



Measles and Rubella in German-Speaking Countries/Areas

Current Issues and Challenges

**Report of the meeting
WHO Regional Office for Europe and Robert Koch Institute Berlin,
Germany**

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Resolution from the meeting

Over the last decade, vaccination coverage and surveillance for measles and rubella have significantly improved in German-speaking areas. Despite this success, and despite the elimination of measles in many parts of the world, measles epidemics continue to occur in western and central Europe. Measles is a serious and occasionally even fatal disease which cannot be treated, but which can be prevented by vaccination. According to UN-resolution A/RES/S-27/2, routine vaccination must be ensured for all children. Furthermore, all 52 Member States in the WHO European Region endorsed the elimination of measles and rubella by the year 2010 at the Regional Committee meeting in 2005 (Resolution EUR/RC55/R7). The Berlin meeting of German-speaking countries and areas has clearly shown that additional measures are required if the goals of measles and rubella elimination are to be met.

There is no simple and uniform way that will lead to success. However, participants of the Berlin meeting agreed that strong political commitment and support for measles and rubella elimination are crucial. Each country should optimize its existing vaccination activities by:

1. Increasing public awareness of the goals.
2. Developing an action plan, taking into consideration local circumstances.
3. Undertaking appropriate measures, locally and at national level.
4. Evaluating overall achievements (e.g., monitoring of vaccination coverage and disease epidemiology).

Additional actions that need to be undertaken include,

- Applying existing laws for preventing infectious diseases.
- Developing national policies to ensure the UN-convention on children's rights for routine vaccination is met.
- Strengthening disease surveillance, timely outbreak detection, investigation and response as well as the required laboratory capacity.
- Improving and validating data on vaccination coverage, especially in children at age 2 years.
- Increasing research efforts and sharing of best practices on successful vaccination strategies.
- Using comprehensive and integrated communication strategies, including campaigns and media work to increase public awareness on the benefits and risks of vaccination and the risks of not being vaccinated.
- Regular training of health workers on the benefits of immunization and ensuring that immunization issues are included in medical and nursing training curricula.
- Defining susceptible populations and addressing them through supplementary immunization activities.

Actions and achievements will be regularly evaluated by WHO.

The group agreed to continue the exchange of experiences and information and to evaluate progress with regular follow-up meetings. The group further agreed to ask WHO to facilitate a communication and information exchange platform.

Berlin, 19 May 2006,

WHO Regional Office for Europe - Robert Koch Institute - Participating Member States

Executive Summary

Thirty-six health experts from four German-speaking countries and areas, the WHO Regional Office for Europe, the European Centre for Disease Prevention and Control, EUVAC.NET and the United States Centers for Disease Control and Prevention met at the Robert Koch Institute, Berlin, 18-19 May 2006. The scope and purpose of the meeting were to review immunization challenges in German-speaking countries with special emphasis on the use of measles vaccine; to share experiences, review surveillance methods and discuss ways to improve the monitoring of vaccination coverage; to share experiences and discuss ways to more effectively address concerns of parents and health professionals about the safety and value of vaccination; and to share experiences about implementing national strategies for measles and rubella elimination and the usefulness of *Eliminating measles and rubella and preventing congenital rubella infection, WHO European Region strategic plan 2005-2010*.

Member States in the European Region approved a resolution at the WHO European Regional Committee in September 2005 (EUR/RC55/R7) entitled *Strengthening national immunization systems through measles and rubella elimination and the prevention of congenital rubella infections*. Public health officials are now defining the strategies and approaches required to reach these targets by 2010 in their national context. The following time schedule was agreed upon at the meeting. WHO will facilitate this process and follow up regularly according to the schedule

Up to Nov 2006	National/local working groups define milestones of national action plans to eliminate measles and rubella.
Nov 2006	National milestones actions implemented with political and financial support.
May 2007	Meeting of participants to evaluate effective and sustainable actions towards measles and rubella elimination implemented in each country/area
Sept 2007	Regional certification commission to define criteria for certification of elimination status in countries.
May 2008	Meeting of participants to evaluate progress toward measles and rubella elimination in each country/area.
Sept 2008	Report to WHO European Regional Committee on progress towards measles and rubella elimination.
2010	Certification of all countries

Time schedule to reach the 2010 measles and rubella elimination targets in German-speaking countries/areas

As an outcome of the meeting, a resolution was supported by all participants, calling for strengthened political commitment and support for measles and rubella elimination.

Proposed actions defined in the report include:

- All countries/areas would exchange fact sheets, brochures and other information material, such as answers to critical questions and translations, electronically and in hard copy.
- All countries/areas agreed that a comprehensive internet presence was crucial to address issues developed by groups opposing immunization.
- All countries/areas were planning a national, rather than a federal, approach to reach elimination targets.
- All countries/areas agreed that public health care staff should be better trained and updated and the general public better informed.
- A framework for collaboration with WHO, EUVAC.NET and ECDC was identified.

Background

In September 2005, the WHO Regional Committee for Europe approved a resolution (EUR/RC55/R7) entitled *Strengthening national immunization systems through measles and rubella elimination and the prevention of congenital rubella infection*. The WHO Regional Office for Europe has published *Eliminating measles and rubella and preventing congenital rubella infection, WHO European Region strategic plan 2005-2010*, which identifies five key strategies to achieve the targets of this resolution:

- Achieve and sustain $\geq 95\%$ coverage with two doses of measles and at least one dose of rubella vaccine through high-quality routine immunization services.
- Provide a second opportunity for measles immunization to susceptible groups.
- Provide rubella immunization opportunities to all rubella-susceptible children, adolescents and women of childbearing age.
- Strengthen surveillance systems by rigorous case investigation and laboratory confirmation of suspected cases.
- Improve the availability of high-quality, valued information for health professionals and the public on the benefits and risks associated with measles and rubella immunization.

The objectives of the meeting of German-speaking countries and areas were:

- To review immunization challenges in German-speaking countries and areas, with special emphasis on the use of measles vaccine.
- To share experiences, review surveillance methods and discuss ways to improve the monitoring of vaccination coverage.
- To share experiences and discuss ways to more effectively address concerns of parents and health professionals about the safety and value of vaccination.
- To share experiences about implementing national strategies for measles and rubella elimination and the usefulness of *Eliminating measles and rubella and preventing congenital rubella infection, WHO European Region strategic plan 2005-2010*.

Greetings and introductions

The meeting was opened by **Prof. Dr. Reinhard Burger**, Vice President, Robert Koch Institute, who noted that participants had many common challenges: complex health systems, federal systems with decentralized governance, and parents and health professionals who questioned vaccination. In Germany, the control of measles and rubella has progressed, but the goals of the *Intervention programme on measles, mumps and rubella*, announced by Robert Koch Institute in 1999, have only been partially reached. To meet these goals all Länder needed to be committed. With recent measles outbreaks in Germany in mind, Prof. Dr. Burger appreciated the opportunity to share experiences and expressed hope that German-speaking countries and areas would find a uniform approach for action.

Dr. Nedret Emiroglu, Regional Adviser, Vaccine-preventable Diseases and Immunization, WHO Regional Office for Europe, welcomed all participants to the meeting and expressed her thanks to the Ministry of Health, Germany, and the Robert Koch Institute, for hosting this important meeting. WHO is prepared to assist German-speaking countries and areas in addressing their challenges in meeting the 2010 measles and rubella elimination targets. Through this meeting, WHO hoped to learn how this could be done.

Dr. John Spika, Responsible Officer, Accelerated Disease Control, Vaccine-preventable Diseases and Immunization, WHO Regional Office for Europe, noted that vaccine coverage of $>95\%$ has not yet been achieved in many Western European countries, including the German-speaking ones. As a consequence, the measles incidence in many of these countries is above the benchmark for measles elimination of <1 case per million population. A number of outbreaks have occurred in the last two years in the European Region, and these are very effectively demonstrating where the weaknesses in measles control are.

Session 1: Immunization programmes in German-speaking countries/areas: the challenges

Austria

Dr. Jean-Paul Klein, Head of Department III/A/1, Federal Ministry for Health and Women, and Prof. Heidemarie Holzmann, Institute for Virology, Medical University of Vienna, Vienna, Austria

Plans and recommendations

There is not a national vaccination plan for MMR, but vaccination recommendations are integrated into the National Immunization Plan. The Minister of Health decides on recommendations after hearing the national immunization board, whose recommendations are crucial. A measles elimination plan is being developed by the Austrian Federal Institute for Healthcare (Österreichisches Bundesinstitut für Gesundheitswesen); it will follow WHO recommendations.

Information

National vaccination recommendations are issued once a year, usually in March. They are published on the home web page of the Ministry of Health, in a special issue of the official medical journal of the chamber of medical doctors and in a special leaflet for parents.

History and vaccination schedule

Combined MMR vaccine has been used since 1994. Until 2003, one dose at age 2 – mostly given by practitioners – was followed by one dose at age 13 given in school by the public health care service. Since 2004, the first dose has been given from age 12 months, and the second dose at least one month later. Any child may get a catch-up dose at any time and a catch-up dose is also recommended for seronegative women after delivery. Therefore, at the moment three birth cohorts are vaccinated: those receiving their 1st and 2nd doses according to the new schedule and those receiving their 2nd dose at 13 years of age.

Access to vaccination and costs

Only doctors are allowed to perform vaccinations in Austria. Vaccination is not mandatory, and unvaccinated children meet no disadvantages. Medical doctors have to inform patients about possible adverse events following immunization and to obtain informed consent before vaccination. Medical doctors have to report adverse events following immunization to health authorities, as well as all vaccinations performed.

Vaccination is free of charge. There is an annual call for tenders to procure vaccines. Payment is divided: 2/3 from Ministry of Health, 1/6 from federal states, 1/6 from social insurance. Other costs, such as health care staff, are provided by the nine federal states.

Surveillance of vaccination

Vaccination coverage is assessed by continuous stock control of purchased vaccines, with monthly evaluation of vaccines in stock and of vaccines delivered (by region and by category). Federal states report annually to the Ministry, including data about birth cohort, age, category, vaccination status and date of vaccination. However, not all federal states have electronic registers and not all registers are compatible. Each year, tens of thousands of vaccinations are not registered although doses are delivered to doctors.

One birth cohort includes approximately 75 000 children. Since 1998, registered vaccination coverage for MMR1 has reached almost 80%. The coverage rate for MMR2 ranges between 60% and 80% depending on birth cohort. Improvements in vaccination coverage surveillance should reveal better vaccination rates.

Surveillance of cases

Measles surveillance is now a case-based, mandatory registration system. The legal basis is the "Epidemiegesetz", using the EU case definition. Until recently, a voluntary sentinel system covered about 8% of the Austrian population; about 250 medical doctors were actively involved.

A measles epidemic reached its peak in 1995-1996; 28 000-30 000 measles cases occurred between 1993 and 1997. In the years 1995, 1996 and 1997 respectively 15, 6 and 3 cases of encephalitis were diagnosed. Fifteen cases of subacute sclerosing panencephalitis have been diagnosed since 1998, only one of them is still alive. Measles incidence peaked in 1995 at 138.1 per 100 000 population, decreased to 4.8 per 100 000 in 1998 and was 0.5 per 100 000 in 2004. The last outbreak, with eight patients, was of nosocomial origin. Doctors were not aware of measles and did not separate the infected children.

Challenges

- Vaccination coverage should be enhanced, especially in federal states with low reported vaccination coverage.
- An improvement in coverage documentation is crucial. A single nationwide electronic vaccination register is needed.
- To enhance measles surveillance, the laboratory and mandatory case databases should be more closely connected.
- Reporting rates and quality of reports by practitioners should be improved.

Germany

Dr. Anette Siedler, Department for Infectious Diseases Epidemiology, Robert Koch Institute, Berlin, Germany

Plans and recommendations

A programme to achieve a better acceptance of vaccination and higher vaccination coverage was established in 1999. Also, an intervention programme on measles, mumps and rubella was proposed by Robert Koch Institute in autumn 1999. Only parts of these programmes have been implemented. The most significant progress has been in surveillance. Reasons for this include the lack of binding vaccination goals; the lack of communication about the goals and actions defined; and the lack of an evaluation process.

Vaccination recommendations are issued by the Standing Committee for Vaccination (Ständige Impfkommision, STIKO) at the Robert Koch Institute. The federal states, health insurance plans and Associations of Statutory Health Insurance Physicians (Kassenärztliche Vereinigungen) receive new or modified recommendations from STIKO. However, public health care is the responsibility of the 16 federal states who each decide whether to follow the STIKO recommendations. Health insurance plans have the responsibility to decide whether or not to reimburse physicians for administering the vaccines.

Information

Recommendations are usually published in the Epidemiologic Bulletin of the 30th week of the year. It is subsequently spread widely to the general public by professional associations, the pharmaceutical industry, non-governmental organizations, such as the German Green Cross and the media. Furthermore, medical doctors should inform their patients about possible vaccinations.

History and vaccination schedule

In the former German Democratic Republic vaccination was mandatory; however there was no mumps vaccination and only partial rubella vaccination. In the former West Germany MMR-vaccine was introduced in 1980. Mandatory vaccination was stopped after the reunification and unvaccinated children meet no disadvantages. Since 1991, two doses of MMR have been recommended in all German federal states; since 2001, the 1st dose has been given at age 11-14 months, and the 2nd dose at age 15-23 months. In general, vaccinations are delivered later than recommended.

Access to vaccination and costs

About 85% of vaccinations are delivered by practitioners and 15% by public health services, clinics or other sources. Medical doctors have to inform patients about possible adverse events following immunization and to obtain informed consent before vaccination.

Vaccines are bought on the open market; any approved vaccine is available. If a vaccine is recommended by a federal state and doctors associations have agreements with health insurance providers, immunization is usually paid for by health insurance. Travel vaccinations are paid by the individual person; vaccinations required for specific work-related activities are paid by employers.

Surveillance of vaccination

According to a protection against infection act (*Infektionsschutzgesetz* or *IfSG*), public health services register vaccination status at school entry and transmit data to the Robert Koch Institute. Public health services conduct local surveys in schools and kindergartens. Additional statistical data are provided from specific groups. Access to accounting data from doctors' associations on delivered vaccinations is new. According to *IfSG*, notification to the Paul Ehrlich Institute about adverse events following immunization is mandatory for doctors. In addition, doctors should report diseases in vaccinated persons to the Ärztekammer (medical association) and/or the manufacturer, and the manufacturer must report to the Paul Ehrlich Institute.

In 2004, vaccination coverage at school entry was registered for approximately 90% of children. Coverage was about 92% for MMR1 and about 65% for MMR2. The former West Germany in general has lower vaccination coverage than the former German Democratic Republic. On local levels, differences in coverage are even larger.

Surveillance of cases

In October 1999, vaccine manufacturers, the Robert Koch Institute and the German Green Cross started a public-private partnership entitled *Arbeitsgemeinschaft Masern* (AGM). Sentinel surveillance for measles has been conducted by more than 1 200 practitioners, mostly paediatricians, within AGM, and they report monthly (including zero cases). These cases are laboratory confirmed. Doctors participating in AGM ask patients why they have not been vaccinated, so the proportion of cases who were vaccinated is known.

Since 2001, the *IfSG* has required physicians to notify suspected and confirmed measles cases and deaths to local health authorities (Gesundheitsamt). Every direct or indirect laboratory confirmation of measles virus must also be notified. Data are electronically passed to the authority of a federal state and then to the Robert Koch Institute; these data are published weekly.

From 1999 to 2005, AGM collected data on 2 897 measles cases; 90% were not vaccinated, 6% were vaccinated, 4% had unknown vaccination status. Besides refusal, forgetfulness was a strong reason for non-vaccination. Through *IfSG*, ~13 500 measles cases have been reported since 2001. The incidence decreased from 7.32 per 100,000 population in 2001 to 0.15 in 2004, but had increased to 1.49 by mid-May 2006. Local or regional outbreaks in the western federal states account for most measles cases. Recently a major outbreak occurred in Nordrhein-Westfalen.

Challenges

- Some parents question the value of vaccination, and groups oppose immunization.
- Responsibilities for immunization are completely decentralized.
- Political support to facilitate and coordinate vaccination efforts is not always evident.
- Vaccination programmes lack legislated responsibilities and evaluation.
- Surveillance of immunization coverage has to be improved to include data on age specific vaccination coverage and data on timely vaccination coverage.
- Groups with low vaccination coverage need to be identified and addressed.
- Surveillance for rubella needs to be introduced.
- Outbreak management needs to be improved.
- Local socio-demographic variations may need to be addressed in national immunization recommendations.

South Tyrol

Dr. Peter Kreidl, Epidemiologist, Epidemiologic Observatory, and

Dr. Giulia Morosetti, Director, Unit of Hygiene and Public Health, Health Department 23, South Tyrol, Italy

Plans and recommendations

The plan to eliminate measles is partially fulfilled. Notifications, laboratory confirmation and information have been enhanced. In 2003, a supplementary immunization activity was conducted. Since 2004, a second dose of MMR2 has been offered at age 5-6 years and age 11-15 years. Persons are actively invited to immunization. A special approach has been defined to reach vulnerable groups, mostly those unvaccinated or exposed to unvaccinated people. By 2006, measles vaccine coverage of >95% by age 24 months of age and an incidence <1 per 100 000 are expected according to the national plan. Thus, it is planned to reach measles elimination by 2007. However, South Tyrol is far from achieving those goals as outbreaks continue to occur.

Information

Public health services on local and federal levels inform the public by leaflets, brochures, posters, meetings, press releases, films/videos and/or through personal encounters. Persons opposing immunization are well organized and conduct their own information campaigns. It is predominantly the 69% of the population who are German-speaking that are influenced by the immunization skeptics.

History and vaccination schedule

Several vaccinations are mandatory in Italy but not MMR. MMR has been used since 1991. Initially MMR1 was given at age 15-18 months, but since 2002 it is given at age 12-15 months.

Access to vaccination and costs

Vaccination is free of charge. Children should be invited three times by letter from the local municipalities; however, an evaluation in 2002 in South Tyrol found that only some local municipalities did so. In 2004, most municipalities were doing this. In larger cities, only public health doctors and nurses (Fachärzte und Sanitätsassistentinnen der Hygienedienste) vaccinate; in the rest of the territory, general practitioners (Sprengelhygieniker) are allowed to vaccinate. As of 2006, paediatricians are also allowed to vaccinate. Immunization does not take place at schools. Unvaccinated children meet no disadvantages.

Surveillance of vaccination

Since 2003, doctors are obliged to report adverse events following immunization electronically. The number of vaccine doses given also has to be reported to local public health authorities. Cluster sampling surveys (ICONA) were made in 1998 and 2003.

One birth cohort includes approximately 5 000 children. MMR1 immunization rates are <70% at age 24 months. The supplementary immunization activity in 2003 reached 10-20% of children in each targeted birth cohort. An increase in congenital rubella infections is expected if coverage does not increase. Many parents do not care about MMR vaccination; they believe measles is harmless or that vaccination involves serious risks for adverse effects. Since MMR vaccination is not mandatory, many see this as an indication that the vaccination is not important.

Surveillance of cases

Doctors have to report cases of measles, mumps and rubella within two days of diagnosis to public health authorities. Epidemics occurred in 1997 and 1999; 3 844 measles cases were registered between 1996 and February 2006. During the same period, 2 298 clinically diagnosed cases of rubella were reported. Since 2003, surveillance has been enhanced: doctors notify by telephone and nurses then contact each measles case at home to check vaccination status, isolate exposed persons, actively follow-up exposed persons and offer vaccination. The first cases of an outbreak are laboratory confirmed; one-quarter of the measles cases in 2003 were >15 years of age.

Challenges

- Measles and rubella virus continue to circulate due to inadequate vaccination coverage – the next outbreak is expected among adolescents.
- Health care providers and the public need better information, including information about adverse events following immunization, and this needs to be provided on a continuous basis. An information campaign addressing teachers and the general public will start in autumn 2006.
- There is a need to enhance surveillance and documentation of measles cases and adverse events following immunization, including the need to identify and address vulnerable groups, e.g., exposed, unvaccinated persons, the need to identify second measles cases in families, and the need to obtain laboratory confirmation of first cases.
- Encouraging cooperation among everyone involved in vaccination and control of infections.
- Increasing the number of immunization opportunities and actively inviting parents – a second supplementary immunization activity is planned for 2007.
- Strengthening monitoring of rubella antibodies in pregnant women – a seroprevalence study (SERUB study) in women aged 18–45 years will start during 2006.
- Enhanced political support is necessary

Switzerland

Dr. Jean-Luc Richard, Scientific Collaborator, Epidemiology and Infectious Diseases Division, Swiss Federal Office of Public Health, Bern, Switzerland

Plans and recommendations

There is no measles and/or rubella elimination plan. MMR is recommended as a basic vaccination in the Swiss vaccination plan. The Swiss Federal Office of Public Health (SFOPH) and the Federal Commission for Vaccination revise this plan annually.

Information

The Swiss vaccination plan is sent to all physicians. Physicians must inform parents about recommended vaccinations, including the benefits and the risks. Parents are informed on several occasions, e.g., through personalized information from paediatricians or general practitioners during periodic consultations or other visits. A variety of information material is distributed by SFOPH, groups of physicians and the pharmaceutical industry. Immunization is discussed at maternity services concerning birth and childcare, unfortunately it is often discouraged on these occasions.

History and vaccination schedule

Immunization is not mandatory in Switzerland. MMR1, given at age 12–24 months, was introduced in 1985. MMR2 was added in 1996 for all children at age 5–7 years. As of 2001, MMR1 has been recommended at age 12 months and MMR2 at age 15–24 months, at which time a 4th dose of DTaP/Hib/IPV is also given. Catch-up vaccination with two doses of MMR is recommended at any time until age 40 years.

Access to vaccination and costs

Paediatricians and primary care physicians vaccinate children and adults. School physicians and nurses deliver catch-up vaccinations at schools free of charge. Schedules of visits differ between cantons. Unvaccinated children meet no disadvantages. SFOPH never organizes catch-up vaccination. Some cantons deliver catch-up vaccinations at school entry and at school ending by school health services.

Mandatory health insurance pays for all recommended basic vaccines, including MMR; however, patients must cover 10% of the cost themselves. Vaccines for health care workers are paid by the employer.

Surveillance of vaccination

The first national coverage study was conducted during 1999–2003. SFOPH repeats this survey in one-third of cantons every three years, so that all cantons are done on a 3-year cycle. Physicians must report adverse events following immunization to a federal service.

Coverage with at least one dose of measles and rubella vaccine for children aged 2 years did not change between 1991 and 2003; it was ~82%. At school entry, coverage was ~88%, and at school ending, almost 94%. At school entry, ~37% had MMR2, and at school ending, almost 54%. Rubella coverage was slightly lower. Coverage for children aged 2 years differs between the cantons, ranging between 65% and >95% - the coverage being lowest in German-speaking parts of Switzerland (79% vs. >90%). While over 90% of children receive three doses of DTaP/Hib/IPV vaccine, only about 84% receive the 4th dose.

Surveillance of cases

Measles surveillance has been done since 1986 by the Swiss Sentinel Surveillance Network; 250 physicians, representing 3% of all primary care physicians, report weekly to SFOPH. About 60% of measles cases and 50% of rubella cases have clinical specimens tested in the laboratory. It has been mandatory to report measles and congenital rubella infection since 1999. Reports of cases are sent by mail to the cantonal medical officer, who then reports to SFOPH. Laboratories must report confirmed cases to the cantonal medical officers and SFOPH. SPSU, a network of 35 paediatric clinics, report congenital rubella infection to SFOPH. Mandatory reports of laboratory-confirmed rubella cases are planned for 2008.

Major measles epidemics occurred in 1987, 1997 and 2003 with 10 500, 6 400 and 1 100 cases respectively. The measles incidence was 90 per 100 000 population during the 1997 epidemic and decreased to 2 per 100 000 in 2004. Rubella incidence evolved similarly. Genotyping has been possible since 2003 and is performed by the Robert Koch Institute. Five different genotypes were identified in outbreaks from 2003 to 2005. It is unclear whether endemic measles transmission has ended in Switzerland. In the 2003 outbreak, 25% of cases were age 15 years or older; 81% of all cases were unimmunized.

Challenges

Improving MMR vaccination coverage

- Enhance information of mediators e.g. physicians, midwives, infant health counsellors
- Answer the fears/objections raised by skeptical parents and alternative medicine (users and providers)
- Use new approaches, such as internet.
- Heighten parents' awareness of measles risks for children and promote timely MMR vaccination
- Remove some organizational barriers to immunization access, e.g. develop a recall system (mainly for immunization after age 6-12 months)
- Systematically give an appointment for the subsequent vaccination
- Reduce the number of missed opportunities
- School health services and their catch-up vaccinations must receive strong political commitment

Improving surveillance

- Improve sensitivity (increase reporting of clinical cases by better information to physicians),
- Improve specificity (systematic laboratory testing of all suspected cases),
- Improve timeliness of measles/rubella reporting
- Maintain regular cantonal vaccination coverage surveys despite growing organizational and financial difficulties
- Use surveillance data for action (outbreak control is the responsibility of the cantons)

Discussion and conclusions of Session 1

Each German-speaking country or area has its individual approach to measles and rubella vaccination, surveillance and elimination; and their federal structures lead to further minor or major differences at a local level, with healthcare responsibilities being very diverse. Countries/areas that developed national elimination plans have not actively encouraged their implementation (e.g., by offering incentives) and their implementation has not been regularly evaluated or adapted to local epidemiologic situations. While vaccination coverage has improved, it is still below $\leq 90\%$ in children aged 2 years and in most of the older age groups as well, resulting in continued outbreaks.

All countries/ areas expressed the need to improve surveillance for measles and rubella and for vaccination coverage; the quality of surveillance differed widely. Vulnerable groups need to be identified and reached, and outbreak management needs to be improved in some countries.

Each country/area also has to address groups actively opposing immunization – although they account for an estimated 3-4% of the population, they have great impact by being able to engage journalists, who in general wish to show a balanced approach. Stressing that these groups constitute a small minority is essential when working with the media. Safety issues (e.g. hexavac safety, autism) have influenced immunization coverage in several countries. Participants spoke in favor of using professional public relations campaigns. The aims of information strategies should be to:

- Improve compliance of health care staff with surveillance and vaccination goals
- Increase awareness of the risks of infectious diseases, the safety of vaccines and vaccination opportunities – particularly among parents and mediators
- Convince staff at maternal services (e.g., midwives) of the benefits of vaccination
- Increase awareness on a political level to obtain more political support

Participants agreed that doctors and other health care staff need information on immunization and information on how to address the concerns of groups opposed to vaccination. Information material for parents and health care staff should address frequent questions and issues about immunization safety. Uniform European material might be useful (a collection is added to this report). Midwives may be addressed in two ways: by participation in decision making processes on different levels as is done in Switzerland and Magdeburg (Germany) and by a mandatory duty to inform about official vaccination strategies, as done in Niedersachsen (Germany).

Session 2: Monitoring immunization coverage methods to improve the timeliness of data

Switzerland – a 3-year cycle of cluster surveys

Phung Lang, Institute for Social Preventive Medicine, University of Zurich, Zurich, Switzerland

Only one canton out of 26 had had a routine method to determine immunization coverage. Between 1999 and 2003, a survey was implemented with the aim to establish a cost-effective method, collecting comparable immunization data for three age groups in all cantons. Existing infrastructure was used; however, a comparison of coverage data among cantons needs to recognize that vaccination policies differ between cantons; different methods of data collection were used for school children; and the number of non-responders was unknown.

Method: Vaccination rates were assessed at age 24-35 months (toddlers), 8 years (schoolchildren) and 16 years (adolescents). Two methods were used: random sampling and cluster sampling. In Genf, the health department had already conducted a mandatory check of all vaccination cards in children aged 28 months. The response rate was about 90%.

A 3-year rolling cycle is now being used. In general, SFOPH contributes 1/3 of the costs; about 2/3 are contributed by the canton. Of 26 cantons, 10 took part in 2004-2005, 8 will participate in 2005-2006 and 8 will participate in 2006-2007. Random sampling is being used by 16 cantons. An address list of all children resident in the canton is needed. Either the list already exists or it is compiled for

the canton. From this list, children are selected randomly. Selected families receive two letters approximately four weeks apart and a telephone call within three to four months if there is no response. Cluster sampling is being used by 11 cantons; after a sample size calculation, approximately 60 municipalities (Gemeinden) are selected. Randomly selected addresses of children are provided by municipalities and families are also contacted with two letters and one telephone call.

Results: Participation rates have been assessed for nine cantons: An average of 97% of the municipalities took part. About 18% of parents did not respond; for approximately 1/3, a telephone number could not be found. However, follow-up by telephone is very useful for toddlers, since mothers are still at home. Fifteen percent of non-responding parents did not want to take part. They were weary of telephone marketing and surveys. Measles vaccination coverage of toddlers in year 2005 was 86%; coverage at age 8 years was 90%, coverage at age 16 years was 95%. The data for the second dose were 74% in schoolchildren and 75% in adolescents.

Discussion: The 3-year cycle of simple random sampling and/or cluster sampling is feasible, although it will be a challenge to maintain high participation. Vaccination coverage in Switzerland has increased but still suboptimal.

South Tyrol – ICONA Study

Dr. Peter Kreidl, Epidemiologist – Epidemiologic Observatory, Health Department 23, South Tyrol, Italy

The objectives of the vaccination-related EPI cluster sampling survey in Italy in 2003 were to evaluate coverage with routine vaccines at age 12 to 23 months, to learn about parents' objections to childhood immunization and reasons for delayed immunization, to evaluate data on routine immunization coverage and to evaluate quality and acceptance of existing vaccination services.

Method: EPI cluster sampling survey, using WHO method. Thirty clusters were chosen randomly, one cluster consisting of seven persons. Every region in Italy randomly chose 210 participants; in Milan, Naples and Rome, an additional 100 participants were included. Contact was attempted three times at different hours of the day, reasons for non-response were documented. Target groups were interviewed at home.

Results: Immunization coverage in children aged 12 to 23 months increased considerably between ICONA-1998 and ICONA-2003, but is still <70%. On a local level in South Tyrol, immunization coverage varies widely. About 65% of parents received letters inviting them to MMR1 vaccination.

Discussion: Major reasons to not immunize timely were: lack of information, parents considered measles to be harmless, and timeliness was not considered to be important. Cluster sampling surveys are a quick, low cost method that can be adapted to any sample size and purpose. A team of 10 to 15 people can conduct an immunization coverage survey within one week and costs are low. The confidence intervals around the estimated coverage can be wide, especially if clusters are homogenous by themselves, but the clusters within one region differ considerably.

Pilot project vaccination registry in Sachsen-Anhalt

Dr. Eike Hennig, Public Health Authority and Veterinary Health Authority, Sachsen-Anhalt, Germany

Any routine vaccination of a child up to 7 years of age must be reported to public health authorities in Sachsen-Anhalt, according to the public health services law (*Gesundheitsdienstgesetz § 4 Abs. 3*); however, very few vaccinations were reported before the pilot vaccination registry project in Sachsen-Anhalt. Data reported in the pilot included name, birth date, address, and type and day of vaccination. Informed consent of the parents was needed. The aim of the registry was to provide all children with timely immunization and a registry was thought to aid this by identifying vulnerable groups. The pilot in Magdeburg and Halle was developed to explore why reporting levels were low.

Method: Immunization physicians, parents and public health authorities (Gesundheitsamt) received a questionnaire regarding knowledge levels of the notification law and their views on immunization.

Results: 50 paediatricians, 1 163 mothers from Magdeburg and Halle and 24 gesundheitsamt from Sachsen-Anhalt took part. The law was known to 88% of physicians, 26.1% of parents and 100% of gesundheitsamt. About 88% of paediatricians and 84% of parents would accept being reminded about vaccinations by the gesundheitsamt. About 78% of parents would accept reporting. However, ~1/3 of paediatricians believed it would be too time consuming; and another 26%-30% raised objections regarding data protection and questioned whether reporting would be in line with existing laws. No gesundheitsamt used reporting data to remind parents of vaccinations due. Seventy-seven percent of children received MMR1, most of them timely, and 44% received MMR2. Up to 40% of physicians now report vaccinations.

Discussion: Most young mothers would accept mandatory reporting – the important issue is to overcome the concerns of paediatricians. Their consent is crucial to implement mandatory reporting of immunization. Mandatory notification causes considerable work for the gesundheitsamt by their collecting data and communicating with parents and physicians.

Discussion and conclusions of Session 2

Although mandatory, established surveillance tools and outbreak containment tools do not work properly. Mandatory reporting of vaccinations may raise the importance of immunization among some groups, but concerns were raised that among critical population groups, mandatory notification of vaccinations, as in Sachsen-Anhalt, could be counter productive. It was also pointed out that in Austria mandatory reporting for doctors does not enhance notification rates. The starting point is to inform and motivate doctors.

Data security should not adversely impact the work of public health services. Germany was identified as one of very few countries without a monitoring system for immunization coverage in age-specific cohorts. Consequently, vulnerable groups cannot be identified properly – this is critical information needed to start public health programmes for preventing outbreaks or for responding quickly to an outbreak. Stronger promotion of mandatory reporting of diseases and immunization was again proposed.

A “no vaccination - no school” policy was not deemed to be legally feasible in German-speaking countries/areas, since the right to be educated would collide with compulsory immunization. Other sources of information, such as data from doctors’ associations or information from routine health consultations in the second life year might be used to assess vaccination coverage.

The right to handle personalized data might be extended from the doctor to basic public health authorities as was done in Italy. Electronic reporting of data is a means of facilitating work on all levels. It also includes the chance to access timely personalized data, while still observing data security. However, this requires harmonization of programmes and data streams which, at this stage, is not possible in most of the participating countries/areas.

Session 3: Strengthening vaccination awareness

South Tyrol – European Immunization Week activities; communication strategies and methods

Dr. Giulia Morosetti, Director, Unit of Hygiene and Public Health, Health Department 23, South Tyrol, Italy

South Tyrol took part in European Immunization Week, 17-23 October 2005. The challenges for immunization programmes in South Tyrol are described in *Session 1* of this report. Key messages in South Tyrol were: Vaccinations are safe; Diseases are dangerous; and Parents should trust in public health authorities. Information material, e.g. poster, leaflets, brochures, radio spots and a website, were developed and distributed widely. Health care professionals, local mediators and journalist were successfully informed during workshops before the launch of European Immunization Week. In some critical regions, open information evenings for parents and other groups were organized, however with low participation. In contrast, 500 people visited an anti-vaccination meeting held as a reaction to European Immunization Week – with an entrance fee of 20 €.

Discussion: European Immunization Week in South Tyrol cost 30 000 €. The media response was good. Due to activities during the week, paediatricians have now been allowed to immunize as of 2006. Visits by WHO representatives focused awareness on the week and the key messages. Participation in European Immunization Week entailed considerable work for the involved public health authorities. A professional task force (“Team Impfwoche”) and timely planning is needed. European Immunization Week must be considered part of a larger approach to increase immunization coverage.

Measles outbreak in a Bavarian district starting from cases in a private school

Dr. Maike Nikutta, Health Office (Landratsamt) Weilheim-Schongau, Germany

Before 2005, measles outbreaks had not occurred in Bavaria for a number of years. In 2005, an outbreak started in a Montessori school, resulting in 106 cases (105 of which were un-immunized). The Montessori school with the most cases never took part in school immunization initiatives of the public health service, so immunization coverage at the school was unknown; it did not observe its reporting duties; the pupils of various ages were mixed in classes; pupils from different districts (Landkreise) visited the school; and the cooperation during the outbreak was very limited, as it was at other affected schools. The parents tended to be skeptical of immunization; they often did not immediately inform the school or kindergarten about the disease in their child; and some did not visit a doctor when their child developed measles. Some doctors either did not diagnose measles, or if they did, they did not report or reported cases with non-matching criteria; some avoided the costs of laboratory confirmation; and some did not inform parents properly. Public health authorities found it difficult to coordinate activities across several districts. Whitsuntide Pentecost vacations were felt to help stop transmission.

Discussion: Contacting parents directly was very useful in order to inform them and to pick up additional cases. Public health authorities in the future should consider forcing any target group to comply with activities to contain an outbreak. This would include information for the general public, isolation of exposed persons and checking immunization cards.

Measles surveillance in Tyrol

Dr. Melanie Wohlgenannt, Tyrol Government (Landessanitätsdirektion), Innsbruck, Austria

Since 2001, measles cases, suspected cases and measles deaths have been reported by doctors and laboratories; however, reporting is not considered important by doctors, especially paediatricians, since they assume everybody is immunized; however, compliance to immunization is declining. The public health service continuously contacts parents of unimmunized children during school tours. One kind of data available shows only purchased vaccine, not delivered doses. The UNIMED-programme

was started in 2000 to provide data on doses delivered; however, it only shows vaccinations by doctor and district where vaccination was received and personal data of the vaccinated patient. There is no national surveillance system. Some federal states of Austria collect data electronically. Some doctors providing immunizations in Tyrol do not have data sets compatible with the regional surveillance data system, therefore documentation is performed manually. Manual data entry also takes place at higher levels. Surveillance data may have up to a 2-year delay. Forty-four of 45 paediatricians and 300 out of 480 general practitioners with national health insurance contracts are registered to provide immunizations in Tyrol. However, vaccinations provided by 40 paediatricians are not reported. It remains unknown why many parents do not ensure immunization of their children.

Discussion: Reprogramming UNIMED data resources is planned, however, resources to do it are current not available. Dr Wallenko said his district is planning to issue immunization coupons with a bar code to all newborns – a coupon given to a doctor could be linked to immunization. But different federal states in Austria use different bar codes; one uniform approach to data collection is needed.

How measles awareness in the media is related to vaccination

Sean Monks, 'Paediatricians on the Net' GmbH, Munich, Germany

The website of the paediatricians' association "Berufsverband der Kinder- und Jugendärzte" (BVKJ) addresses the general public. It displays daily news about the health of children and adolescents. Any item shown on the website is agreed upon beforehand by a scientific committee - including public health authorities, if appropriate. Resources come from subscriptions of paediatricians paying to be listed in the website's doctors' address list. No advertisements are on the site, enhancing its acceptance by the general public. Daily news attracts journalists. Many paediatricians almost immediately inform the BVKJ-Website about interesting cases. Paediatricians ask parents (e.g., of a SSPE-case) whether they would accept sharing their story with the general public. Agreeing parents are referred to 'Paediatricians on the Net'. The family remains anonymous in any TV spot. Film material is offered free of charge to every TV station, also in Austria and Switzerland; however, BVKJ has to be named as the source to increase awareness of the website. The material is also used for educational purposes. The impact of the TV spots is seen from the number of MMR doses sold.

Discussion: Emotionally appealing films may help to increase vaccination coverage. Timing and information given should go in line with public health authorities. 'Paediatricians on the Net' invites participants of the meeting to immediately get in contact in case of outbreaks or complicated cases. It also offers existing material for use free of charge.

Vaccination bus and immunization days in North Rhine Westphalia (NRW)

Gabriele Ahlemeyer, Federal Institute of Public Health (LÖGD), Münster, Germany

A measles outbreak with around 1 600 cases occurred in NRW in 2002, mostly in the Cologne district (Regierungsbezirk Köln). An evaluation of students at school entry revealed low vaccination coverage and great variations in coverage on a local level. As a consequence, LÖGD began initiated vaccination days and weeks. In addition, a vaccination bus was sent to low coverage areas. Posters, press releases, leaflets and radio broadcasts were used to inform the public. The Government of NRW pays for most of the vaccines delivered by the bus; municipalities (Kommunen) contribute as well. Local public health authorities use the bus free of cost. During 2004, 1 777 MMR doses were administered using the bus to 15% of all bus visitors; in 2005, 1 502 MMR doses were administered. Within two years, coverage among children at school entry was increased; no district was below 40% coverage in 2004 and most districts were above 60%. The bus is, in general, very well accepted.

Discussion: A vaccination bus is a flexible tool to reach target areas and groups. It is well accepted by LÖGD and the general public, but it requires full cooperation of local mediators, such as teachers. A proper evaluation of its success would be desirable.

Ways of promotion in Switzerland

Roger Naef, Dipl. Sc. Nat. ETH, Swiss Federal Office of Public Health, Bern, Switzerland

Anti-immunization groups receive considerable public interest in Switzerland, and public health authorities and medical professionals have been underrepresented in the public discussion about the benefits and risks of immunization. As a consequence, the Federal Government (Bundesrat) in 2001 decided that comprehensive information on immunization should be available to all target groups, and the director of the Federal Office of Health (Bundesamt für Gesundheit, BAG) took the decision to initiate a prevention campaign. The key to success has been an advisory group (Konsultativgruppe), including public health authorities and parents and midwives associations, anti-immunization groups, vaccination manufacturers, doctors' associations and others. The group agreed upon an action plan of promoting immunization in Switzerland. The campaign was continually and comprehensively evaluated with a special focus on the anti-immunization movement. A lot of material has been developed (e.g., brochures, fact sheets, posters, vaccination hotline, collected answers to critical questions (Impf-Argumentarium), website and DVD). An exhibition was initiated in cooperation with UNICEF; several additional international organizations have since become partners of the campaign. Strong efforts were invested in networking to make sure the information would reach critical target groups. The initial budget for the project was less than one million Swiss francs, and it is now less than half a million Swiss francs. Currently, two persons are involved with the project.

Discussion: The Swiss campaign was acknowledged by participants as a very good example. Inviting all groups to participate in the advisory group facilitated acceptance of the campaign. The method of "Systemanalyse" with a comprehensive analysis of the situation supported a fruitful discussion, thus contributing to success. Participants expressed interest to answers developed to critical questions. Scientific information did not suffice; an emotional approach was needed and achieved by the DVD, the exhibition and a nightlight for babies. Networking is crucial with respect to costs and workload. Anti-vaccination mediators need a special approach. Gynaecologists reach mothers before birth and are now a target for information in several countries/areas.

European Immunization Week – plans for 2006

Katrine Habersaat, Technical Officer, Vaccine-preventable Diseases and Immunization, WHO, Copenhagen, Denmark

In the WHO European Region, large outbreaks of vaccine-preventable diseases, declining or stabilizing immunization coverage and large groups of vulnerable/ hard-to-reach children in all countries of the Region are concerns. Reasons for this include groups opposing immunization and media scares questioning the necessity and safety of immunization and in addition, low public and political interest in immunization. As a consequence, WHO launched the pilot European Immunization Week during 17-23 October 2005. Nine countries/areas within the Region took part. The goal was to increase immunization by raising awareness of the need and right of every child to be immunized. A special focus was placed on vulnerable groups. Every country/area identified and implemented activities tailored to their national challenges and needs. WHO contributed with technical support, a logo and standardized material, consultations and guidelines.

An evaluation of the 2005 activities demonstrated that the initiative succeeded in generating strong interest from internal and external stakeholders, as well as a notable impact among target audiences. The initiative furthermore enabled immunization teams to gain access to and support from senior policy makers and to advocate for future programme investment. An essential recommendation of the evaluation was to continue European Immunization Week as an annual initiative, gradually becoming Region-wide.

Discussion: Media turned out to be a positive stakeholder. European Immunization Week was an effective means to refresh and reinforce public knowledge of the importance of childhood immunization. Awareness will hopefully increase if European Immunization Week is repeated yearly. It was recommended strongly that European Immunization Week be evaluated on national level as it is rather expensive. The initiative cannot be measured by increased immunization coverage alone, although the long-term goal is increased immunization. Shorter term goals include increased

knowledge levels; awareness of the initiative and its messages; and increased interest and resources from national policy and decision makers.

Discussion and conclusions of Session 3

Strong political commitment leads to financing campaigns that help to reach targets. The Swiss information campaign was an example of how political commitment can lead to action. An initial comprehensive analysis of the situation elicited much information, contributing to its success. Inviting all groups into the advisory group facilitated broad acceptance of the campaign.

'Paediatricians on the Net' GmbH showed the impact of emotional TV spots and press releases on MMR vaccine use. Meeting participants were encouraged to access it in case of outbreaks or complicated cases as it offered existing material free of charge. All countries/areas agreed that more emotional information, especially TV spots, was essential to reach the media and improve public awareness; they considered this to be key to the success of awareness campaigns; however, it was noted that every immunization campaign should be evaluated.

Information addressing anti immunization arguments was asked for. Several countries/areas have already developed information material in different languages, addressing arguments of the anti vaccination movement, and these can be shared. The Swiss advisory group is a successful approach to address anti immunization opinion makers.

European Immunization Week will be an effective means to refresh and reinforce public knowledge of the importance of childhood immunization, as it did elicit considerable media response in South Tyrol. Problems experienced at the local level clearly identify the need for widely distributed information, advocacy and a greater awareness of the value of vaccination. While European Immunization Week is not a replacement for routine vaccination programmes, every country/area can adapt it to their own needs. Both immunization coverage and increased awareness could be indicators for success.

Round table discussion

The feasibility of implementing the WHO strategy for measles and rubella elimination

The questions discussed were

1. Given the issues identified, what initiatives could be undertaken in each country to address them and better enable your country to meet the year 2010 targets for measles and rubella elimination?
2. What initiatives could be undertaken with the other countries present at this meeting, and how could they be initiated?
3. What could international organizations like WHO and ECDC do to support countries' ability to meet the year 2010 targets?

Information material

Preliminary list - participants were invited to contribute to it, for example by sending suggestions to intranet host.

FAQ

Lay public

www.kinderaerzteimnetz.de unter Impfen schützt / Häufige Fragen

Autonomous Province of South Tyrol (Italy): Fragen der Bevölkerung zur Impfproblematik und diesbezügliche Antworten des Landesgesundheitswesens, 2005 (hard copy)

Health care professionals

www.rki.de unter Infektionsschutz / Impfen / siehe FAQ

Answers to critical questions and arguments of the anti-vaccination movement

Health care professionals

Risiken von Infektionskrankheiten und der Nutzen von Impfungen. U. Heininger. Bundesgesundheitsbl.-Gesundheitsforsch-Gesundheitsschutz. 2004, 47: 1129-1135
Impfratgeber: Evidenz anstelle von Behauptungen. C.-A. Siegrist et al. Schweizerische Ärztezeitung 2005; 86: Nr. 9, 539-552
Impfgegner und Impfskeptiker. C. Meyer, S. Reiter. Bundesgesundheitsbl.-Gesundheitsforsch-Gesundheitsschutz. 2004, 47: 1182-1188

Lay public

Kinder Impfen? Ja! Wieso? Argumentarium. November 2002; kostenlos bestellen unter www.bbl.admin.ch/ oder Email an: verkauf.zivil@bbl.admin.ch
Book: Schutzimpfungen im Dialog. Die häufigsten Fragen zum Thema Schutzimpfungen. Verlag im Kilian, see www.kilian.de/web/kilian_inhalte/de/fachbuch.htm

General information about diseases and vaccination - lay public

www.forum-impfen.de (first apply for account, printable), 17 Antigens; languages: German, English, Russian, Turkish
www.infomed-verlag.de (free access, printable) 37 combination/travellers vaccines, German
www.dgk.de (to be ordered on paper) 25 combination/travellers vaccines, German
<http://www.cdc.gov/nip/publications/VIS/default.htm#dtap> (free access, printable) 19 (combination/travellers) vaccines, up to 30 languages
http://www.provinz.bz.it/gesundheitswesen/prevenzione_d.htm
www.kinderaerzteimnetz.de, see Krankheiten A-Z
Switzerland: information material on vaccination in 15 different languages on cantonal level
Austria: Material of National Immunization Day (contact: Holzmann)
www.dgk.de "1. Nationale Impfwoche" see background material distributed in Berlin
www.bzga.de brochures for parents
Autonomous Province of South Tyrol (Italy): "Impfung schützt: Leitfaden für das Fachpersonal im Gesundheitswesen", 2005 (hard copy and at http://www.provinz.bz.it/gesundheitswesen/prevenzione_d.htm)
Autonomous Province of South Tyrol (Italy): Bericht über die Durchimpfungsraten in Südtirol August 2005 (hard copy)

Films with more emotional approach

Switzerland: DVD "Impfen – Chance für die Gesundheit" distributed in Berlin.
Germany: please contact Monks (access free)

General information about disease for health care professionals

www.ssi.dk/euvac/ Measles, Mumps, Rubella, Pertussis. English
www.rki.de see Infektionskrankheiten (derzeit:
www.rki.de/cln_006/nn_226928/DE/Content/InfAZ/InfAZ_node.html_nnn=true)
Schweiz: Fact sheets of Bundesamt für Gesundheit
Austria: Material of National Immunization Day (contact: Holzmann)

List of contraindications

Health care professionals

www.cdc.gov/nip/recs/contraindications.htm
www.rki.de see Infektionsschutz / Impfen / Empfehlungen der STIKO
Autonomous Province of South Tyrol (Italy): Schutzimpfungen im Kindesalter: Leitfaden über Kontraindikationen für das Fachpersonal im Gesundheitswesen, 2002 (hard copy)

Evidence based data on adverse events

Health care professionals

www.rki.de see Infektionsschutz / Impfen / Nebenwirkungen und Komplikationen
www.rki.de see Infektionsschutz / Impfen / Epidemiologisches Bulletin 6/2004 (free access); as well as book: "Impfaufklärung in der Praxis" see www.infomed-verlag.de



Measles and Rubella in German-Speaking Countries and Areas Current Issues and Challenges

18-19 May 2006, Robert Koch Institute, Berlin

Programme

18 May, Thursday

- 10.00 Registration & Coffee
- 11.00 **Greetings and introductions**
- Welcome (10 minutes) Prof. Burger
- Opening remarks and meeting objectives (10 minutes) Dr Emiroglu
- Eliminating measles and rubella in the WHO European Region (20 minutes) Dr Spika
- 11.40 **Immunization programmes in German-speaking countries/areas: the challenges**
- Chair: Professor Schmitt*
- Austria (20 minutes) Dr Klein
- Germany (20 minutes) Dr Siedler
- South Tyrol/Italy (30 minutes) Dr Morosetti
Dr Kreidl
- 13.30 *Lunch (50 minutes)*
- 14.20 *Chair: Austria*
- Switzerland (20 minutes) Dr Richard
- Discussion (50 minutes)**
- 15.20 *Coffee Break (20 minutes)*
- 15.40 **Monitoring immunization coverage methods to improve the timeliness of data**
- Chair: Switzerland*
- Switzerland – a 3-year cycle of cluster surveys (30 minutes) Dr Lang
- South Tyrol – the ICONA study (20 minutes) Dr Kreidl
- Germany – a vaccination register pilot project, Saxony-Anhalt (30 minutes) Dr Hennig
- 16.40 **Discussion**
- 17.00 **Lessons learned and end of day wrap-up** Professor Schmitt

19 May, Friday

8.30 **Strengthening vaccination awareness**

Chair: Germany

South Tyrol – European Immunization Week initiative; communication strategies and methods (30 minutes)

Dr Morosetti

Measles outbreak in an anthroposophic community in Bavaria (30 minutes)

Dr Nikutta

Austria / Tyrol (30 minutes)

Dr Wohlgenannt

10.00 *Coffee break (20 minutes)*

10.20 Chair: Italy

How measles awareness in the media is related to vaccination (30 minutes)

Mr Monks

Use of a vaccination bus & immunization days in North Rhine Westphalia (30 minutes)

Mrs Ahlemeyer

Ways of promotion in Switzerland (30 minutes)

Mr Naef

European Immunization Week – annual initiative to raise awareness across the Region (30 minutes)

Ms Katrine Habersaat

12.20 Discussion

12.50 *Lunch (60 minutes)*

13.50 **Feasibility of implementing the WHO strategy for measles and rubella elimination in German-speaking countries – a round table discussion involving representatives from each country and ECDC**

Chair: WHO

(90 minutes)

16.00 Conclusions and farewell

Coffee break



Measles and Rubella in German-Speaking Countries and Areas Current Issues and Challenges

Robert Koch Institute, Berlin, Germany, 18 - 19 May 2006

List of Participants

Austria

Dr Anton Hlava

Österreichisches Bundesinstitut für Gesundheitswesen
Stubenring 6
A-1010 Wien
Austria

Telephone No. : +43 1 515 61 269

Fax No. : +43 1 513 84 72

Email : hlava@oebig.at

Dr Heimo Wallenko

Abt. 12 - Sanitätswesen
Amt der Kärntner Landesregierung
Hasnerstrasse 8
A-9021 Klagenfurt
Austria

Telephone No. : +43 (0)50 536 31 202

Email : post.abt12@ktn.gv.at

Dr Melanie Wohlgenannt

Tiroler Landesregierung - Abteilung Sanitätsdirektion
Abteilung Sanitätsdirektion
Eduard-Wallnöfer-Platz 3
A-6020 Innsbruck
Austria

Telephone No. : +43 512 508 0

Email : m.wohlgenannt@tirol.gv.at

Dr Jean-Paul Klein

Head - Department III/A/1
Federal Ministry for Health and Women
Radetzkystrasse 2
A-1030 Vienna
Austria

Telephone No. : +431 71100 4103/4105

Fax No. : +43 1 713 44 04 1520

Email : jean-paul.klein@bmgf.gv.at

Prof Heidemarie Holzmann

Institut für Virologie
Medizinuniversität Wien
Kinderspitalgasse 15
A-1095 Wien
Austria

Telephone No. : +43 1 531 14 87051

Email: heidemarie.holzmann@meduniwien.ac.at

Italy

Dr Peter Kreidl

Epidemiologist - Epidemiologic Observatory
Health Department 23
Corso Liberta 23
I-39100 Bolzano
Italy

Telephone No. : +39 471 41 1586

Fax No. : +39 471 41 1579

Email : peter.kreidl@provinz.bz.it

Dr Giulia Morosetti

Director – Unit of Hygiene and Public Health
Health Department 23
Autonomous Province South Tyrol
Corso Libertà 23
I-39100 Bolzano
Italy

Telephone No. : +39 0471 4117 40
Fax No. : +39 0471 4117 59
Email: hygiene@provinz.bz.it

Dr Florian Guerra

Dienst für Hygiene und öffentliche Gesundheit
Sanitätsbetrieb Bozen
Amba Alagi Strasse 33
I-39100 Bolzano
Italy

Telephone No.: +39 320 338 5830
Fax No.: +39 0471 909201
Email: florian.guerra@asbz.it

Dr Martina Born

Dienst für Hygiene und öffentliche Gesundheit
Sanitätsbetrieb Meran
Goethestrasse 7
I-39012 Merano
Italy

Telephone No.: +39 0473 222 533
Fax No.: +39 0473 222525
Email: martina.born@asbmeran-o.it

Germany**Prof. Dr. Reinhard Burger**

Vizepräsident des Robert Koch Institute
754-2602
Nordufer 20
D-13353 Berlin
Germany

Telephone No.: +49-01888-754-2226
Fax No.: +49-01888-

Email: Leitung_RKI@rki.de

Dr Anette Siedler

Department for Infectious Diseases Epidemiology
Robert Koch Institute
Seestrasse 10
D-13353 Berlin
Germany

Telephone No. : +49 30 4547 3452
Fax No. : +49 30 4547 3514
Email : siedlera@rki.de

Dr Sabine Reiter

Department for Infectious Diseases Epidemiology
Robert Koch Institute
Seestrasse 10
D-13353 Berlin
Germany

Telephone No. : +49 30 4547 3461
Fax No. : +49 30 4547 3533
Email : reiters@rki.de

Dr Annette Mankertz

Head of Laboratory
NRC Measles, Mumps, Rubella
Robert Koch Institute
Nordufer 20
D-13353 Berlin
Germany

Telephone No. : +49 30 4547 2516
Fax No. : +49 30 4547 2598
Email : mankertza@rki.de

Dr Ines Steffens

Redaktion Epidemiologisches Bulletin
Robert Koch-Institut
Nordufer 20
D-13353 Berlin
Germany

Telephone No. : +49 30 4547 2324
Fax No. : +49 30 4547 2628
Email : steffensi@rki.de

Dr Monika von dem Knesebeck
Bundeszentrale für gesundheitliche
Aufklärung (BZgA)
Ostmerheimer Strasse 220
D-51109 Köln
Germany

Telephone No. : +49 221 8992 266
Fax No. : +49 221 8992 300
Email: monika.knesebeck@bzga.de

Mr Sean Monks
Monks 'Ärzte im Netz' GmbH
Tegernseer landstrasse 138
D-81539 München
Germany

Telephone No. : +49 89 642 482 16
Fax No. : +49 89 642 095 29
Email: s.monks@monks.de

Mrs Gabriele Ahlemeyer
Landesinstitut für den öffentlichen
Gesundheitsdienst NRW Standort Münster
Von-Stauffenbergstrasse 36
D-48151 Münster
Germany

Telephone No. : +49 251 7793 216
Fax No. : +49 251 7793 220
Email: gabriele.ahlemeyer@loegd.nrw.de

Dr Regine Kämmerer
Ministerium für Arbeit, Gesundheit und
Soziales des Landes Nordrhein-Westfalen
Fürstenwall 25
D-40219 Düsseldorf
Germany

Telephone No. : +49 211 855 3565
Fax No. : +49 211 855 3036
Email: Regine.Kaemmerer@mags.nrw.de

Dr Michael Kinet
Deutsche Akademie für Kinder- und Jugendmedizin e.V.
Eichendorffstrasse 13
D-10115 Berlin
Germany

Telephone No. : +49 30 4000 588 0
Fax No. : +49 30 4000 588 88
Email: kontakt@dakj.de
michael.kinet@uminfo.de

Dr Maike Nikutta
Landratsamt Weilheim-Schongau
Amtsgebäude - Abt. 6 Gesundheitsamt
Stainhartstrasse 7
D-82362 Weilheim i. OB
Germany

Telephone No. : +49 881 681 620
Fax No. : +49 881 681 699
Email: m.nikutta@ira-wm.de

Dr Wilhelm Miebach
Bundesministerium für Gesundheit - Referat GI 1
Übertragbare Krankheiten, AIDS, Seuchenhygiene
Wilhelmstr. 49
D-10117 Berlin
Germany

Telephone No. : +49 1888 441 3254
Fax No. : +49 1888 441 4935
Email: wilhelm.miebach@bmg.bund.de

Dr Eike Hennig
Gesundheits- und Veterinäramt
Lübeckerstrasse 32
D-39124 Magdeburg
Germany

Telephone No. : +49 391 540 60 44
Fax No. : +49 391 540 60 06
Email : hennig@ga.magdeburg.de

Prof H. J. Schmitt
Vorsitzender der STIKO
Pädiatrische Infektiologie
Kinderklinik und Kinderpoliklinik
der Johannes-Gutenberg-Universität
Langenbeck Strasse 1
D-55131 Mainz
Germany

Telephone No. : +49 6131 175033
Fax No. : +49 6131 175662
Email : hjschmit@uni-mainz.de

Prof. Burghard Stück

Ehrenpräsident – Deutsches Grünes Kreuz
Schulenburg 126
D-12101 Berlin
Germany

Telephone No. : +49 30 785 9008
Fax No. : +49 30 785 9008
Email: dr.stueck@snafu.de

Dr Elke Göhring-Zwacka

Regierungspräsidium Stuttgart
Abteilung 9
Landesgesundheitsamt
Wiederholdstr. 15
D - 70174 Stuttgart
Germany

Telephone No. : +49 711 18 49 0
Fax No. : +49 711 ...
Email: elke.Goehring-Zwacka@rps.bwl.de

Switzerland**Mr Roger Naef**

Dipl. sc. nat. ETH
Swiss Federal Office of Public Health
Immunisation programmes
Hess Strasse 27 e
CH-3003 Bern
Switzerland

Telephone No. : +41 31 322 74 99
Fax No. : +41 31 323 8799
Email : roger.naef@bag.admin.ch

Dr Jean-Luc Richard

Scientific Collaborator
Epidemiology and Infectious Diseases Division
Swiss Federal Office of Public Health
Schwarztorstrasse 96
CH-3003 Berne
Switzerland

Telephone No. : +41 31 323 87 06
Fax No. : +41 31 323 87 95
Email : jean-luc.richard@bag.admin.ch

Ms Phung Lang

Institut für Sozial- und Präventionsmedizin (ISPM)
Universität Zürich
Hirschengraben 84
CH-8001 Zürich
Switzerland

Telephone No. : +41 1 634 46 08
Email: plang@ifspm.unizh.ch

Dr Hans Binz

Präsident der Vereinigung der
Kantonärztinnen und Kantonärzte der Schweiz
Gesundheitsamt
Ambassadorshof
CH-4509 Solothurn
Switzerland

Telephone No. : +41 32 627 93 61
Fax No. : +41 32 627 93 50
Email : hans.binz@aio.ktso.ch

Dr Hugo Schön

Kinderarzt FMH
Eichenweg 2
CH-6280 Hochdorf
Switzerland

Telephone No. : +41 41 910 46 05
Fax No. : +41 41 910 37 05
Email: kinderarzt.hochdorf@hin.ch

Partner representatives

CDC

Dr Amra Uzicanin

Medical Epidemiologist
National Immunization Programm
Global Immunization Division (GID)
Centers for Disease Control (CDC)
1600 Clifton Road, MS-E05
30333 Atlanta, GA
USA

Telephone No. : +1 (404) 639 8747
Fax No. : +1 (404) 639 8573
Email: aau5@CDC.GOV

ECDC

Dr Bernadette Gergonne

Expert in Unit for Surveillance and Communication
European Centre for Disease Prevention and Control (ECDC)
Tomtebodavägen 11A
SE-17183 Stockholm
Sweden

Telephone No. : +46 8 41 04 78 23
Fax: + 46 8 30 00 57
Mobile: + 46 76 10 10 714
Email : Bernadette.gergonne@ecdc.eu.int

EUVAC.net

Dr Mark Muscat

Statens Serum Institut
Department of Epidemiology
Artillerivej 5
DK-2300 Copenhagen S
Denmark

Telephone No. : +45 3268 8254
Fax No. : +45 3268 3874
Email : mmc@ssi.dk

Interpreters

Mr Robin Mitchell

Thaler Str. 27
D- 13129 Berlin
Germany

Telephone No. : +49 30 47 41 455
Fax No. : +49 30 47 44 625
Email : Robin.Mitchell@t-online.de

Ms Silke Fritz

Knobelsdorffstr. 27
D- 14059 Berlin
Germany

Tel. / Fax : +49 30 30839050
Mobile: +49 171-4832031
Email : silke.fritz@dolmetschen-uebersetzen.net

World Health Organization, Regional Office for Europe

Dr Nedret Emiroglu

Regional Adviser
Vaccine Preventable Diseases and Immunization

Telephone No. : +45 39 17 14 50
Fax No.: +45 3917 18 63
E-mail: nem@euro.who.int

Dr John Spika

Responsible Officer
Accelerated Disease Control
Vaccine Preventable Diseases and Immunization

Telephone No.: +45 39 17 13 79
Fax No: +45 39 17 1 863
E-mail: jsp@euro.who.int

Ms Katrine Habersaat

Technical Officer
Vaccine Preventable Diseases and Immunization

Telephone No. : +45 39 17 14 23
Fax No.: +45 3917 18 63
E-mail: kah@euro.who.int

Rapporteur

Mrs Heike Thiesemann-Reith

Alte Kasseler Str. 2
D- 35039 Marburg
Germany

Telephone No. : +49 178 88 67728
Fax No. : +49 1212 6 77 28 6 77 28
Fax No.: +49 6421 61 43 44
Email : htr-science@email.de