GUIDELINES FOR THE ORGANIZATION OF MEASLES–RUBELLA VACCINATION CAMPAIGN
in 2014-2015
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<tr>
<td>CRS</td>
<td>Congenital rubella syndrome</td>
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<td>GAVI</td>
<td>Global Alliance for Vaccines and Immunization</td>
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<tr>
<td>MR</td>
<td>Measles-rubella vaccine</td>
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<tr>
<td>MMR</td>
<td>Measles - mumps - rubella vaccine</td>
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<tr>
<td>EPI</td>
<td>Expanded Program on Immunization</td>
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<tr>
<td>VVM</td>
<td>Vaccine vial monitor</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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PART I. INTRODUCTION

Since 1985 the Expanded Program on Immunization (EPI) has been implemented nationwide and brought about great achievements in health care and protection for children in Viet Nam. Polio elimination was achieved in 2000, neonatal tetanus elimination in 2005, as per the country’s commitment to the international community. Other diseases included in the Expanded Program on Immunization have also been effectively prevented and controlled. Viet Nam is making great efforts towards achieving measles elimination and control of hepatitis B. However, beside the progresses gained in reducing the incidence of the above mentioned contagious diseases, in recent years Viet Nam has suffered the burden of certain vaccine preventable diseases, amongst which is rubella and the serious consequences of rubella infection.

Rubella is a contagious disease caused by the rubella virus. Rubella virus is transmitted by respiratory routine, and symptoms include rash, low fever, swollen lymph nodes, etc. While the illness is generally mild in children, it has serious consequences in women infected with rubella virus during their first three months of pregnancy, causing miscarriage, fetal death or congenital defects known as congenital rubella syndrome (CRS) and congenital rubella infection. Almost every year rubella outbreaks are reported in Viet Nam, in 2005 alone there was a large scale epidemic, with over 11,000 cases. In fact, rubella incidence rates were much higher, as several cases with mild symptoms generally do not seek medical care at health facilities. According to the World Health Organization (WHO), there are an estimated 1,267-6,145 CRS cases reported every year in Viet Nam (accounting for 1/3 of the total CRS cases in the Western Pacific Region), and Viet Nam ranks second among countries with the highest CRS incidence rates in the Region.

Rubella vaccine has been proved to be very safe and highly efficacious in the prevention of the disease. In many countries where rubella vaccine is included in national immunization programme, rubella infection and CRS have been eliminated, and this has reduced the burden caused by the consequences of the disease for families and society. The WHO recommends the use of rubella vaccine in countries where rubella is considered a priority health issue. The Western Pacific Region has endorsed a target of decreasing rubella incidence to < 10 cases per million population and CRS incidence to < 10 cases per million live births, ideally by 2015. Between 2011 and 2013 four countries, including the Philippines, Laos, Cambodia and Mongolia, used over 23 millions doses of measles-rubella vaccine in national immunization campaigns. Up to now 30/37 countries and areas in the Western Pacific Region have included measles-rubella vaccine or MMR vaccine in their EPIs.

Having got Government approval, a proposal was made by the Expanded Immunization Project and The Global Alliance for Vaccines and Immunization (GAVI) has agreed to support the project to introduce measles – rubella combined vaccine into EPI for children aged 1-14 years nationwide by a campaign in the years 2014 and 2015.

Successful implementation of the campaign will contribute greatly to reducing the rubella and CRS burden in the future. With the expected rate of over 95% of children vaccinated against measles and rubella, measles and rubella virus circulation will be stopped and the incidence rates greatly reduced. The campaign will help Viet Nam achieve the goal of measles elimination by 2017 and rubella elimination in the future.
This “Guidelines for Organization of measles-rubella vaccination campaign” is prepared by the Expanded Immunization Project to assist health workers at all levels in developing plans, organising and implementing the campaign successfully.

PART II. AIMS OF AND BASIC INFORMATION ABOUT MEASLES - RUBELLA VACCINATION CAMPAIGN

1. AIMS:
To reduce the incidence of measles and rubella, reduce the burden of congenital rubella syndrome, and by thus doing, improve Vietnamese children’ physical health, and contribute to achieving the objectives of the Expanded Immunization Project under the Health National Target Programme in the 2012-2015 period.

2. OBJECTIVES
2.1 To administer measles-rubella vaccine to 95% of children aged 1-14 years nationwide. Maximally reduce the number of missing subjects, especially high risk subjects who have not received vaccines through routine immunization, such as out-of-school children, children living in remote or secluded areas, or of migrant families.
2.2 To ensure safety and quality of immunization according to Circular 12/2014/TT-BYT issued on 20/3/2014 of the Ministry of Health guiding the management and use of vaccines in immunization.

3. VACCINATION SUBJECTS
All children aged 1-14 years shall be given one dose of measles-rubella vaccine during the campaign, including those who have previously received measles vaccine, or MMR, (excluding children who have been vaccinated against measles, measles & rubella, or measles, mumps & rubella within less than 01 month prior to the scheduled vaccination day under the campaign). The estimated number of children to be vaccinated is approximately 23 millions.

DO NOT administer measles-rubella vaccine to children who have just been vaccinated against measles, measles-rubella or measles, mumps, and rubella within 01 month prior to scheduled vaccination day under the campaign

4. IMPLEMENTATION AREAS.
The campaign will be implemented in the 63 provinces/cities nationwide, involving 100% of districts and wards/communes.

5. IMPLEMENTATION SCHEDULE.
Due to capacity and to ensure achievement of the set objectives, the campaign will not be implemented simultaneously nationwide. There will be three rounds:
- Round 1: vaccination coverage for children born between 1/1/2009 and 31/8/2013 nationwide, (children aged 1 – 5 years, i.e kindergarten/ nursery school children and other children in the community), to be implemented in 9-10/2014.
Round 2: vaccination coverage for children born between 1/1/2004 and 31/12/2008 nationwide (children aged 6-10 years, i.e. students in grades 1, 2, 3, 4, and 5 of primary schools), to be implemented in 11-12/2014.

Round 3: vaccination coverage for children born between 1/1/2000 and 31/12/2003 nationwide (children aged 11 – 14 years, i.e. students in grades 6, 7, 8, and 9 of lower secondary schools), to be implemented in 1-2/2015.

Note:

- Based on specific geographical conditions and characteristics of residential areas in each province, especially in certain high risk areas, remote and/or secluded, hard-to-reach areas, all children aged 1-14 years should be given the vaccine in one round of the campaign. Rollup mode should be applied in the campaign, beginning with immunization for students at schools, then at the health stations, and lastly in clusters of villages/hamlets or village/hamlet.
- Campaign implementation schedule can be adjusted appropriate to specific climate/weather conditions of each province, provided that plans be made and approved by the National Steering Committee.
- Students of lower secondary schools and primary schools who are not in the campaign’s target age group should also be given the vaccine.

6. BASIC INFORMATION ABOUT MEASLES – RUBELLA VACCINE

6.1 What is measles – rubella vaccine?

- Measles - rubella vaccine is a combined (MR) vaccine consisting of 2 live attenuated antigens of measles and rubella virus for immunization against measles and rubella.
- The vaccine used in the campaign is supplied in boxes of 50 vials x 10 doses of measles - rubella vaccine in freeze-dried form.

*Picture: vaccine and solvent vials*
- Manufacturer: Serum Institute of India Ltd.
- Dosage and route of administration
  + Dosage: 0.5 ml.
  + Route of administration: Subcutaneous injection

6.2 Requirements on vaccine and solvent storage.
- Storage temperature required for measles-rubella vaccine is +2°C - +8°C. A vaccine vial monitor (VVM) is attached to the vial cap to flag heat damaged vaccine.
- Solvent must be stored in a refrigerator at +2°C - +8°C within 24 hours before adjuvant dilution of vaccine.

6.3 Immunization safety information.
- Measles-rubella vaccine is very safe
- Generally, adverse events following measles-rubella vaccination are not different from reactions associated with measles vaccine or rubella vaccine alone.
- Burning and/or stinging at the injection site may occur within 24 hours following vaccination and last for 2-3 days. Mild fever may occur approximately 5 to 12 days among 5-15% of children following vaccination and last 1-2 days. Rash occurs 5-10 days following vaccination in 2% cases and usually disappears within 2 days. Encephalitis has also been reported, but rare (less than 1 child out of 1,000,000 given measles vaccine). No definite causal relationship has been established between these events and vaccination.
- Adverse reactions to the rubella vaccine may include arthralgia (25%) or arthritis (10%) in adolescents and women; the symptoms often last from a few days to 2 weeks. However, such reactions are rare in children and men given the vaccine (0%-3%). Symptoms may develop 1-3 weeks following vaccination and last from 1 day to 2 weeks.

7. CAMPAIGN IMPLEMENTATION STRATEGY AND METHOD

To maximaly reduce the number of missing subjects eligible for immunization under the campaign, and to effectively mobilize available resources, rollup mode will be applied in the implementation of the measles - rubella vaccination campaign, i.e. vaccination will be organized in rounds and in one district/ commune after another.

Campaign provinces with a large proportion of hard-to- reach mountainous and remote communes would face difficulties in mobilizing human resources, transporting, maintaining vaccines, and managing immunization subjects. Applying the rollup method, therefore, will help overcome such difficulties and ensure achievement of the campaign objectives.

To ensure quality and efficacy of immunization, integration of other activities in the campaign is not recommended.

As there is a great number of children to be given measles – rubella vaccine during the campaign, including both school children and children in the community, careful planning of detailed schedule is very important and suitable vaccination points should be set up:

➢ at commune health stations
outside the commune health stations (outreach vaccination points), with children in one hamlet/village or a cluster of hamlets/villages being given the vaccine at one vaccination point.

- in lower secondary schools, primary schools, kindergartens and nursery schools; and
- in high risk areas, remote or secluded, hard-to-reach areas, with immunization teams.

Limits for the operation time of each vaccination point depends on the number of children eligible for immunization against rubella under the campaign, as well as the number of health workers working at each vaccination point. Plans should be developed to ensure sufficient time to give vaccine to all eligible children, with no vaccination point being overcrowded; time should also be given to reviewing the list of eligible children, searching for eligible children and encouraging parents to have their children vaccinated, especially in high risk areas.
PART 3: CAMPAIGN PREPARATION AND ORGANIZATION

1. KEY ACTIVITIES IN CAMPAIGN PREPARATION.

1.1 ESTABLISHMENT OF STEERING COMMITTEES AT DIFFERENT LEVELS

To ensure successes for the campaign, as well as to maximally mobilize available resources, establishment of Campaign Steering Committees at all levels is an urgent and important task.

a) National Steering Committee.

The National Steering Committee shall include in its membership representatives of the Ministry of Health, Expanded Immunization Project and related sectors, agencies and mass organizations.

b) Steering Committees at different levels (provinces, districts and communes)

Members of the Steering Committees at these levels include:

- Chairman or Vice Chairman of the People’s Committees
- Leaders of the Health sector.
- Representatives of related sectors, agencies and social organizations, including Education, the Women’s Union, Border Force and Military Health.

1.2 ISSUANCE OF DOCUMENTS GUIDING CAMPAIGN IMPLEMENTATION

The issuance of guiding documents by competent authorities at all levels bears an important significance, creating maximal conditions regarding legislation, guidance of the local health network and orienting relevant sectors and agencies in providing supportive human resources for the campaign.

It is necessary that guiding documents on the coordination of various sectors, branches and mass organizations with the health sector; and between systems of preventive medicine and therapy with other related units of the health sector be issued by Provincial Departments of Health.

Subjects of vaccination in the campaign include school children, and children at kindergartens and nursery schools. It is necessary, therefore, that documents be issued by education authorities to ensure the participation and close coordination of teachers in listing and registering eligible subjects, in propagandizing for and organization of the campaign.

In localities on the borderline with poor access, documents guiding the coordination and support of the military health workers and border guards should be in place.

1.3 ORGANIZATION OF LAUNCHING AND TRAINING WORKSHOPS:

a) Workshops on campaign launching

Workshops on campaign launching shall be held at regional, provincial and district levels for people involved in the campaign to thoroughly grasp the importance, significance and objectives of the campaign, as well as advantages and difficulties that may arise during implementation, and to discuss measures for implementation and coordination between agencies and organizations, to ensure effective campaign implementation.

Participants:

- At provincial level:
  - Leaders of the Provincial People’s Committee.
+ The Campaign Steering Committee.
+ Provincial Department of Health, Provincial Center for Preventive medicine.
+ Leaders of related agencies and mass organizations (education, communication sectors, etc.).

- At district level:
  + Leaders of the People’s Committee.
  + The Campaign Steering Committee.
  + District Center for Preventive medicine, District Health Office.
  + Leaders of related agencies and mass organizations (education, communication sectors, etc.).

- At commune level:
  + Leaders of the Commune/ Ward People’s Committee.
  + Commune/ward Campaign Steering Committee.
  + Head and staff of the commune health station.
  + Leaders of related agencies and mass organizations (education, communication sectors, etc.) of district and commune levels.

b) **Workshops on plan development and training activities:**

As this will be a large scale campaign, with a huge amount of diversified subjects to be vaccinated, and the vaccine must be administered by injecting, it is prerequisite that health workers involved in the campaign be given training in planning, as well as in vaccine storage and use. Training will be organized in turn and by level, from the provincial to commune ones.

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**Plans should be developed and training for commune health workers completed at least two months prior to campaign commencement**

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**Participants:**

+ Provincial level: leader(s) of the Provincial Department of Health, Director of Provincial Center for Preventive Medicine. Head of the Infectious Disease Control Department, Staff specializing in EPI – provincial hospital.
+ District level: District Center for Preventive Medicine, District Health Office, District Hospital.
+ Commune level: commune health station staff.

**Key contents:**

+ Objectives, requirements and target subjects of the campaign.
+ Development of implementation plans, including identification of eligible subjects, vaccine needs, immunization materials, budget, human resources, vaccine and material supply plans. Setting up vaccination points, arrangement of vaccination for children at points other than commune health stations, in places away from residential areas, in areas that borders different communes/districts, industrial zones, plans for dredging injections.
+ Plans for communication and community mobilization activities before and during the campaign.
+ Investigation, searching for and listing all eligible subjects, especially those who have not received vaccines through routine immunization and children living in remote, secluded areas, children of migrant parents who are not registered as permanent residents in the locality, etc.
+ Safe immunization practices: maintenance and use of measles-rubella vaccine, use of auto-disable syringes, safe boxes, measures for management and safe disposal of used syringes and needles.
+ Prevention and management of shocks.
+ Use of recording/reporting and campaign evaluation Forms.
+ Requirements and plans for inspection and supervision before, during and after campaign.

1.4 LISTING AND REGISTRATION OF VACCINATION SUBJECTS

Listing of subjects is an important step and a must in preparing for the campaign, to minimise the number of children that are not immunised. The “List of children to be vaccinated against measles-rubella under the campaign” Form will be used (see Form 1A/CD-1B/CD).

**Listing subjects eligible for vaccination, especially those in remote areas, disadvantaged areas, areas between localities, children of non-resident migrant families, and children who do not have permanent homes is a must and must be completed at least 1 month prior to commencement of each round**

**1.4.1 Steps in listing subjects:**

- Mapping the locality (village/hamlet)
  
  Location and description of residential areas, especially high risk ones and health facilities and schools available in the locality.
  
  - Identification of high risk areas (see details in the next section)
  
  - Assigning staff on duty and schedule.
  
  - Listing and registration of vaccination subjects at schools (Form 1A/CD) and in the community (Form 1B/CD), in each hamlet/village, especially in the identified risk areas. Non-resident children living in the locality should also be included on the list (Form 1B/CD).
  
  - Checking and verifying data by comparing with other sources of information (population data provided by the People’s Committee or local police, etc.)
  
  - Additional registration for children if needed.
  
  - Supervision and inspection of the listing procedure and results, especially in the community.

**1.4.2 People involved in listing vaccination subjects:**

- Management boards of schools in the locality should be notified and requested to assign their teachers (including staff in charge of school health service) to list students eligible for vaccination in each of their classes.

- The network of health workers and collaborators, including village/hamlet health workers, population collaborators, cadres from the Women’s Union, Youth League, Veterans Association or village/hamlet heads, etc.
Note: During visits to households to make list of children eligible for vaccination, especially in risk areas with hard-to-reach households in remote and secluded areas, or in urban, suburbs areas with residential mobility, industrial zones, and families who do not have permanent homes fishermen’ families on coastal areas), parents should be provided information about the campaign.

1.4.3 Listing vaccination subjects

The “List of children to be vaccinated against measles - rubella under the campaign” Form will be used when listing subjects eligible for vaccination:

- Students in secondary schools, primary schools, kindergartens and nursery schools: Coordinate with schools to list all eligible students in each class (Form 1B/CD). Special attention should be paid to new school dropouts, children who have just moved to other schools or those attending schools outside their place of usual residence, so as to avoid missing or coincidence of subjects.

- Children in the community, both young and out-of-school children: health workers will coordinate with local collaborators to visit households and make lists of all eligible children in the locality by production brigade, village, inhabitant unit or cluster of hamlets. Children in each village/inhabitant unit will be recorded into one separate list to facilitate the check up and supervision of vaccination subjects during the campaign. Non-resident children who are present in the locality at the time of campaign should also be included in the list (Form 1A/CD), especially in identified risk areas.

- Calculate the total number of children (born between 2000 and 2014) to be vaccinated by age group, using the lists of children at schools and households - the community. The ‘Counting number of children vaccinated under the campaign’ Form (Annex 14) shall be used to calculate the total number of children by year of birth from the list of children to be vaccinated against measles – rubella under the campaign (Forms 1A/CD and 1B/CD) that have been made at schools, households and in the community.

- Compare data on the list by age group with other statistic data, such as Immunization registration book/records kept at the health stations, lists of registered residents in each administrative area and other lists kept by local authorities or health stations to detect gaps or differences (if any), to find out the reasons for the gaps and continue to coordinate with local staff, or seek the support of local authorities to find children who have not been included on the list, so as to avoid missing or coincidence of subjects.

- Supervising the listing of eligible subjects is a priority in the supervision activities to be conducted before the campaign by provincial and district staff. The health station of each commune/ward should proactively select some villages/hamlets and conduct random checkups to see if any subjects are not included in the lists of eligible subjects. Checklists to be used for supervision prior to campaign, including that of listing subjects, are provided in the Annexes.

1.4.4 Identification of high risk areas and listing subjects to minimize the number of eligible children missing injections:

1) Following are basic criteria to be applied in the identification of risk areas (tables of areas can be made, with criteria for each area/locality)
– Areas with measles or rubella deaths or outbreak(s) reported in 2012, 2013 and early 2014.
– Areas with many children under 12 months who have not been given first or second dose of measles vaccine (<90%), or the rate of full immunization for children under 12 months is <80%.
– Areas having secluded, mountainous, hard-to-reach population groups.
– Coastal, river side areas with fishing villages and fishing families who do not have permanent homes.
– Urban areas / suburbs with large number of non-resident children, or industrial zones with migrant population who are not registered as permanent residents.
– Areas between localities (away from administrative center of the locality, but closer to health facilities of the neighboring commune/district, etc.)

After risk areas have been identified applying the above mentioned criteria and marked on the map, listing of eligible children to be vaccinated under the campaign will be conducted in the community (according to the listing schedule of the commune/ward). Use the “List of children to be vaccinated against measles – rubella under the campaign” Form and coordinate with local collaborators or police to check each household to make list of children eligible for vaccination in the high risk areas that have been identified.

2) Note: when making lists of eligible children in high risk areas, communication materials should be taken along to provide the parents with necessary information about the campaign.

3) When setting up vaccination points in high risk areas, convenience of access and time for the parents should be ensured to avoid missing subjects.

1.5 ESTIMATING VACCINE AND IMMUNISATION MATERIALS NEEDS

Vaccine and immunisation materials form an indispensable factor and contribute greatly to the campaign’s successes. Health workers should be able to estimate minimal needs of immunisation materials for the campaign. Following are the materials needed:

+ Measles-rubella vaccine, and solvent
+ 0.5ml and 5ml syringes/needles
+ Safe boxes for used syringes/needles
+ Emergency aid boxes for shock management.
+ Refrigerators, cold boxes.
+ Vaccine thermoses
+ Cold bottles and ice
+ Other supplies (cotton, pincers, enamel trays, tablecloths, etc.)

a) Vaccine

| TOTAL AMOUNT OF VACCINE = TOTAL SUBJECTS X EXPECTED PERCENTAGE X 1.15 |
| (OF WHICH: 10% FOR WASTAGE AND 5% FOR RESERVED DOSES) |

Note: Each vaccination point needs at least 1 vaccione vial per vaccination section
b) Auto-disposable 0.5ml syringes/needles

\[
\text{AMOUNT OF SYRINGES (0. ML) = TOTAL SUBJECTS X EXPECTED VACCINATION RATE X 1.1}
\]

c) 5ml syringes for adjuvant dilution of vaccine

\[
\text{AMOUNT OF 5ML SYRINGES = \frac{TOTAL VACCINE DOSES}{10 (DOSES IN 1 VIAL)} X 1.1}
\]

d) Safe boxes

\[
\text{AMOUNT OF SAFE BOXES = \frac{TOTAL SYRINGES}{100} X 1.1}
\]

- Total amount of syringes/needles including auto-disposable 0.5 ml and 5ml syringes
- A 5 liter safe box can contain around 100 syringes/needles.

Each vaccination table or mobile vaccination team should be equipped with enough safe boxes corresponding to number of subjects as calculated above.

e) Emergency aid boxes: each box should contain at least:

- Adrenalin: ¼ mg or 1 mg = 2 vials
- Distilled water: 10 ml = 2 vials
- Syringes/needles 10ml and 1ml: 2 pieces each size
- Hydrocortisone hemisuccinate 100mg or methyprednisolone (Solumedrol 40mg or Derpersolone 30mg): = 2 vials
- Sterilization supplies (cotton, bandage, and alcohol)
- Tourniquets
- Anaphylaxis emergency aid chart

Each vaccination point or mobile vaccination team should be equipped with at least 1 EMERGENCY AID BOX

f) Vaccine thermoses:
Each vaccination table or mobile vaccination team should have at least 2 vaccine thermoses (1 is for storing on-the-use vaccine, the other is for storing unused vaccine and solvent).

\g) Cold bottles or ice: 
One vaccine thermos should contain 4 readily made cold bottles.

h) Amount of ice is calculated using the formula = 4 kg ice/day/thermos if no cold bottle is available.

\i) Refrigerators:
District health centers should have 1-2 refrigerators/ice makers in place for vaccine storage and freezing cold bottles.

Other supplies, such as enamel trays, cotton and pincers should be stimated based on the actual need of local vaccination points/teams.

1.6 COMMUNICATION AND SOCIAL MOBILIZAZION
The aims of communication activities are to ensure all relevant people and the community/society have clear and proper understanding of the measles-rubella vaccination campaign, especially:

+ the dangers of measles and rubella to children’s health and life, and to the community
+ information about the vaccine: who should receive the vaccine and the benefits of measles - rubella vaccination
+ vaccination date, hour and venue.

The target audience of communication activities include:

+ Families having children eligible for vaccination;
+ People in the community involved in the organization of the campaign: grassroots collaborators (village/hamlet health workers, village/hamlet heads, collaborators, members of the Red Cross Organization, etc.); and
+ Agencies directing the campaign and relevant agencies/organizations, including leaders of local government, staff of local agencies and organizations, especially the education sector, military health staff and border guards in remote, secluded, and disadvantaged areas.

Various communication forms should be made use of to suit different target groups an local situation.

Key messages should be conveyed (see details in Section 4, Annexes)

a) Before the campaign

- Continuously carry out the propaganda for at least 2 weeks using locally available mass media such as the provincial television and district/ commune radios.
- Key contents to be conveyed as mentioned above.
- Various communication forms and means, such as articles in local newspapers, posters, leaflets distributed and/or displayed at populated and busy sites, commune health stations, hospitals, marker place/malls, etc. should be used.
- Special attention should be paid to commune/ward loudspeaker systems, and talks with parents during visits to households to register subjects and distribute invitation letters.
- Invitation letters or notification sent to parents should be considered a useful tool to mobilize subjects to participate in the campaign. Basic information on the vaccination date, hour and venue should be clearly indicated. (see detail in Annexes)

b) During the campaign

Slogan contents should be precise, easy to read, easy to understand.

- Where possible, campaign launching ceremonies should be organized.
- Large print slogans with information about vaccination time and venue should be hung at provincial/district/commune/village centers.
Slogans and leaflets should be available at vaccination points to provide information about the campaign.

Propaganda for the campaign should be conducted continuously on the mass media (television, radios) throughout the campaign.

c) Social mobilization is one of the important factors contributing to success of the campaign.

Social mobilization includes the investment and support of sectors/agencies and social organizations in term of resources, as well as the participation of parents and the children themselves in the preparation and implementation of the campaign.

At all levels, guidance, supervision and support are needed from the Party, local authorities, branches, sectors, mass and social organizations and individuals, to gain material and spiritual assistance for the campaign. It is possible to mobilize the participation of medical (university and college) students in the campaign.

Mobilization of resources at different levels requires the guidance, supervision, inspection and support of the Party Committees, local government and related agencies/organizations.

In risk areas, such as mountainous, remote and hard-to-reach localities, or urban areas/surburbs, participation and coordination with military health units and border guards is indispensable.

1.7. INSPECTION AND SUPERVISION OF ACTIVITIES PRIOR TO THE CAMPAIGN:

The primary aim of supervision before the campaign is to ensure timely completion of plan development and progress of activities in the preparation for the campaign, especially activities such as listing subjects, plans for setting up vaccination points, as well as plans for communication activities to mobilize the community and human resource, logistics, etc.

− Local staff at different levels play an important role as they should collaborate with supervisors when being supervised/monitored and expeditiously apply measures to improve the quality of activities and accelerate the progress of preparation for the campaign.

− Provinical/city Steering Committee and Center for Preventive Medicine shall, in coordination with agencies and organizations, develop schedule for supervision and inspection visits to areas under their ambit (district authorities shall visit wards/communes to inspect/monitor preparation activities); items/issues to be checked include:

1. Lists of eligible children by area and the total number of children to be vaccinated by age group, the accuracy of which has been verified (Forms 1A/CD-1B/CD).

2. The guidance of the Steering Committee, especially plan to mobilize local resources.

3. The coordination with agencies and organizations at grassroots level and above, to ensure provision of resources for campaign preparation.

4. Campaign implementation plans and progress of plan implementation, including communication activities and community mobilization.
5. Plans for and actual reserves of sufficient amount of vaccine, syringes/needles and other supplies, including provision of ice.

6. Plans and equipment for shock prevention and management.

1.8 COMPLETION OF CAMPAIGN IMPLEMENTATION PLAN

- Plans for the implementation of the campaign in communes/wards should be based on the data acquired after listing subjects at schools and the community, and specific situation of the locality, as well as capacity of human resources available.

- Development and completion of campaign implementation plans for district and provincial levels should be based on the micro plans of communes/wards in the locality (and on the framework plan that has been disseminated).

- Beside the role of local government in guiding the campaign, the role of the health sector in supervision of and giving advice on organization of campaign, the coordination and specific role of each related agency, especially the education system, military health units, border guards and the Women’s Union, etc. should be clearly speculated in the campaign implementation plans.

2. ACTIVITIES IN CAMPAIGN IMPLEMENTATION

2.1. HANDING OVER AND STORAGE OF VACCINE, SOLVENT AND OTHER IMMUNISATION MATERIALS

- Provinces will provide vaccine to districts 2 - 5 days prior to campaign commencement. As the rollup mode will be applied, vaccine could be delivered in 1 or 2 rounds depending on the capacity of refrigerators available at District Centers for Preventive Medicine.

- Communes receive vaccine and keep in refrigerators at the commune health stations. Remote and hard-to-reach communes have to preserve adequate ice and cold bottles, and use large cold boxes (25 liters, 8 liters) or thermal boxes to ensure proper storage of vaccine in many days.

- Distributing and transporting to vaccination points: each vaccination point should have at least 2 vaccine thermoses or more available if there are many children to be vaccinated. One of these 2 thermoses will be used to keep ice to support the other when its ice gets thawed and may cause damage to the vaccine. This is especially important to vaccination points located far from administrative center of the locality.

- Cold chain and ice used in vaccine storage: cold chain systems at different levels in each province/city should be checked to ensure readiness for vaccine storage throughout the campaign, Provincial and District Centers for Preventive Medicine should have plans in place to mobilize vaccine thermoses and cold boxes from other districts and communes, in order to facilitate campaign districts and communes to maximally ensure vaccine quality and needs of immunization materials.

- Additionally, commune health centers should develop plans for procurement of ice needed for vaccine storage (as refrigerators at commune health stations cannot meet the needs of ice supply). Places where ice could be procured should be specified and contracts signed with the providers, to make sure to provide at least 4 kg of
ice/vaccination point/day. If ice cannot be procured in the commune, the District Center for Preventive Medicine should be notified for alternative measures to be taken.

- Solvent should be handed over together with the vaccine. Solvent can be stored in a cool place if there is not sufficient space in the cold chain. Solvent should be kept cold within 24 hours before adjuvant dilution of vaccine, but should not be frozen.

- Other supplies used for immunization (syringes/needles, safe boxes, etc.) must be assembled at the commune level at least one week before the campaign.

- Other related documents to be supplied prior to campaign commencement include:
  - Guidelines for organization of the campaign.
  - Communication materials: posters, leaflets, CDs....
  - Statistic Forms and Forms used in listing subjects.
  - Invitation letters, vaccination certificates.
  - Vaccination recording/reporting Forms.

2.2. HUMAN RESOURCE MOBILIZATION

Human resources for vaccination are mobilized from among local staff, including health, education and other related agencies. Responsibilities of staff participating in the campaign should be specified, among which the key tasks include:

- Communication-information and social mobilization activities, chiefly conducted by agencies, in coordination with grassroots collaborators.

- Setting up of vaccination points at lower secondary schools, primary schools and kindergartens/nursery schools, with the support and participation of teachers-in-charge and staff in charge of school health service (if any) who are assigned by the school management board.

- Performance of vaccination and reporting/recording results will be done by health workers.

- Supervision and inspection of the campaign, and support to solve problems that may arise during campaign implementation will be the responsibility of staff of higher levels specializing in supervision.

2.3. SETTING UP VACCINATION POINTS AND ENCOURAGING SUBJECTS IN THE LOCALITY TO GET VACCINATED

Children eligible for vaccination can be classified into 3 groups and get vaccinated at different sites as follows:
2.3.1 Fixed vaccination points at commune health stations or schools:

Locations of vaccination points depend on the situation of each locality; but there should always be fixed ones at commune health stations and schools in the locality. Time limits for the operation of this type of vaccination points should not be fixed, to allow sufficient time to give vaccine to all eligible children in the locality, so that there would not be too many subjects gathering in one section, as well as time spared for subjects checkup and mobilisation, to ensure all eligible children in the locality are given the vaccine.

As only one kind of vaccine is used in the campaign, the number of children to be vaccinated each section/vaccination point can be more than 50, but should not be more than 100.

2.3.1.1 Requirements on location and arrangement of vaccination points:

Vaccination points must be easy to access, airy, and large enough for setting up places of reception, screening examination, injection and writing records.

Tables should be arranged in such a manner to ensure convenience and one way process.

As for vaccination points at schools, school management boards should be requested to provide spacious rooms for vaccination activities, and enough tables and benches to ensure the one way process: children would queue up for vaccination, then move to the monitoring table under the supervision of health workers and/or teachers. After all students in one class have been vaccinated, another class would be called in, to prevent confusion.

2.3.1.2 Requirements on human resource:

- There are at least 3 HEALTH WORKERS who have been trained in immunisation skills and shock prevention and management
- Trained health workers will undertake the screening examination, provide guidance on post injection care, administer injections and deal with shocks (if any);
- Vaccination assistants will guide and arrange subjects at the vaccination point, record results on the list of subjects, write certificates after administering vaccine.
- At school based vaccination points, participation of teachers is required, to ensure that all students get vaccinated, and to solve any problems that may arise.

2.3.1.3 Requirements on supplies:

Tables, chairs/benches, vaccine, solvent, vaccine thermoses, 0.5ml auto-disposable syringes/needles, 5ml syringes, safe boxes, emergency aid boxes, sugar solution, Forms, lists of subjects, etc.

2.3.1.4 Activities at vaccination points include:

1. Organising the reception of children and parents.
2. Screening examination to detect contraindicated children as per regulations, and providing instructions on post injection monitoring and care are compulsory.

3. Preparing and administering vaccine to children.

4. Recording after administering vaccine to children.

5. Inserting used syringes/needles into safe boxes and safely disposing them as per regulations.

6. Collecting and summing up data and reporting after each section.

2.3.2 Outreach vaccination points
- In remote and disadvantaged areas far from health stations and with secluded population, outreach vaccination points should be set up.
- Requirements on both supplies and human resources for 1 outreach vaccination point are as above.
- One vaccination point for closely situated villages should be set up, however, do not assign too many villages to 1 vaccination point (it is possible to allocate 2 villages to 1 point if these are not too remote and difficult to reach, and 4-5 villages/point if access is convenient).
- Rollup method should also be applied by each outreach vaccination point: children of the nearby villages will receive the vaccine first, then the team would move to farther villages. It is not advisable to let people travel more than 5 km to the vaccination point.
- Arrangement for outreach vaccination points depends on the specific situation of each locality, but it should also be based on micro plans of the commune/ward, including:
  + Areas and number of children to be vaccinated in a certain period of time.
  + Time limits for the operation of each outreach vaccination point should be clearly specified and the communes/villages in the areas be informed of this;
  + Time limits for the operation of each outreach vaccination point should be clearly specified and the community be informed of this in advance; time spared for subjects check up will be decided in coordination with local staff, to be consistent with the operation time of the vaccination point.

- Requirements on human resources:
  
  | there are at least 2 HEALTH WORKERS who have been given training on immunisation skills and shock prevention and management |
  
  - Trained health workers will undertake the screening examination, provide guidance on post injection care, administer injections and deal with shocks (if any);
  - Vaccination assistants will guide and arrange subjects at the vaccination point (especially the waiting area), record on the list of subjects, write certificates after children are vaccinated (if assigned with this responsibility).
  - At school based vaccination points, participation of teachers is required, to ensure that all students get vaccinated, and to solve any problems that may arise.
  - Grassroots collaborators/ volunteers will help encouraging all eligible children in the locality to come for vaccination, and perform other tasks during the section.

2.3.3 Encouraging eligible subjects in the locality to get vaccinated:
- Based on the lists of children to be vaccinated that have been made, invitation letters will be written and sent to households 3 - 5 prior to campaign commencement. Invitation letters
should not be distributed too early, least parents may forget to take their children to the vaccination point.

- The date, hour, and venue of vaccination should be clearly indicated in invitation letters. It is possible to divide the time into intervals for each geographic area (village, inhabitant unit...) so that there would not be too many subjects gathering at one time.

- Parents of school children who will get vaccinated at schools will be given notice 3 - 5 days prior to campaign commencement.

2.4 SAFE IMMUNIZATION PRACTICES:
Safety and quality of immunization must be ensured, including:
- Vaccine and solvent are stored according to standard procedure;
- Proper adjuvant dilution of vaccine.
- Screening, indications and counselling provided prior to vaccine administration.
- Safe injection technique.
- Post injection monitoring and management of shock (if any).
- Disposal of used syringes /needles.

a) Vaccine and solvent storage
After adjuvant dilution, measles -rubella vaccine must be kept cold to ensure its efficacy.

- **Requirement 1:**
  *Vaccine must be stored cold between 2°C - 8°C and protected from sunlight.* Ice bags and cold bottles must be regularly checked to make sure that vaccine is kept cold.

- **Requirement 2:**
  *Solvent must be stored cold between 2°C - 8°C* for at least 24 hours before use.

- **Requirement 3:**
  Only withdraw vaccine into a syringe when there is a child waiting to be vaccinated.

b) Adjuvant dilution vaccine.
- Use the right solvent provided with the vaccine by the manufacturer.
- Make adjuvant dilution just before injection, do not dilute many vials in advance.

c) Indications and contraindications:

Contraindications.
- Children who are being treated with cortisocoteroids, or with drugs that affect the immune system or radiation should not be given the vaccine.
- Measles-rubella vaccine should not be given to pregnant women, to persons who are having fever or progressive infections, suffering leukemia, severe anemia or other serious blood disorders, severe renal failure, decompensated heart failure, those who have just been given blood transfusion or are under gamma-globulin therapy, or those who may be allergic to any components of the vaccine.
- As the vaccine contains neomycin in its composition, it is absolute contraindication in cases that have a history of allergy, hypersensitivity or anaphylactic reactions to neomycin.

Delaying vaccination:
- Measles-rubella vaccination will be delayed for children who are having a fever or acute infections.
- Respiratory diseases, diarrhoea or other mild illnesses should not be considered contraindications to measles-rubella vaccine injections. Vaccination is especially important to malnourished children.
d) Measles-rubella vaccine injection techniques.
- Administration route: subcutaneous injection
- Dosage: 0.5ml
- Injection site: outside upper circumference
- Ensure one sterilized syringe/needle for one injection.
- Destroy vials that have been diluted for more than 6 hours.
- Do not prefill several syringes with vaccine and wait for children to come for injections, or transport these syringes from one vaccination point to another.
- Used syringes/needles must be placed into safe boxes for safe disposal.

e) Shock prevention.
Measles-rubella vaccine is a highly safe vaccine with low adverse reaction rate. Data collected from the campaign implementation showed that the number of children who got shock by Measles-rubella vaccination was not significant. However, it should be noted that just one case of catastrophe that is not managed well can cause panic and anxiety among many families, and prevent them from having their children vaccinated.

Health workers should have good mastery of and be able to apply shock prevention measures that are given in the ‘Circular on the prevention and provision of primary aid to anaphylactic shock’ issued by the Ministry of Health. Provincial and district health centers should invite doctors specializing in shock prevention to provide training for grassroots level health workers, and have plans to assign staff and health facilities on duty to assist in management of emergency cases during the campaign.

Throughout the whole campaign, it is necessary for staff to be ready and calmly manage shocks that may occur

- Assign professionals to be on emergency duty at health facilities to timely deal with post injection reactions.
- Have a list of nearby hospitals/polyclinics, with contact numbers and addresses, ready for children having reactions to immunization (if any) to be taken to.
- Have support of hospital mobile emergency aid transport teams when needed.
- Advise parents to feed their children before having them vaccinated. Prepare sugar solution at vaccination points for children in case they feel hungry by the end of the morning or afternoon vaccination section.

f) Safe disposal of syringes/needles.
As there will be a large amount of used syringes/needles to be disposed at one time, plan must be developed to ensure safe disposal of these items. It is important that Centers for Preventive Medicine should develop plans suitable to local conditions for the safe disposal of these syringes.
In remote and secluded areas, used syringes/needles could be burned or buried.

2.5 SUPERVISION AND INSPECTION DURING AND AFTER THE CAMPAIGN
Aims of supervision:
- During the campaign: to identify and timely solve problems that may arise, to achieve the targets and ensure quality of the campaign.
- After the campaign: quick assessment conducted to identify areas with missing subjects so as to timely organize dredging injections.
Thus supervision and inspection activities require the participation and open collaboration of local staff at all levels, and should be implemented right from the campaign’s preparation and throughout the whole campaign, so as support can be timely provided and shortcomings corrected.

Checklists used for campaign supervision are given in the attached annexes.

a) **During the campaign:**

Supervision activities will be conducted at all levels. Each district should set up several supervision teams to supervise vaccination points, in order to avoid missing subjects and timely manage adverse events. It is possible to organize cross supervision visits – that is supervisors from one district can supervise another district. The “CAMPAIGN SUPERVISION AND INSPECTION FORM” (Forms 4A and 4B) will be used by supervisors to record findings during visits.

Supervision activities can contribute to ensuring vaccination quality and safety, at the same time to make sure no vaccination subject would be missed. At the end of each vaccination day, supervisors will meet the campaign directors to verify the works done during the day and propose solutions, as well as make preparations for the next day.

**Supervision shall be conducted at all levels during campaign, including:**
1. Supervision of safe immunization practices.
2. Supervision of progress of campaign implementation, to detect missing subjects
3. Supervision of the collection and disposal of used syringes/needles.
4. Supportive activities during campaign.
5. Special support for high risk areas.
6. Recording and reporting.

To timely collect information during campaign implementation and deal with adverse events that may occur, review meeting should be held at the end of each day, with the participation of the campaign Steering Committees and supervisors.

Management and assessment contents include the vaccination rates that have been achieved during the campaign, surveillance data on measles campaign management, plans for and preparation work to be done at each level, training activities, immunization rates, immunization materials, safe immunization, disposal of syringes/needles, management, supervision, social mobilization, etc. All these issues will be assessed in the supervision/inspection forms.

b) **After the campaign:**

c) Form 5C/CD will be used to conduct quick assessment upon campaign completion to quickly evaluate the results and have plans to organize dredging injections for children that have missed the injections. Quick assessments in disadvantaged areas and areas between localities, which are more likely to have missing subjects, will be given priority.
1. Calculating and reporting coverage rates.
2. Storage of unused vaccine and solvent.

2.6 **ORGANIZATION OF DREDGING INJECTIONS**

For certain reasons some eligible children whose names are on the lists, or those who have not been registered but are present in the locality at the time of campaign, may miss the injections. These should be identified and given dredging injections. Giving dredging injections is one of the required activities in the campaign plan.

- Coordinate with local collaborators to notify and encourage parents to have their children vaccinated. Add the names of non-resident children who are present in the
locality at the time of campaign into the list of children to be vaccinated and count these separately, using the provided recording and reporting Form.

- At the end of each vaccination section, the names of children who have not been given the vaccine should be identified and marked on the lists, and non-resident children present in the locality at the time of campaign identified. It is necessary that announcements be broadcast on the commune/ward loudspeakers, and notice sent to households, to make sure these children will be brought to the vaccination points to get the injections.

- The number of children missing the injections should be counted, and vaccination teams organized accordingly, as well as time and supplies needed for the dredging injections.

- Assignment of staff responsible for visiting households to inform them of the time and venue for dredging injections, and encouraging parents to have their children vaccinated, should be done.

- School children whose injections have been delayed shall be given the vaccine on routine immunization day.

2.7 PROGRESS RECORDING AND REPORTING

- After each vaccination session, the number of children on the list who have been given vaccine at the vaccination point should be counted and reported to the commune/ward health station.

- The total number of children in the commune/ward having been given the vaccine shall be reported to the District health center every afternoon.

- Results shall be collected and reported to the higher level authority via telephone by the province/district authorities on a daily basis, in the afternoon.

- The following Forms are to be used in reporting.
  + Form 2 is used for immediate report on the last day of the campaign.
  + Form 3 is used for reporting campaign sum up (within 15 days after the campaign termination)