

## General

### **Reducing measles mortality in emergencies (WHO/UNICEF Joint Statement)**

[WHO/V&B/04.03](#)  
page 3

Urgent, structured and coordinated supplementary immunization activities, together with vitamin A supplementation, are the most effective means of reducing measles mortality during and after complex emergencies. UNICEF and WHO will fully support national authorities and other partners to ensure that all children are immunized against measles.

### **Immunization in practice: a practical resource guide for Health workers 2004 update\_\_\_\_\_Module 1: Target diseases**

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Vitamin A supplementation can be combined with immunization services for children and women when health officials know or suspect that vitamin A deficiency is present in an area or among a certain population. Vitamin A may be given at the same time as immunization.

Opportunities for linking Vitamin A and routine immunization are shown in Appendix 1\_20.

The optimal interval between (Vitamin A) doses is 4-6 months. The minimum recommended safe interval between doses is one month. The interval between doses can be reduced to treat clinical vitamin A deficiency and measles cases.

### **Immunization in practice: a practical resource guide for Health workers 2004 update\_\_\_\_\_Module 6: Holding an immunization session**

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If your country provides vitamin A supplementation during routine immunization, you must screen mothers and children younger than 5-years-old for vitamin A supplementation at every immunization contact.

Ideally, infants and children should receive vitamin A doses of 100 000 IU (6-11 months) or 200 000 IU (12-59 months) every 4-6 months. Repeat supplementary doses should never be less than 4 weeks apart unless the child is being treated for measles or eye signs of VAD.

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If vitamin A was distributed during NIDs in your program area within the past four months:

- \_ Assume that all infants and children 6-59 months of age have received a dose (or 12-59 months in countries where infants under 12 months are not given vitamin A with NIDs).
- \_ Do not give another dose unless the caretaker says the child did not participate in NIDs.
- \_ Do not look for records as vitamin A doses given at NIDs are not meant to be recorded due to the difficulty of recording at mass campaigns.

### **Immunization in practice: a practical resource guide for Health workers 2004 update\_\_\_\_\_Module 6: Holding an immunization session**

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Vitamin A capsules do not need to be stored in a refrigerator and may be kept out of the cold chain but, like vaccines, they must be handled with care.

They must be kept dry.

They must be kept out of direct sunlight.

They must not be frozen.

Store the 100 000 IU and 200 000 IU capsules in separate, labelled bottles to avoid mixing up the two doses.

When you open a new bottle, put the date on it. An opened bottle can be used no longer than a year or till the expiry date, whichever comes first.

### **WHO-UNICEF joint statement on strategies to reduce measles mortality worldwide**

[WHO/V&B/01.40](#)

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Strategies for achieving sustainable reduction of measles mortality:

Goal: Reduce the number of annual measles deaths by half by 2005.

1. Routine immunization: achieve >90% routine vaccination coverage (in each district and nationally) with at least one dose of measles vaccine administered at 9 months of age or shortly thereafter.
2. Second opportunity for measles vaccination: for all children through routine or supplemental activities.
3. Measles surveillance: establish effective surveillance for measles to report regularly the number, age and vaccination status of children contracting or dying from measles, to conduct outbreak investigations and to monitor immunization coverage.
4. Improve management of complicated cases: including vitamin A supplementation and adequate treatment of complications.

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Strategies for achieving and maintaining interruption of indigenous measles transmission

Goal: Achieve and maintain interruption of indigenous measles transmission in large geographical areas.

1. Routine immunization: achieve very high (i.e. > 95%) immunization coverage (in each district and nationally) with the first dose of measles vaccine administered through routine services.
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3. Measles surveillance: investigation and laboratory testing of all suspected measles cases (case-based surveillance). Isolation of measles virus should be attempted from all chains of transmission.
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### **WHO-UNICEF joint statement on strategies to reduce measles mortality worldwide**

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Measles immunization provides an opportunity to reach children with other measures that improve overall child health, including:

- \_ supplemental vitamin A doses;
- \_ rubella immunization and surveillance activities.

### **Measles vaccines (WHO position paper)**

[WER 2004, vol. 79, 14, pp 130-142](#)  
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Vitamin A supplementation has been shown to markedly reduce measles-associated mortality in developing countries and should always be given to measles patients in areas where vitamin A deficiency is prevalent.

### **WHO/UNICEF joint statement - Global plan for reducing measles mortality 2006-2010**

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In conflict or emergency areas, WHO and UNICEF have a commitment to ensure that, at a minimum, measles vaccine and vitamin A supplements are administered. (WHO/UNICEF joint statement: reducing measles mortality in emergencies, 2002.)

### **WHO-UNICEF guidelines for developing a comprehensive multi-year plan (cMYP)**

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(T)here are real benefits to combining immunization with three other interventions, namely vitamin A (VitA) supplementation, the distribution of insecticide-treated bednets for malaria prevention, and anthelmintics.

The cost of integrating the national immunization programme (NIP) service delivery with other health programmes may be incremental to the NIP budget, as some costs might be included in other programme budgets. However, incremental costs such as transport of bednets may need to be included within the immunization budget if not covered elsewhere.

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## **Measles**

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Urgent, structured and coordinated supplementary immunization activities, together with vitamin A supplementation, are the most effective means of reducing measles mortality during and after complex emergencies. UNICEF and WHO will fully support national authorities and other partners to ensure that all children are immunized against measles.

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Strategies for achieving and maintaining interruption of indigenous measles transmission

Goal: Achieve and maintain interruption of indigenous measles transmission in large geographical areas.

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## Policy

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Vitamin A supplementation can be combined with immunization services for children and women when health officials know or suspect that vitamin A deficiency is present in an area or among a certain population. Vitamin A may be given at the same time as immunization.

Opportunities for linking Vitamin A and routine immunization are shown in Appendix 1\_20.

The optimal interval between (Vitamin A) doses is 4-6 months. The minimum recommended safe interval between doses is one month. The interval between doses can be reduced to treat clinical vitamin A deficiency and measles cases.

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[WHO/IVB/05.11](#)  
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### **WHO-UNICEF guidelines for developing a comprehensive multi-year plan (cMYP)**

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## **Program Management**

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## **Rubella**

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## **Schedule**

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## Vaccine Administration

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## Vaccine Handling

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