

**MEASLES & RUBELLA
STRATEGIC FRAMEWORK
2021-2030**



ACKNOWLEDGMENTS

This document was developed by the Measles & Rubella Initiative, with oversight provided by its Leadership and Management teams. Koby Langley and Mary Agocs (American Red Cross), John Lange, Kate Dodson and Lori Sloate (United Nations Foundation), Robin Nandy and Yodit Salhemarian (UNICEF), William Schluter and Robert Linkins (US Centers for Disease Control and Prevention), and Kate O'Brien, Ann Lindstrand, Katrina Kretsinger and Natasha Crowcroft (WHO) provided invaluable guidance to shape and shepherd the development of this Framework.

The Measles & Rubella Initiative would like to warmly thank the more than 90 experts who provided input through structured consultation throughout the second half of 2019 and early 2020. Experts ranged from countries in all Regions, Measles-Rubella technical working groups and partner institutions, and provided formative thoughts and feedback via interviews, surveys, and face-to-face consultations during the September 2019 Measles and Rubella Initiative (M&RI) Partners' meeting hosted by the American Red Cross.

The experts included key representatives from national governments; members of WHO's Strategic Advisory Group of Experts (SAGE) on Immunization; chairs of the Regional Immunization Technical Advisory Groups; chairs of the Regional Measles-Rubella Verification Committees; the American Red Cross; the Bill & Melinda Gates Foundation; the US Centers for Disease Control & Prevention; the Developing Countries Vaccine Manufacturers Network; the European Centre for Disease Prevention and Control; Gavi, the Vaccine Alliance; the International Federation of the Red Cross; John Snow, Inc.; the Lions Club; Médecins Sans Frontières; the Sabin Vaccine Institute; Save the Children; the Task Force for Global Health; the UN Foundation; UNICEF; the World Health Organization; and the World Bank.

In addition, experts from WHO's SAGE Working Group for Measles and Rubella, WHO (Headquarters and Regional Offices), UNICEF (Headquarters and Regional Offices), UN Foundation, US Centers for Disease Control & Prevention, and the American Red Cross reviewed and commented on the draft versions of the framework.

The Measles & Rubella Initiative would like to specifically thank Thomas Cherian, Melissa Ko, Stefano Malvoti and Carsten Mantel from MMGH Consulting for their assistance throughout the development of this Framework.



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ACRONYMS AND ABBREVIATIONS

MRSP 2012-2020	Global Measles and Rubella Strategic Plan 2012-2020
MRSF 2021-2030	Measles and Rubella Strategic Framework 2021-2030
COVID-19	Coronavirus disease 2019
CP	Core principles
CRS	Congenital rubella syndrome
CSO	Civil society organization
Gavi 5.0	Gavi, the Vaccine Alliance 2021-2025 strategy
GPW13	13th WHO General Programme of Work 2019-23
HCD	Human centered design for health
IA2030	Immunization Agenda 2030
IPC	Infection prevention and control
IT	Information technology
ITFDE	International Task Force for Disease Eradication
JEE	Joint external evaluation
MCV1	First dose of measles-containing vaccine
MCV2	Second dose of measles-containing vaccine
MI4A	Market Information for Access Initiative
MOV	Missed opportunities for vaccination
MR	Measles-Rubella
PHC	Primary health care
PIRI	Periodic intensification of routine immunization
SAGE	WHO Strategic Advisory Group of Experts on Immunization
SDG	Sustainable development goals
SIA	Supplementary immunization activity
SP	Strategic priorities
TIP	Tailoring immunization programmes
TPP	Target product profile
UHC	Universal health coverage
UNICEF	United Nations Children's Fund
WHO	World Health Organization

EXECUTIVE SUMMARY

Measles remains an important cause of morbidity and mortality, accounting for close to 9.7 million cases and more than 140,000 measles-related deaths in 2018¹. Rubella remains endemic in many countries and congenital rubella syndrome (CRS) continues to be reported with long-term consequences. As one of the most contagious diseases and given the need to maintain high population immunity

to prevent outbreaks, measles outbreaks serve as a tracer (the “canary in the coal mine”) that highlights health system weaknesses and inequities. These characteristics position the presence of clusters of measles cases as one of the key indicators to measure the quality and strength of national immunization programmes and of public health programmes in general.



► **Photo:**
Children showing off their finger markings following vaccination in Lao People's Democratic Republic.
WHO/Daniel Hodgson

OVERVIEW OF GLOBAL MEASLES AND RUBELLA STRATEGIC PLAN 2012-2020

The Global Measles and Rubella Strategic Plan 2012-2020 (MRSP 2012-2020) rallied efforts to protect and improve the lives of children throughout the world through the control of measles and rubella. Implementation of the MRSP 2012-2020 resulted in the following key achievements over the past decade:

- By the end of 2019, 178 WHO Member States introduced a second dose of measles-containing vaccine (MCV2) and 173 initiated rubella vaccination².
- Global coverage with both MCV2 and rubella vaccines increased to 71% in 2019².
- During 2018, approximately 346 million people received measles vaccination through 45 supplementary immunization activities (SIAs) in 37 countries³.
- Surveillance quality and capacity to detect and respond to outbreaks improved.
- Eighty-two countries were verified as having eliminated measles and eighty-one having eliminated rubella, by the end of 2018³.
- An estimated 23 million deaths were averted due to measles vaccination between 2000-18³.

Although important achievements were made, several contextual changes and implementation challenges impeded progress and contributed to an increasing number of outbreaks and a resurgence in measles cases.

i. 2012 MCV2 coverage was 48% and Rubella coverage was 39%



CONTEXTUAL CHANGES

- A shift in the epidemiology of measles with a higher proportion of cases in young infants and older age groups, highlighting unaddressed immunity gaps.
 - Increasing identification of the role of healthcare acquired infections in sustaining outbreaks.
 - Increased recognition of immunity gaps in refugees and displaced populations as well as cross-border populations who are often not included in the national immunization plans.
 - Disruption in services and cancellation of planned SIAs because of the COVID-19 pandemic, exacerbating immunity gaps.
 - Declining appetite for vertical disease control programmes and non-selective country-wide campaigns.
-

IMPLEMENTATION CHALLENGES

- Health system weaknesses leading to low or very low vaccination coverage with two doses of measles and rubella containing vaccines in several countries leading to persistence of unimmunized children and an over-reliance on unsustainable and disruptive vaccination campaigns.
- Inadequate mechanisms for catch-up vaccinationⁱⁱ to fill the immunity gaps in older children and adults.
- Increasing vaccine hesitancy in several countries leading to declining coverage and increased outbreaks.
- Inadequate monitoring and surveillance quality and capacity for verification of elimination and for identifying chains of transmission to prevent and interrupt measles outbreaks.

ii. Catch-up vaccination – refers to vaccinating an individual with any vaccines missed per the national immunization schedule. It can be delivered through regular routine immunization service delivery (fixed, outreach, mobile, school), periodic intensification of routine immunization (PIRI) activities, or any other strategy to ensure individuals have the opportunity to receive routine immunizations for which they are eligible. This is distinct from the concept of ‘catch-up SIAs’ that are one-time campaigns to vaccinate the main target population responsible for disease transmission in order to rapidly reduce the number of susceptible individuals, other ‘catch-up campaigns’ that sometimes accompany new vaccine introductions, or from the strategy of ‘catch-up, keep-up, follow-up, speed-up’ used for measles elimination in the Region of the Americas

REQUIRED PIVOTS FOR 2021-2030 TIME PERIOD

While the core strategies identified in the 2012-2020 MRSP will remain relevant in the post-2020 period, the following strategic pivots were identified for the next strategic period:

-
- ▶ Efforts to close measles and rubella immunity gaps should shift from a one-size-fits-all approach to the use of efficient and more effective tailored approaches to address local challenges, including the mainstreaming of catch up vaccination through the use of the life-course platform.
-
- ▶ Measles and rubella activities should be firmly embedded within Immunization and other PHC programmes.
-
- ▶ The roles and responsibilities of national and sub-national governments and of global, regional, and national stakeholders should be clearly defined and each held accountable for delivering on their responsibilities.
-
- ▶ Surveillance should progressively shift from disease-specific to comprehensive and sustainable; the data should be used by national ministries of health and partner agencies at all levels for decision making.
-
- ▶ National and sub-national capacity for outbreak preparedness and response should be strengthened by leveraging global health security capacities and processes; data from outbreak investigations should be used to close equity gaps and inform system strengthening plans.
-
- ▶ Cross-border monitoring, information sharing, and collaboration should be strengthened to fill immunity gaps and prevent and respond to measles outbreaks.
-
- ▶ Development and use of innovative delivery platforms and new technologies, e.g. microarray patches and rapid diagnostic test, for delivering vaccines and improving surveillance should be accelerated.
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THE MEASLES AND RUBELLA STRATEGIC FRAMEWORK 2021-2030 AND ALIGNMENT WITH IA2030

The measles and rubella strategic framework 2021-2030 (MRSF 2021-2030) aims to provide a high-level framework that will guide the development of regional and national strategies and operational plans. The MRSF 2021-2030 was developed through a broad consultative process to obtain feedback on achievements and major short falls of the past decade, and to define the strategic pivots and focus areas for the next decade. It will serve as a disease-specific strategy within the umbrella of the Immunization Agenda 2030 (IA2030) structure and is in alignment with other key agency strategy documents, including the 13th WHO General Programme of Work 2019-23 (GPW13), the UNICEF Immunization Roadmap 2018-2030 and the Gavi Alliance 2021-2025 strategy (Gavi 5.0).

The Measles and Rubella Strategic Framework 2021-2030 envisions **“A world free from measles and rubella”**.

The goal for the 2021-2030 period is to **“achieve and sustain the regional measles and rubella elimination goals”**ⁱⁱⁱ.

The MRSF 2021-2030 adopts the structure of IA2030, including its strategic priorities, describing the measles and rubella-specific objectives under each strategic priority along with the focus areas for achieving the objectives. It also describes how the core principles of IA2030 will be applied to each of the priority and focus areas within the context of measles and rubella elimination. The objective of this framework is to guide all stakeholders at country, regional, and global levels to plan and implement more effective measles and rubella elimination and control activities and to raise the ambition level towards achieving a world without measles and rubella.

iii. Measles elimination is defined as “the absence of endemic measles transmission in a defined geographical area (e.g. region or country) for ≥12 months in the presence of a well-performing surveillance system”. Rubella elimination is defined as “the absence of endemic rubella transmission in a defined geographical area (e.g. region or country) for ≥12 months and the absence of CRS cases associated with endemic transmission in the presence of a well-performing surveillance system”. Weekly Epidemiological Record 2013;88(9):89-100.

SECTION 01

Overview

INTRODUCTION

THE VISION

THE GOAL

CORE PRINCIPLES

INTRODUCTION

Measles and rubella vaccination is an integral part of immunization programmes, contributing to the achievement of the global immunization goals and also more broadly to Global Health Security and the Sustainable Development Goals (SDGs)⁴. Measles and rubella vaccination is also central to the Immunization Agenda 2030 (IA2030) by stimulating progress towards universal health coverage and equity in immunization. It could stimulate the establishment of life-course vaccination through strengthening second year of life platforms for the delivery of the second dose of measles-containing vaccine (MCV2) and school-based immunization delivery platforms for catch-up vaccination^{iv}.

The Global Measles and Rubella Strategic Plan 2012-2020 (MRSP 2012-2020) period saw a significant reduction in the measles and rubella disease burden, a steep increase in the introduction of a second dose of measles-containing (MCV2) and rubella vaccines, and improvements in surveillance. During 2018, approximately 346 million people received measles vaccination through 45 supplementary immunization activities (SIAs) in 37 countries. Estimated measles-related deaths declined by 73% and estimated measles cases by 76% from 2000 to 2018. By the end of 2018, 82 and 81 countries were verified as having eliminated measles and rubella, respectively while the Region of the Americas sustained rubella elimination since this was verified in 2015³.

Despite the enormous progress made, the regional measles and rubella elimination targets for 2020 will not be met and emerging challenges are cause of growing concern. The Region of the Americas, which was verified to have eliminated measles in 2016, lost its elimination status in 2018. The global number of reported measles cases more than doubled in only one year from 170,000 in 2017 to 350,000 in 2018⁵. This upward trend in cases continued into 2019 with several countries experiencing large outbreaks of measles. In 2019, the Democratic Republic of Congo, Ukraine and Brazil reported 333,017, 57,282, and 18,203 confirmed cases of measles, respectively while Chad reported over 26,600 suspected cases⁶. Vaccination coverage remains low or very low in several countries. In 2019, 7 countries had MCV1 coverage below 50% and 23 had coverage below 70%, indicating that 30-50% of children in these countries had not received any doses of measles vaccine through the routine service delivery mechanisms⁷.

Several contextual changes and implementation challenges impeded progress towards achieving the measles and rubella elimination targets, as summarized in Table 1. The COVID-19 pandemic that started in late 2019, led to an interruption of routine vaccination services in many countries and cancellation or postponement of planned SIAs. As a result of COVID-19 as of June 2020, 29 countries have postponed measles campaigns, 18 of which are experiencing ongoing measles outbreaks. An additional 13 countries may postpone campaigns later in the year. In all,

iv. Catch-up vaccination – refers to vaccinating an individual with any vaccines missed per the national immunization schedule. It can be delivered through regular routine immunization service delivery (fixed, outreach, mobile, school), periodic intensification of routine immunization (PIRI) activities, or any other strategy to ensure individuals have the opportunity to receive routine immunizations for which they are eligible. This is distinct from the concept of ‘catch-up SIAs’ that are one-time campaigns to vaccinate the main target population responsible for disease transmission in order to rapidly reduce the number of susceptible individuals, other ‘catch-up campaigns’ that sometimes accompany new vaccine introductions, or from the strategy of ‘catch-up, keep-up, follow-up, speed-up’ used for measles elimination in the Region of the Americas..

over 178 million persons are at risk of missing measles shots in 2020. Among these, several countries including Ethiopia, the Democratic Republic of Congo, the Central African Republic and Nepal, have decided to proceed with their campaigns in spite of COVID-19 because of the increasing risk of death from measles virus and are implementing infection prevention and control procedures during the campaigns to reduce the risk of COVID-19 transmission. A prolonged pandemic and a consequent

decline in the global economy has the potential to further impact health systems worldwide and reverse the gains in measles and rubella elimination and control achieved so far. Re-establishing routine immunization services and catching up on missed vaccinations will need to be a priority in the next decade to mitigate the risks of large outbreaks and to get back on track for achieving the measles and rubella elimination and control goals.

▼ **Table 1:** Contextual changes and implementation challenges for achieving measles and rubella goals and targets.

Contextual changes



A shift in the epidemiology of measles with higher proportions of cases in young infants and older age groups, highlighting unaddressed immunity gaps.



Increasing identification of the role of healthcare acquired infections in sustaining outbreaks.



Increased recognition of immunity gaps in refugees and displaced populations as well as in cross-border populations often not included in the national immunization plans.



Disruption in services and cancellation of planned SIAs because of the COVID-19 pandemic, leading to declining coverage and increase in immunity gaps.



Declining appetite for vertical disease control programmes and non-selective country wide campaigns.

Implementation challenges



Health system weaknesses that lead to low or very low coverage with two doses of measles and rubella containing vaccines leading to persistence of unimmunized children and to an over-reliance on unsustainable and disruptive non-selective campaigns in several countries.



Inadequate mechanisms for catch-up vaccination to fill the emerging immunity gaps in older children and adults.



Increasing vaccine hesitancy in several countries leading to declining coverage and resultant outbreaks.



Inadequate surveillance quality and capacity for verification and maintenance of elimination and for identifying chains of transmission to prevent and interrupt measles outbreaks.

THE CASE FOR MEASLES AND RUBELLA ELIMINATION AND CONTROL

Measles remains an important cause of morbidity and mortality, accounting for an estimated 9.7 million cases and more than 140,000 measles-related deaths in 2018¹. In addition, measles may have long-term consequences by predisposing to other infections through a prolonged immunosuppressive effect lasting 2 to 3 years after infection⁸ and by contributing to malnutrition in children. Rubella also has long-term consequences for the estimated 103,000 infants born with congenital rubella syndrome. Figure 1 provides a high level overview for the case for measles and rubella control and elimination.

▼ **Figure 1:** The case for measles and rubella elimination and control⁹



Measles and rubella are important contributors to childhood mortality and morbidity.

Measles predisposes to other infections and contributes to malnutrition.



Measles is a key marker of inequity and its control a marker of the strength of immunization systems.



Measles vaccination accounts for 59 to 76 per cent of the economic benefits from vaccination in the 94 low- and middle- income countries.

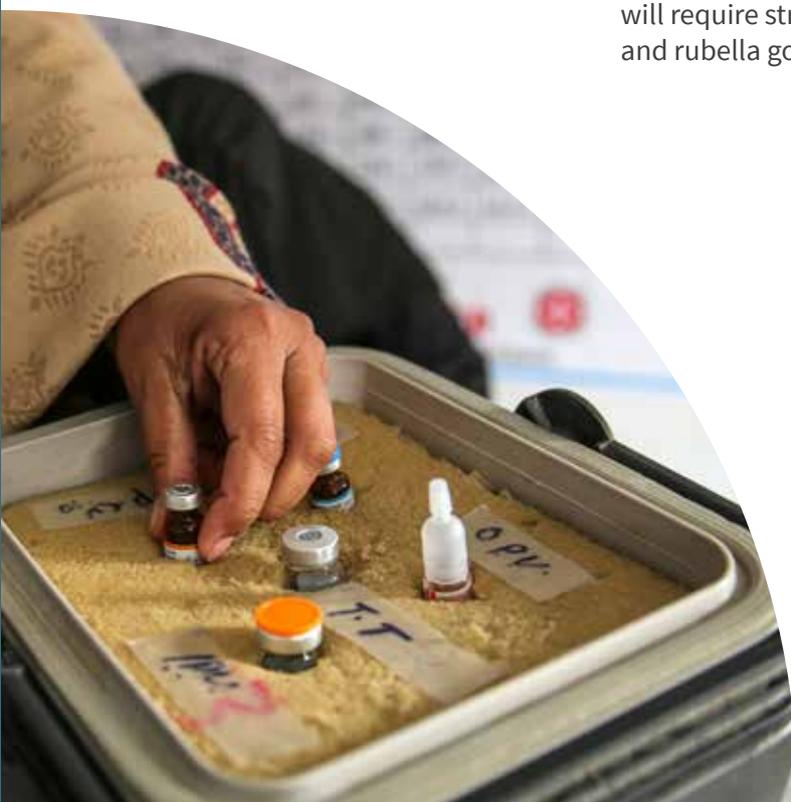
As one of the most contagious diseases with the need to maintain high and equitable population immunity, measles outbreaks serve as tracers (the “canary in the coal mine”) to highlight health inequities and identify gaps where immunization programmes and overall primary health care (PHC) systems need to be strengthened. These characteristics position measles and rubella as one of the key indicators to measure the quality and strength of national immunization programmes and of public health programmes and health systems in general.

Measles vaccination has a high return on investment: in 94 low- and middle-income countries, measles vaccination accounts for 76% of the estimated return on investments of \$ 21 per dollar invested in immunization using the cost-of-illness approach and for 59% of the estimated return of \$ 54 per dollar invested using the value of statistical life approach for the period 2021-2030⁹. As measles vaccine is generally delivered in combination with rubella vaccine, the return on investments will be even greater, given the marginal incremental costs, the systems efficiencies achieved and the additional morbidity prevented.

As we move into the next decade, increasing the focus on measles and rubella is critical to ensure progress towards the SDG3 goal to achieve universal health coverage (UHC) for two reasons: (1) measles and rubella still significantly contribute to morbidity and mortality; and (2) the role of measles and rubella elimination and control activities in strengthening immunization programmes and contributing to PHC by serving as a marker for health system weaknesses and persistent inequities in access to care. The renewed interest in PHC and achieving UHC coupled with the shifts in the immunization environment (e.g., decreased appetite for vertical programmes), along with other contextual changes will require strategic pivots for achieving measles and rubella goals in the next decade.

▼ **Photo:** A health worker prepares measles vaccine in Pakistan.

WHO/Asad Zaidi



REQUIRED PIVOTS FOR 2021-2030 TIME PERIOD

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- ▶ National and sub-national capacity for outbreak preparedness and response should be strengthened by leveraging global health security capacities and processes; data from outbreak investigations should be used to close equity gaps and inform system strengthening plans.
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THE MEASLES AND RUBELLA STRATEGIC FRAMEWORK 2021-2030 AND ALIGNMENT WITH IA2030

The measles and rubella strategic framework 2021-2030 (MRSF 2021-2030) aims to provide a high-level framework that establishes a shared vision, a common goal, priorities, and focus areas for the next decade that will guide the development of regional and national strategies and operational plans. It will serve as a disease-specific strategy within the umbrella of the Immunization Agenda 2030 (IA2030) structure and aims to establish convergence with other key agency strategy documents, including the 13th WHO General Programme of Work 2019-23 (GPW13), the UNICEF Immunization Roadmap 2018-2030 and the Gavi Alliance 2021-2025 strategy (Gavi 5.0).

The MRSF 2021-2030 was developed through a broad consultative process to get feedback on the achievements and major shortfalls of the past decade, as well as the strategic pivots, priorities and focus areas required for the next decade. The consultative process included a desk review of relevant reports and documents followed by consulting with over 70 individuals through interviews and an online survey. These individuals included representatives of national and multilateral agencies, CSOs, academia and national ministries of health. The results from this first consultation phase was shared with a wider group of stakeholders at the Measles and Rubella Partners meeting in November 2019 to obtain further feedback. Based on the stakeholder feedback, the MRSF 2021-2030 was developed through an iterative process under the guidance of the Leadership and Management Teams of the Measles & Rubella Initiative. The MRSF 2021-2030 adopts the general structure of the IA2030 while describing the measles and rubella-specific objectives and focus areas within each of the IA2030 strategic priorities (SPs) and the application of the IA2030 core principles (CPs).

The MRSF 2021-2030 is not meant to serve as a detailed action plan. The objective of this framework is to guide all immunization stakeholders at country, regional, and global levels to plan and implement more effective measles and rubella elimination activities and to raise the ambition level towards achieving a world without measles and rubella.

THE MEASLES AND RUBELLA STRATEGIC FRAMEWORK 2021-2030

Vision



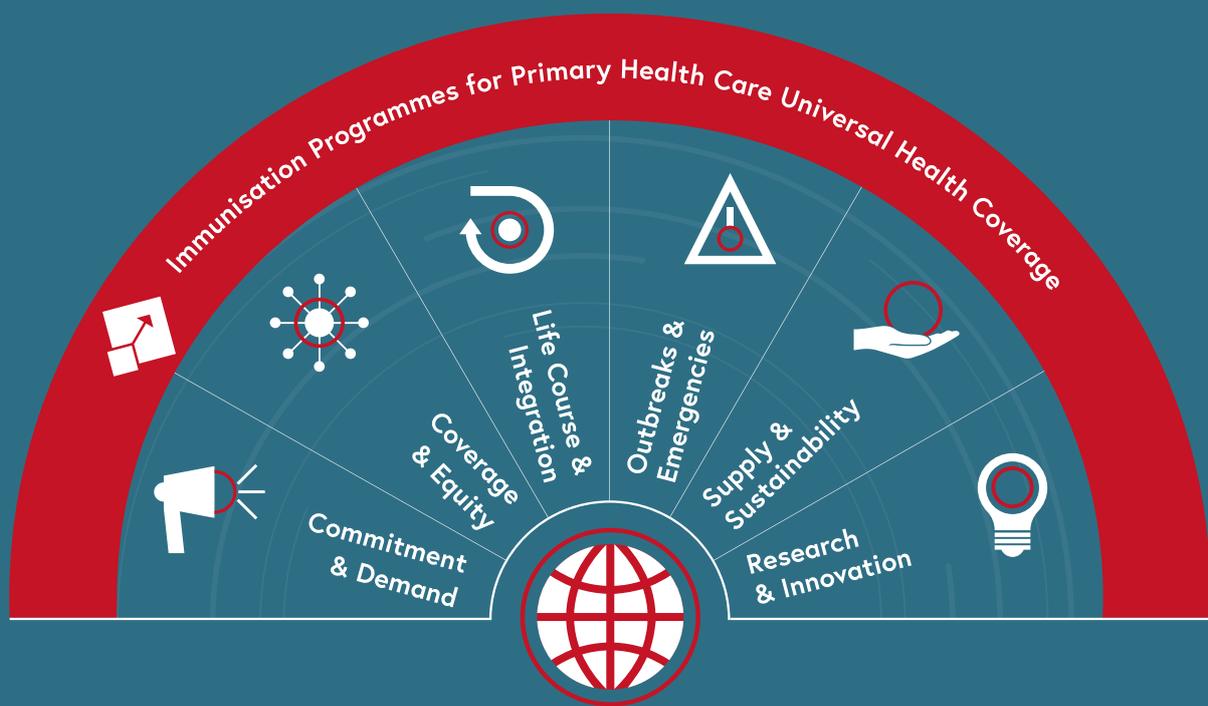
A world free of measles and rubella

Goal



Achieve and sustain the regional measles and rubella elimination goals

Strategic priorities



Core principles



People Centred



Country Owned



Partnership Based



Data Guided

THE VISION



A world free of measles and rubella

Eradication of a disease represents the ultimate sustainable improvement in public health¹⁰. Regional elimination is a stage on the path towards global eradication but is a fragile state that needs to be continuously maintained to prevent importations and subsequent spread. The vision statement reflects the views of the WHO Strategic Advisory Group of Experts (SAGE) and the International Task Force for Disease Eradication (ITFDE), which state that measles can and should be eradicated, though the timelines and targets for eradication will only be set when the necessary conditions for eradication are met^{11,12}.

THE GOAL



Achieve and sustain the regional measles and rubella elimination goals

The measles and rubella goals for 2030 reflect the fact that all six WHO regions have established or expressed a commitment to achieving regional elimination of measles and rubella^v. The targets and milestones for achieving elimination vary between regions and this variability will be captured in the monitoring and accountability framework that will eventually accompany the MRSF.

v. Measles elimination is defined as “the absence of endemic measles transmission in a defined geographical area (e.g. region or country) for ≥ 12 months in the presence of a well-performing surveillance system”. Rubella elimination is defined as “the absence of endemic rubella transmission in a defined geographical area (e.g. region or country) for ≥ 12 months and the absence of CRS cases associated with endemic transmission in the presence of a well-performing surveillance system”. Weekly Epidemiological Record 2013;88(9):89-100.

MRSF 2021-2030 STRATEGIC PRIORITIES

The MRSF 2021-2030 adopts the same Strategic Priorities as the IA2030. The objectives for Measles and Rubella under each SP is shown below.



SP1 Primary Healthcare and Universal Health Coverage

Incorporate all measles and rubella activities, including surveillance and case management, as key components of effective primary health care (PHC) systems in support of universal health coverage (UHC).

Develop and enhance measles and rubella surveillance as part of a comprehensive surveillance platform and improve the collection and use of monitoring and surveillance data for action.



SP2 Commitment & Demand

Improve ownership and accountability of measles and rubella goals and targets at all levels and improve community demand for and uptake of measles and rubella containing vaccines.



SP3 Coverage & Equity

Identify and close immunity gaps to measles and rubella by effectively utilizing all relevant contacts between individuals and the health system, establishing or strengthening new contact points where required, and using targeted approaches to reach underserved populations.



SP4 Life-Course & Integration

Leverage the life-course approach for delivery of the second routine dose of measles and rubella containing vaccines and for catch-up vaccination; and integrate measles and rubella activities with other health and non-health activities.



SP5 Outbreak & Emergencies

Ensure outbreak preparedness for timely detection and effective response to limit the spread of measles and rubella and reduce related morbidity and mortality.



SP6 Supply & Sustainability

Ensure continued, timely and quality supply of measles and rubella containing vaccines, vaccination supplies and laboratory reagents and that measles and rubella activities, including surveillance, are sustainably financed.



SP7 Research & Innovation

Foster research and innovation to overcome barriers to achieve high measles and rubella population immunity and to generate and use high quality disease and programme data.

OVERARCHING GUIDING PRINCIPLES

In alignment with IA2030, the MRSF 2021-2030 has four core principles (CP) that are applied to each SP. The section below provides an overview of the CPs of MRSF 2021-2030.



CP1 People-focused

Identifying under-immunized populations and communities, defining the root causes of under-vaccination, and tailoring gender-responsive interventions to ensure high and equitable access to vaccination for all individuals and communities.



CP2 Country-owned

Improving country ownership at national and sub-national levels to ensure that measles and rubella indicators and milestones are prioritized and monitored at all administrative levels. Ensuring all stakeholders commit to and are held accountable for achieving a set of agreed goals, targets and milestones for measles and rubella within their national health plans.



CP3 Partnership-based

Establishing partnerships to maximize the impact, accelerate progress in achieving shared goals, promote sustainability, and create synergies in delivering packages of interventions. Strengthening and expanding measles and rubella partnerships, particularly at the local level, across: (i) disease control programmes; (ii) organizations, particularly CSOs; (iii) private sector (corporate and private service providers); and (iv) non-health sectors, e.g. education.



CP4 Data-guided

Generating high quality monitoring and surveillance data and using them at all levels to monitor progress, drive decision-making, evaluate strategy effectiveness, and inform operational planning to effectively and efficiently close measles and rubella immunity gaps.

SECTION 02

Strategic Priorities

**SP1 PRIMARY HEALTHCARE AND UNIVERSAL
HEALTH COVERAGE**

SP2 COMMITMENT & DEMAND

SP3 COVERAGE & EQUITY

SP4 LIFE COURSE & INTEGRATION

SP5 OUTBREAK & EMERGENCIES

SP6 SUPPLY & SUSTAINABILITY

SP7 RESEARCH & INNOVATION

STRATEGIC PRIORITIES

In alignment with IA2030, the MRSF 2021-2030 has seven SPs. The sections below briefly describe the measles and rubella-specific objectives and focus areas under each SP and how the CPs may be applied. It should be noted that **although each SP is presented separately, they are interconnected, and all are needed to achieve the MRSF's goal**. For example, surveillance is and will continue to play a key role

to support the achievements of the objectives of each SP. Further, SPs 2 (commitment and demand), 3 (coverage and equity), and 4 (life-course and integration) must be holistically applied to achieve the needed high population immunity. The SPs and CPs apply to stakeholders at the global, regional, national, and subnational levels. Each SP includes some illustrative actions that could be taken.

► Photo: A team of health workers provide vaccination outreach service to remote villages in Fiji.
WHO/Yoshi Shimizu





STRATEGIC PRIORITY

01

Primary Health Care and Universal Health Coverage

OBJECTIVE 1

Incorporate all measles and rubella activities, including surveillance and case management, as key components of effective PHC systems in support of UHC.

KEY FOCUS AREAS

Establish appropriate linkages between vaccination and other health interventions to achieve UHC. Planning and delivery of measles and rubella containing vaccines must be linked to the delivery of other scheduled vaccinations and health interventions to improve efficiencies. Close collaboration and cohesive actions of all relevant programmes should be fostered to improve the uptake of each of the concomitantly administered interventions.

Use measles outbreaks as the trigger for action to improve universal access to a minimum package of health interventions. As measles outbreaks highlight communities that lack or do not access basic health services, measles serves as a marker of inequity in health service delivery. An outbreak of measles could serve as the trigger for tailored interventions in and beyond immunization as well as for identifying gaps where system strengthening is needed. Outbreak response should include root cause analysis to define the reasons for immunity gaps, with proposals for sustainable remedial actions that promote the reintegration of immunization into the PHC system where required. In addition to vaccination, outbreak response must take a more holistic approach, including appropriate case management and nutritional support.

OBJECTIVE 2

Develop and enhance measles and rubella surveillance as part of a comprehensive surveillance platform and improve the collection and use of monitoring and surveillance data for action.

KEY FOCUS AREAS

Strengthen comprehensive surveillance. Surveillance is an essential component of measles and rubella elimination, as well as immunization programmes in general. Data on measles cases, together with their geographic and age distribution highlight immunity gaps that are not always identified by monitoring vaccination coverage alone. Surveillance data serve to guide effective operational planning. With an increase in the number of disease control programmes, it is important to pivot away from fragmented, vertical, and unsustainable surveillance structures. Collaborations across different disease programmes to share a common governance mechanism, support the strengthening of national core capacities for surveillance, and share laboratory networks and quality control processes will lead to a more efficient, sustainable, and comprehensive surveillance system.

Strengthening comprehensive surveillance systems to meet elimination standards will also improve the ability to prevent, detect and control measles and other disease outbreaks in a timely manner. While sustainable surveillance that meets established standards¹³ is primarily the responsibility of national governments, technical support and coordination at regional and global levels are essential for quality assurance and data sharing. This includes maintaining and further enhancing the support provided through the Global Measles and Rubella Laboratory Network (GMRLN)¹⁴. Where measles and rubella surveillance activities were interrupted as a result of the COVID-19 pandemic, these should be re-established as early as possible. Capacities for case detection, investigation and contact tracing established in response to the COVID-19 pandemic should be leveraged to further strengthen surveillance systems.

Improve the collection and use of immunization monitoring data across all administrative levels and disease programmes. The availability of high-quality monitoring data at all administrative levels is essential to monitor programme performance, identify gaps, and inform operational decisions to achieve measles and rubella elimination and control. Renewed efforts will need to be made to improve the quality of data in accordance with recent recommendations¹¹.

Examples of potential actions for surveillance

Promote and strengthen comprehensive surveillance systems supported by laboratory networks.

Promote the training of health workers in early detection, notification and investigation of measles and rubella cases using standardized case definitions, tools, and templates for collecting data.

Develop integrated or interoperable and sustainable data systems to facilitate the collection and sharing of data.

Leverage innovative technologies for data collection and analysis to facilitate the timely availability and use of surveillance and monitoring data.

Supplement routine data collection with surveys and serosurveys to validate the administrative data, identify immunity gaps and collect qualitative information on determinants of vaccination.

Utilise data generated by different disease programmes, where available, to identify gaps in service delivery.

Promote recording and sharing of SIA data and sharing of information across disease initiatives on unvaccinated communities or unmapped settlements.

▼ **Photo:** A baby being vaccinated in Côte d'Ivoire. Nurses are wearing masks and gloves to protect against the Coronavirus.

UNICEF/ Frank Dejo



APPLYING CORE PRINCIPLES TO SP1



CP1 People-focused

Integrate the delivery of measles and rubella vaccination activities with other health interventions to increase convenience, create efficiencies and improve uptake of all the linked interventions.



CP2 Country-owned

Governments and all national stakeholders ensure that measles and rubella activities are optimally financed and an integral part of PHC; contribute to the achievement of UHC; and that measles indicators serve as a tracer for the overall performance of PHC, e.g. MCV2 coverage continues to serve as an indicator to measure progress of SDG3.



CP3 Partnership-based

Coordinate and collaborate with other disease initiatives (e.g. polio, yellow fever, meningitis, cholera, tetanus, influenza, human papilloma virus, Japanese encephalitis, malaria) and health programmes (e.g. maternal, child and adolescent health) given the shared objectives and actions. Further develop partnerships with non-health sectors (e.g. education) and CSOs to expand delivery platforms, increase efficiencies and contribute to the achievement of SDG3.



CP4 Data-guided

Ensure surveillance and programme monitoring are the cornerstone of the MRSF 2021-2030, so the use of these data, including subnational level data, lay the foundation to identify the un- and under-immunized and develop tailored strategies.



STRATEGIC PRIORITY

02

Commitment & Demand

OBJECTIVE

Improve ownership and accountability of measles and rubella goals and targets at all levels and improve community demand for and uptake of measles and rubella containing vaccines.

KEY FOCUS AREAS

Conduct regular assessment of progress against measles and rubella goals, targets, and milestones and establish accountability processes. Commitment by national governments and all key stakeholders to the global, regional, and national measles and rubella goals, targets and milestones are critical to success. Commitment is demonstrated through the regular assessment of progress against the relevant indicators, being accountable for achieving relevant targets and milestones and allocating adequate resources to achieve targets.

Strengthen and sustain political will to achieve measles and rubella goals. Political will and leadership are critical to success. All stakeholders should work collectively to strengthen and sustain political will and commitment of global, regional, and national leaders to achieving measles and rubella elimination goals.

Strengthen national and sub-national capacity for community engagement, demand creation, and risk communication. Countries should improve national and sub-national capacity for community engagement, demand creation, and risk communication, leveraging lessons learnt from other efforts and using both traditional and modern communication and demand creation strategies and techniques to enhance trust, and improve the uptake of measles and rubella containing vaccines. Establishing partnerships with other disease control initiatives and programmes (e.g. within the health or in non-health sectors) will create efficiencies and amplify the impact.

Support countries in identifying barriers to vaccine uptake and develop tailored strategies. The Tailoring Immunization Programmes (TIP)¹⁵, Human Centred Design for Health (HCD)¹⁶ and other similar approaches should be leveraged to promote structured, adaptable and participatory processes to target under-vaccinated or hesitant populations using behavioural insights to understand the barriers and enablers of vaccination and to design, implement and evaluate tailored, gender-responsive interventions.

Examples of potential actions in commitment and demand generation

Establish national monitoring, evaluation and accountability processes that include relevant indicators for measles and rubella.

Use social media to disseminate correct and reliable information about measles and rubella and on the risks and benefits of vaccination.

Monitor the influence of social media and anti-immunization movements on caregivers' attitudes, beliefs, immunization intention and actions and develop appropriate strategies to respond.

Enhance the inter-personal communication skills and knowledge of frontline health workers about measles and rubella.

Design and implement tailored approaches for underserved, and disadvantaged communities.

Proactively implement plans to prevent and respond to adverse events following immunization and to rumours and misinformation about vaccination.

APPLYING CORE PRINCIPLES TO SP2



CP1 People-focused

Actively engage communities to design and implement high-quality service delivery that is responsive to people's needs.



CP2 Country-owned

Work with political leaders, civil society, and immunization champions at the country level to create awareness, build trust and advocate for improving the uptake of vaccination.



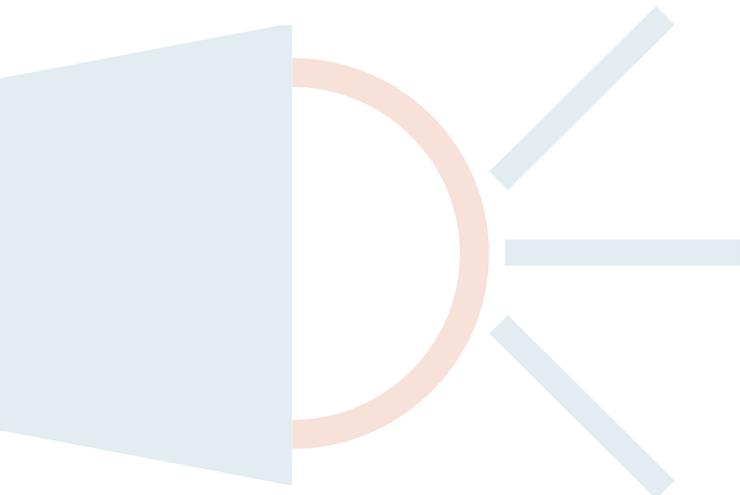
CP3 Partnership-based

Develop partnerships with other disease programmes, non-health sectors, CSOs and the private sector to create efficiencies and build national political will towards immunization in a coherent, rather than in a fragmented vertical fashion.



CP4 Data-guided

Use data to identify communities and areas with low vaccination coverage and conduct formative research to identify root causes for low uptake, monitor community perception and design tailored strategies.





STRATEGIC PRIORITY

03

Coverage & Equity

OBJECTIVE

Identify and close immunity gaps to measles and rubella by effectively utilizing all relevant contacts between individuals and the health system, establishing or strengthening new contact points where required, and using targeted approaches to reach underserved populations.

KEY FOCUS AREAS

Promote integrated service delivery to achieve and maintain high coverage of two doses of measles and rubella containing vaccines. Routine delivery of immunization services integrated with the delivery of other scheduled child health interventions must become the standard for achieving and maintaining high population immunity. Such an approach will provide opportunities for joint actions to improve coverage and strengthen the second year of life platform. In situations where routine services have been interrupted for an undetermined period (e.g., COVID-19 pandemic), children who miss their scheduled doses of vaccination should be carefully monitored and strategies developed to provide catch-up vaccination.

Identify and plan gender-responsive interventions to ensure that vulnerable populations (e.g. migrants, nomadic, socially marginalized, urban poor, indigenous and conflict affected) are vaccinated. This includes ensuring equity-based policies and adequate financing to support vaccination in fragile countries and vulnerable populations and ensuring their inclusion in national immunization plans. Different delivery approaches will need to be explored, such as outreach and differentiated delivery strategies for special populations as well as periodic intensification of routine immunization (PIRI) services. The sustainability of these approaches will be key to long-term success.

Examples of potential actions on coverage and equity

Promote discussion and review of the choice of supplementary means of vaccine delivery to fill immunity gaps, including:

- selective delivery of a supplementary dose, i.e. irrespective of prior immunization history, through SIAs; and
 - selective delivery of a routine dose, usually in combination with other vaccinations, through PIRI.
-

Establish and implement strategies to improve vaccination coverage in urban slums and unauthorized urban settlements.

Identify and address gender barriers to increasing MCV1 and MCV2 coverage (both service provision and demand side factors).

Mainstream the review of data at national and sub-national levels to identify immunity gaps, develop strategies, identify successes and challenges, and inform operational decisions.

Establish mechanisms and partnerships to promote joint preventive campaigns with other disease initiatives.

Establish quality criteria for monitoring the performance and impact of SIAs; criteria should include the use of SIAs to improve routine vaccination.

Identify and close remaining immunity gaps through supplementary means of vaccine delivery.

The need for supplementary means to fill immunity gaps remains well recognized, especially among those without access to routine service delivery. The strategic shift is to use tailored approaches (as opposed to sole reliance on non-selective mass campaigns) by using surveillance, immunization coverage and geo-spatial mapping data to focus on targeting those missed by routine services to deliver routine (e.g. through PIRI) or supplementary doses (e.g. through SIAs) of vaccines. While implementing tailored approaches to fill immunity gaps, special efforts must be made to bring the “missed” individuals within the ambit of routine service delivery and strengthen health systems to sustainably deliver all primary health care services to the communities in which they reside. In the early part of the decade and due to the COVID-19 pandemic, a combination of PIRI and SIAs will likely be required in many countries to fill immunity gaps because of missed routine vaccination doses and the cancellation of planned SIAs.

Promote integrated delivery of vaccines and other non-vaccine preventive interventions during preventive campaigns to create efficiencies and maximize impact.

Where indicated and feasible, joint preventive vaccination campaigns with other disease initiatives, e.g. polio, Yellow Fever, Cholera or Meningococcal meningitis vaccination, or during vaccination campaigns during the World Immunization Week should be planned and implemented. Where appropriate and feasible, other non-vaccine preventive interventions (e.g., vitamin A) may be included.

APPLYING CORE PRINCIPLES TO SP3



CP1 People-focused

Consider the needs and perspectives of targeted populations and take a holistic approach to achieve sustainable high and equitable coverage.



CP2 Country-owned

National immunization programmes take the responsibility for identifying barriers to vaccination and implementing tailored, but sustainable strategies to fill all immunity gaps.



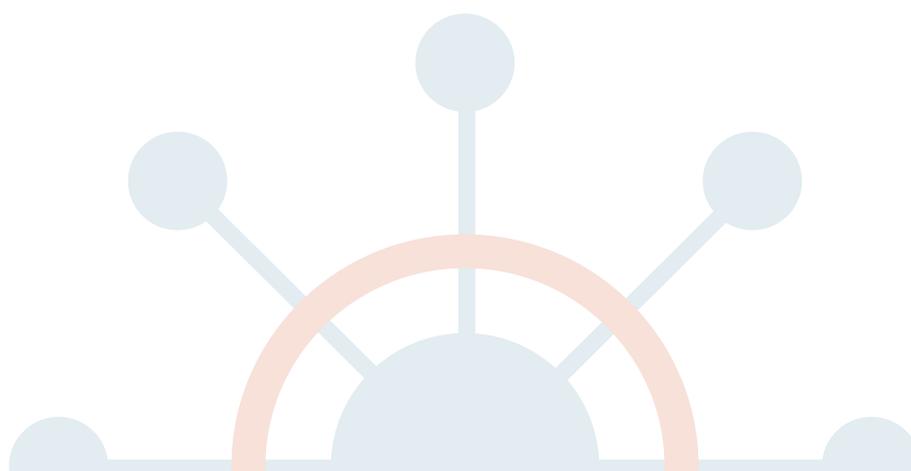
CP3 Partnership-based

Strengthen relationships with CSOs and other national or sub-national level organisations to play an increasing role in identifying and designing interventions to close immunity gaps.



CP4 Data-guided

Use data to identify immunity gaps and inform the planning and monitoring of differentiated vaccination approaches.





STRATEGIC PRIORITY

04

Life-Course & Integration

OBJECTIVE

Leverage the life-course approach for delivery of the second routine dose of measles and rubella containing vaccines and for catch-up vaccination; and integrate measles and rubella activities with other health and non-health activities.

KEY FOCUS AREAS

Leverage the life-course approach for catch-up measles and rubella vaccination¹⁷. Catch-up vaccination will continue to be required for those who missed their two routine doses of measles and rubella containing vaccines. The increasing focus on life-course vaccination, especially at school age, in adolescence and in adulthood will catalyse efforts to mainstream catch-up vaccination and reduce the frequency and scale of SIAs to fill immunity gaps.

Review country policies. Country policies on vaccination (e.g., vaccination eligibility criteria, day-care or school vaccination checks, vaccination of health workers, travellers, etc.) will need review, discussion, and revision to ensure that they enable the life-course approach and facilitate integration.

Establish coordination mechanisms. Governance structures and coordination mechanisms that facilitate joint programming, promote integration between different health programmes and foster inter-sectoral collaboration (e.g. between the health and education sectors, and public and private health sectors) should be strengthened or established to facilitate life-course vaccination. At the national and sub-national levels, such structures and mechanisms will need to consider the local context.



Examples of potential actions on life-course and integration

Apply missed opportunities for vaccination (MOV) strategy more broadly during health facility visits (e.g. at other health check-ups or any other contact with the health system)¹⁸.

Establish day-care or school vaccination checks and catch-up vaccination through school-based health programmes.

Utilise the adolescent health programmes to deliver catch-up doses to unvaccinated adolescents together with HPV and other age-appropriate health interventions.

Establish collaborations with the influenza and occupational health programmes to vaccinate health workers, where they are an important target group.

Implement policies for checking immunization status and catch-up vaccination and, when required, prior to travel to endemic areas.

▲ **Photo:**

A mother holds her son as a nurse prepares to vaccinate him against measles in Democratic Republic of the Congo. UNICEF/Thomas Nybo

APPLYING CORE PRINCIPLES TO SP4



CP1 People-focused

Leverage the life-course platform and integrate measles and rubella vaccination with other interventions to provide additional opportunities to close immunity gaps while improving convenience for the community.



CP2 Country-owned

National governments take responsibility to develop national policies and plans to utilize opportunities for catch-up measles and rubella-containing vaccination and establish the necessary coordination mechanisms between programmes e.g. immunization and occupational health or between sectors, e.g. the health and education sectors.



CP3 Partnership-based

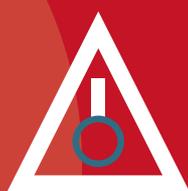
Work in partnership with different health programmes and other sectors, e.g. education, and with civil society to strengthen the life-course platforms and promote integration.



CP4 Data-guided

Utilise data to identify immunity gaps, strengthen life-course platforms and identify opportunities for integration of programmes without losing sight of the key objectives of measles and rubella elimination.





STRATEGIC PRIORITY

05

Outbreak & Emergencies

OBJECTIVE

Ensure outbreak preparedness for timely detection and effective response to limit the spread of measles and rubella and reduce related morbidity and mortality.

KEY FOCUS AREAS

Develop stronger linkages between measles and rubella elimination and control efforts and the International Health Regulations and processes. This should include the use of the Joint External Evaluation (JEE) to assess and strengthen country core capacities to prevent, detect and rapidly respond to measles and rubella outbreaks and promote the inclusion of measles and rubella in the National Action Plans for Health Security.

Strengthen national and sub-national capacity for outbreak preparedness and response in collaboration with other disease programmes. The various national programmes (e.g. epidemiology, immunization, humanitarian and emergency response) and partners should work in close coordination, foster sharing of resources and responsibilities and jointly support national capacity strengthening for outbreak preparedness, detection, investigation and response, including case management, and nutritional support for measles.

Leverage the expertise of CSOs. The ability of CSOs to operate in areas outside the reach of national governments or international agencies should be leveraged to effectively prepare and respond to outbreaks or humanitarian emergencies that predispose to them. Collaboration and partnership with CSOs are key for emergency and outbreak response in countries experiencing protracted conflicts.

Examples of potential actions in outbreak preparedness and response

Promote the development and use of National Plans of Action for Outbreak Preparedness and Response, risk assessment tools, crisis communication plans, guidance on Infection Prevention and Control (IPC) at the hospital level and for active search for cases with community engagement for strengthening measles outbreak preparedness and response.

Identify and engage key CSOs and disease control programmes operating at local levels. Define clear roles and responsibilities.

Develop and conduct joint capacity strengthening activities with other disease programmes and sectors.

Review and revise existing structures to access outbreak response support (at the global / regional levels).

Promote systematic use of root cause analysis following outbreaks to strengthen health systems and PHC delivery.

Strengthen capacity for outbreak investigations to identify root causes of outbreaks and inform corrective actions to improve health systems and routine immunization programmes. An outbreak of measles implies the existence of an immunity gap. Outbreak investigations must be conducted to identify the root causes, identify chains of transmission, and use the results to improve and strengthen the health and immunization systems.

Improve structures and processes to support countries with timely and effective outbreak response. Provide greater clarity on the need, scope, and timelines for an optimal response to measles and rubella outbreaks with vaccination. Streamline global and regional structures and processes, which can include sharing of human resources to conduct epidemiological analyses, assist with campaign planning and implementation, and conduct monitoring activities during and after campaigns.

Improve cross-border collaborations to mitigate the spread of measles and rubella. Cross-border populations are often not included in immunization micro plans, leading to immunity gaps in these communities. Furthermore, population movement across borders increases the risk of importation and spread of outbreaks between neighbouring countries. Increased monitoring of immunization status, timely data sharing and joint action in the border areas will reduce immunity gaps in cross-border communities and mitigate risks of outbreaks.

APPLYING CORE PRINCIPLES TO SP5



CP1 People-focused

Consider the perspectives and needs of all, including fragile, displaced, and other vulnerable communities, in planning and implementing outbreak preparedness and response activities.



CP2 Country-owned

Countries take the responsibility to develop National Plans of Action for Preparedness to strengthen local capacity for outbreak preparedness and response and allocate adequate technical and financial resources.



CP3 Partnership-based

Develop an effective preparedness and response plan to leverage the capacities of global, regional, and national stakeholders, including CSOs, with national governments remaining in charge of the coordinating the response. Explore partnerships outside of the health sector (e.g. in the humanitarian sector).



CP4 Data-guided

Utilise information collected from outbreak investigations to strengthen the routine delivery of vaccination and PHC.



STRATEGIC PRIORITY

06

Supply & Sustainability

OBJECTIVE

Ensure continued, timely and quality supply of measles and rubella containing vaccines, vaccination supplies and laboratory reagents and that measles and rubella activities, including surveillance, are sustainably financed.

KEY FOCUS AREAS

Ensure the timely availability of sufficient vaccine supplies and laboratory reagents and consumables. The right products in the right presentations and at affordable prices will need to be available to meet country and community needs for planned routine vaccination as well as planned and unplanned surges for supplemental immunization and outbreak response. National governments, vaccine manufacturers and global partners should continue to collaborate to ensure vaccine security and improve the health of the supply market for vaccines, supplies and laboratory reagents of assured quality.

Ensure sufficient financing for all measles and rubella activities, including surveillance, are incorporated within health planning and budgeting at all levels. Regular planning and budgeting for measles and rubella activities as part of overall immunization and health planning and budgeting, together with coordination, and advocacy mechanisms should be established to ensure that sustainable funding is available to achieve measles and rubella goals and targets.

Secure financing for fragile areas or countries. Secure sustainable external financial support for conflict-affected and fragile countries via existing (e.g. Gavi) or new financing mechanisms as well as financing at the global and regional levels for coordination, technical support, and monitoring.

Examples of potential actions on supply and sustainability

At the global level, leverage partners' expertise and the existing initiatives (UNICEF, PAHO Revolving Fund, Gavi Roadmap, healthy market framework, and Market Information for Access to Vaccines (MI4A)) to monitor global supply and demand, to establish necessary mechanisms to receive more frequent updates from partners and discuss mid/long-term supply and demand.

Establish mechanisms to ensure supply allocations are reflective of public health priorities in the event of a global shortage of vaccines or other supplies.

Review and improve measles and rubella planning, costing, and budgeting tools in the comprehensive multiyear plan (cMYP) guide.

Include fragile populations in global and regional health and immunization planning and budgeting.

▲ **Photo:**
A mobile vaccination team crosses a stream on its way to a village in Democratic Republic of the Congo.

UNICEF/Thomas Nybo

APPLYING CORE PRINCIPLES TO SP6



CP1 People-focused

Allocate vaccine supply and financing to ensure that the needs of all segments of the population are addressed.



CP2 Country-owned

Match commitments to goals and objectives with sustainable financing to implement the required activities. National governments carry the primary responsibility for financing their immunization and surveillance activities and for working with their partners to ensure sustainable financing flows. National governments also take responsibility for ensuring vaccine and laboratory supplies are available at all peripheral health facilities.



CP3 Partnership-based

Establish partnerships at the country, regional, and global levels to ensure timely availability of measles and rubella containing vaccines and supplies. Further, partnerships will also be needed to develop technical in-country capacities related to vaccine and laboratory supply and sustainability.



CP4 Data-guided

Use data from logistics management information systems to ensure availability and timely distribution of vaccines and laboratory supplies to the point of delivery. Use data on vaccine and laboratory costs, including operational costs, for planning and budgeting.



STRATEGIC PRIORITY

07

Research & Innovation

OBJECTIVE

Foster research and innovation to overcome barriers to achieve high measles and rubella population immunity and to generate and use high quality disease and programme data.

KEY FOCUS AREAS

Conduct formative research. Formative research provides insights and information to tailor immunization services to overcome health system barriers, improve the uptake of vaccination, and document best practices for outbreak control. Share lessons learned from operational and behavioural research and tailor activities to fit different contexts.

Develop and fund innovative vaccine delivery platforms and technologies. Facilitate the delivery of immunization services with fewer human resources, especially to underserved populations, during SIAs and for outbreak response. Discovery, development and use of new technologies to reach such populations should be promoted to accelerate progress towards disease elimination, e.g. through the development and use of the microarray patch technology for vaccination.

Explore, evaluate, and scale up the use of innovative service delivery strategies. Achieving the high levels of vaccination required to interrupt transmission of measles requires new strategies to vaccinate underserved populations or those residing in areas of civil unrest or insecurity. Innovative strategies should be evaluated to develop best practice guidelines to vaccinate such populations.

Improve diagnostics and new information technology (IT) solutions. Develop, evaluate, and scale up diagnostics, e.g. point of care rapid diagnostics, to facilitate the timely detection and investigation of cases of measles and rubella. Evaluate and scale up the use of new IT solutions for recording, reporting, managing, sharing, and using immunization and surveillance data.

Examples of potential actions in research and innovation

Conduct multi-country studies to document best practices for interrupting the spread of measles and rubella during outbreaks.

Evaluate country preferences and develop use cases for innovative delivery platforms and technologies such as the microarray patch technology.

Pilot test and scale up new point of care and rapid diagnostics and define use case scenarios for such tests.

Adapt the TIP and HCD approaches to design more people-centred strategies to improve vaccine delivery and uptake.

Evaluate and scale-up innovative IT solutions for managing immunization and surveillance data.



► **Photo:** A measles and rubella testing laboratory
WHO/Rajiv Kumar

APPLYING CORE PRINCIPLES TO SP7



CP1 People-focused

Reflect the perspectives, priorities, and needs of the communities and individuals in conducting research and development.



CP2 Country-owned

Countries take responsibility for strengthening local research capacity, conduct relevant formative research and evaluate innovative approaches and tools.



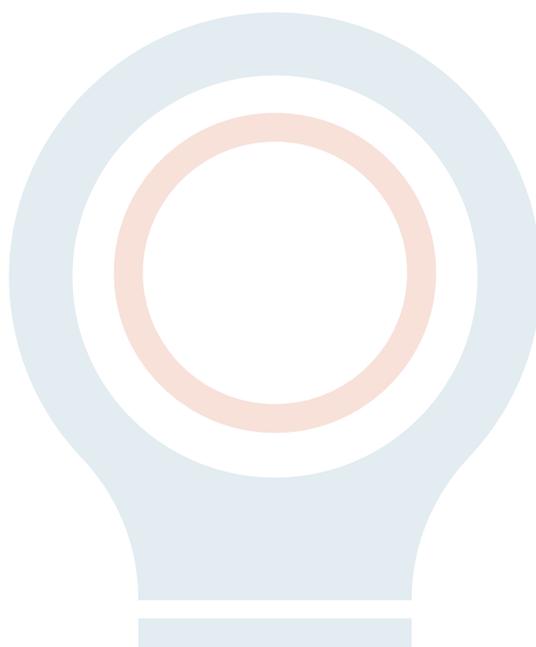
CP3 Partnership-based

Leverage the complementary expertise of different stakeholders to develop innovative technologies, evaluate their applicability and effectiveness, and scale-up their use.



CP4 Data-guided

Use data to inform research on unmet needs and programmatic barriers; share data on research and innovations to inform its applicability and use for achieving measles and rubella goals.



SECTION 03

Operationalization

OPERATIONALIZATION

The MRSF 2021-2030 represents a high-level framework that will guide actions during the next decade but does not capture the details of the operational actions required to fully implement the strategy. These details will need to be developed and included into regional and national strategic and operational plans, which

consider the local context. Synchronization of operational plans with the respective regional and national planning cycles, which may cover a shorter period than the 10-year timeframe of this strategy, may allow the flexibility to adapt to the evolving situation during the decade.

MONITORING AND ACCOUNTABILITY

The MRSF 2021-2030 will be accompanied by a robust monitoring and accountability framework that will include indicators, targets, and milestones as well as a description of the process for monitoring and accountability. Measles and rubella specific goals and indicators in IA2030 will be adopted by the MRSF 2021-2030 and accompanied by additional measles and rubella-specific indicators to monitor progress and understand root causes of success or failure. The regional goals, indicators and targets will also be consolidated and represented in the monitoring and accountability framework of MRSF 2021-2030. At the global and regional levels, the monitoring processes will be harmonized and coordinated with the overall monitoring and evaluation processes for IA2030 to eliminate overlaps or redundancies and reduce the reporting burden on countries. Similarly, the regional and national operational plans will need to be accompanied by monitoring and accountability frameworks and processes at the respective levels. The regional and national milestones and targets will be established based on the local context.

To promote accountability, stakeholder roles and responsibilities will be defined and accompanied by relevant monitoring indicators. All stakeholders will need to commit to monitoring and reporting on the indicators and targets relevant to them.

MANAGEMENT AND COORDINATION

Globally, operationalising the MRSF 2021-2030 will focus on components that are best coordinated globally, with alignment among global stakeholders. It will require communication and advocacy to maintain momentum, mobilise support for MRSF 2021-2030, and promote buy-in to its vision, goal, strategic priorities, and core principles. Appropriate mechanisms for operationalising the regional and national strategies and/or operational plans will be established at the respective levels. Management and coordination at the global and regional levels will be aligned to the governance processes established for the IA2030. The Measles and Rubella Initiative will provide oversight and coordination for the implementation of the MRSF 2021-2030 and will be responsible for global level advocacy and resource mobilization, coordination of technical support, and global level monitoring and evaluation.

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