisions made to ensure that children who are not in the registers (zero-dose, new to the area, etc.) are reached through other methods.

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Note on use of targeted and selective strategies

- **Countries can choose multiple strategies because they are not mutually exclusive.**
- A country could conduct a targeted non-selective campaign in some areas, a selective campaign in others, and the age-range could also vary on the basis of identified immunity gaps in different communities.
- For example, targeted strategies can be implemented along with selective vaccination by conducting a selective campaign in areas that are excluded from mass non-selective vaccination.

Geography	Targeted by community/ age group	Selective by immunization status	Campaign category
National	Yes	Yes	National, targeted selective
		No	National, targeted, non-selective
	No	Yes	National selective
		No	National non-selective
Subnational (targeted)	Yes	Yes	Targeted by geography and community and selective
		No	Targeted by geography and community, non-selective
	No	Yes	Targeted by geography and selective
		No	Targeted by geography and non-selective

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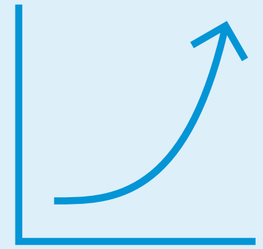
Conclusions

Campaigns can use both targeted and selective strategies.

- There are several examples of countries using selective vaccination in areas excluded from the mass campaign – e.g. Eritrea, Rwanda.

Guidance includes important considerations for implementing targeted and/or selective campaigns.



All campaigns, regardless of the use of selective strategies, can make efforts to improve availability and use of HBRs.

Emphasis on monitoring and evaluation is needed to develop the evidence base for future updates of this guidance.

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Thank you

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Teaser questions!

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Panel Discussions

India | Rwanda | WHO AFRO | WHO HQ

Dr Ratnesh Murugan Dr Hassan Sibomana Dr Balcha Masresha Dr Sylvester Maleghemi

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Discussions

Comments, Questions and Answers

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Closing

Thank you for your participation

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