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Sustaining measles and rubella elimination through the Regional Monitoring and Re-Verification Commission in the Americas

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ABSTRACT The elimination of endemic rubella and measles transmission in the Region of the Americas was verified by the Pan American Health Organization's (PAHO) Regional Verification Commission in 2015 and 2016, respectively. Upon achieving this success, this Commission was disbanded. Shortly afterwards, the Region faced challenges in the post-elimination era, notably responding to and stopping transmission of imported measles cases. As a result, Brazil and Venezuela (Bolivarian Republic of) lost their measles-free status in February 2019 and July 2018, respectively. These events spurred PAHO to form the Measles and Rubella Elimination Regional Monitoring and Re-Verification Commission (MRE-RVC) focused on re-verifying these two countries and providing intensive evaluations of all countries in their efforts to sustain elimination. The MRE-RVC was tasked with advocacy to help revitalize the necessary political commitment to provide sufficient resources to sustain measles and rubella elimination in the Americas. Maintaining measles and rubella elimination in the Region is important, despite the challenges such as the global circulation of measles and rubella viruses elsewhere. This paper outlines the activities of the MRE-RVC to address the challenges and the lessons learnt, and provides insight on sustaining the gains. The main reasons to sustain efforts are: measles vaccine saves more lives than any other vaccine; congenital rubella syndrome is still the leading cause of infectious disease birth defects in the world; and measles vaccination performance remains an indicator of national capacity to maintain health security and a timely response to future infectious disease threats. A global target for measles and rubella elimination is crucial.

Keywords: Measles; rubella; rubella syndrome, congenital; vaccination; Americas.

After the successful polio eradication efforts in the Americas (1), in 1994 the Directing Council of the Pan American Health Organization (PAHO) adopted a resolution to eliminate measles in the Americas by 2000. In 2003, a similar resolution was adopted for the elimination of rubella and congenital rubella syndrome by 2010 (2). Effective strategies for the deployment of vaccination and surveillance led to zero cases in Caribbean countries, which provided the necessary impetus for the measles and rubella elimination strategies to be expanded across the Americas. A concern is the high degree of infectivity of the measles virus, which is perhaps the most infectious virus on the planet. Over time, however, experience has shown that the

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scientific and operational factors necessary for elimination can overcome this challenge. Such factors include high-quality epidemiological and laboratory surveillance and measles–rubella vaccination to homogeneously increase population immunity everywhere, with emphasis on synchronizing these efforts across borders. All this work must be linked to a rapid response to the occurrence of any measles or rubella cases (3, 4).

Experience has also shown that these efforts strengthened essential immunization programs with the accelerated introduction of new, life-saving vaccines, and exposed the serious consequences of congenital rubella syndrome. The timely implementation of measles and rubella elimination strategies greatly enhanced efforts to sustain the gains polio had achieved, especially with the development of a highly trained cadre of public health professionals, valuable experience coordinating across all sectors of society, and the strengthening of health system infrastructure (5). The extent of the disease and economic burden, especially for congenital rubella syndrome, was not well understood previously. A series of economic analyses, beginning in the Caribbean and then repeated in other countries, clearly underscored the opportunities for cost savings (6). Armed with these and other key disease burden data, the Pan American Health Organization (PAHO) has helped countries decide on and then rapidly deploy interventions that have saved countries money at a time when global economic crises of the late 20th and early 21st centuries were severely affecting national health budgets.

The measles and rubella elimination initiative in the Americas also helped countries rapidly respond to other regional and global infectious disease threats, notably, the first urban yellow fever outbreak in 45 years in the Americas in 2008 in Asuncion, Paraguay (7), the H1N1 pandemic of 2009 (8), and the earthquake and cholera outbreak in Haiti in 2010 (9). The initial shock of each of these emergencies paralyzed effective responses, but fortunately only briefly. In all situations, cross-border collaboration with key partners relied upon staff trained in measles, rubella, and polio eradication to implement necessary response actions to maintain health security in the Region.

Despite the emergence of these and other unexpected challenges, the last endemic case of measles in the Americas was reported in 2015, while the last case of rubella and congenital rubella syndrome was reported in 2009 (10). The PAHO Regional Verification Commission verified the elimination of measles, defined as interruption of endemic transmission in the Region, in 2016 and rubella in 2015, which was announced at the 55th Directing Council of PAHO (11). After verifying all countries were free of endemic measles and rubella transmission, the original Regional Verification Commission disbanded shortly after in 2016. The thinking was that countries would need to independently sustain success with the support of national budgets and PAHO. However, the level of support needed was not fully recognized and was underfunded. Two countries, Brazil and Venezuela (Bolivarian Republic of), lost their measles-free status on 5 February 2019 and 18 July 2018, respectively. These events spurred PAHO to form a post-elimination commission focused on re-verifying these two countries, while providing ongoing, intensive evaluations of all countries in their efforts to sustain success. This paper outlines the challenges faced in the Americas to sustain measles and rubella elimination, the activities of the PAHO Measles and Rubella Elimination Regional Monitoring and Re-Verification Commission (MRE-RVC) to address these challenges, lessoned learnt, and insights on sustaining an elimination status.

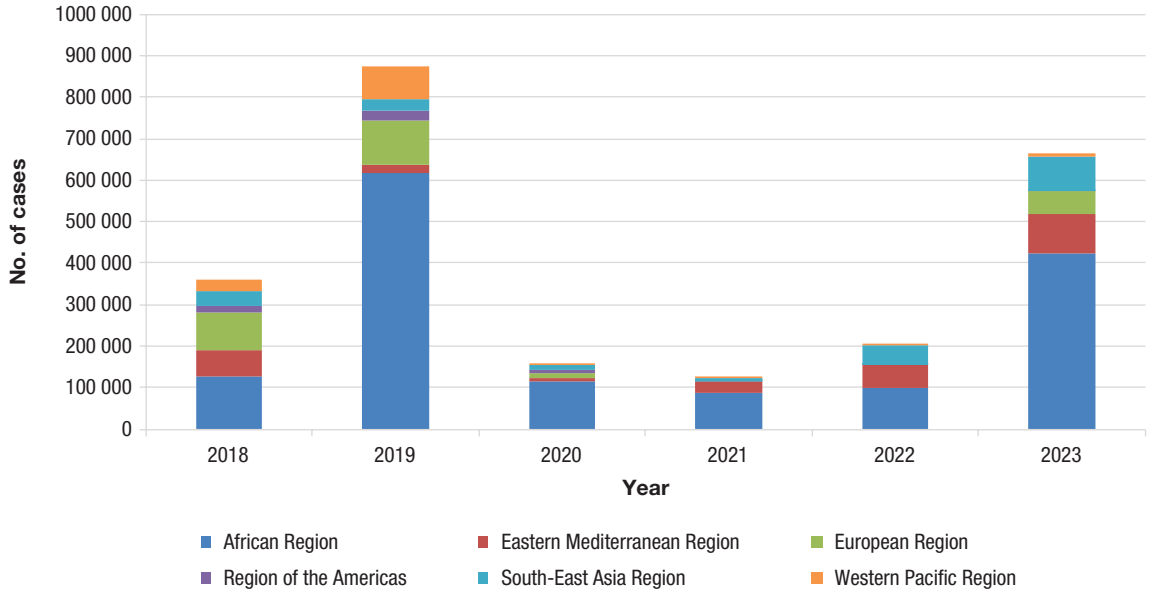
SUSTAINING VERIFICATION OF MEASLES AND RUBELLA ELIMINATION: EARLY SETBACKS

Beginning in 2017, the efforts to sustain measles and rubella elimination took a turn for the worse. Measles returned with a vengeance globally (Figure 1). An import-related outbreak began in the Bolivarian Republic of Venezuela, which then spread to Brazil. This resulted in the largest measles epidemic in 2019 with a total of 20 901 confirmed measles cases reported in Brazil, including 17 816 cases in the state of Sao Paulo. These outbreaks led to the re-establishment of endemic transmission in both the Bolivarian Republic of Venezuela and Brazil. Another import-related outbreak began in minority religious ethnic groups who refused measles vaccinations in New York, United States of America, which then spread to the rest of the state and subsequently across the country. It took nearly a year of intense efforts to interrupt transmission in the United States. These events threatened the measles-free status of the Region of the Americas. Interestingly, rubella containment remained relatively unthreatened (Figure 2). The decision by the Regional Verification Commission to verify the achievement of measles and rubella elimination is made more difficult by the high risk of measles importation when virus circulation is occurring in other parts of the world. Any decision by the Commission is therefore fragile, as evidenced by the increased global movement of populations and recent declines in vaccination coverage and performance of surveillance. The coronavirus disease 2019 (COVID-19) pandemic is a case in point. Vaccination coverage dropped, scheduled measles–rubella supplemental immunization activities were postponed in many countries, and quality of surveillance declined (12). Therefore, all decisions at any time must be based on the evidence of well performing surveillance systems, rapid response capabilities, and the likelihood of sustainable high vaccination coverage.

With this backdrop of failed or delayed measles containment efforts, a new commission was formed in January 2019, called the PAHO Measles and Rubella Elimination Regional Monitoring and Re-Verification Commission (MRE-RVC) (13). The main focus of the new commission is to re-verify countries that lost their measles elimination status and evaluate the sustainability of measles and rubella elimination over time in each country. The objectives of the MRE-RVC are to "course correct" the set backs in countries that struggled with measles importations and to sustain success in all other countries. The specific terms of reference include the following.

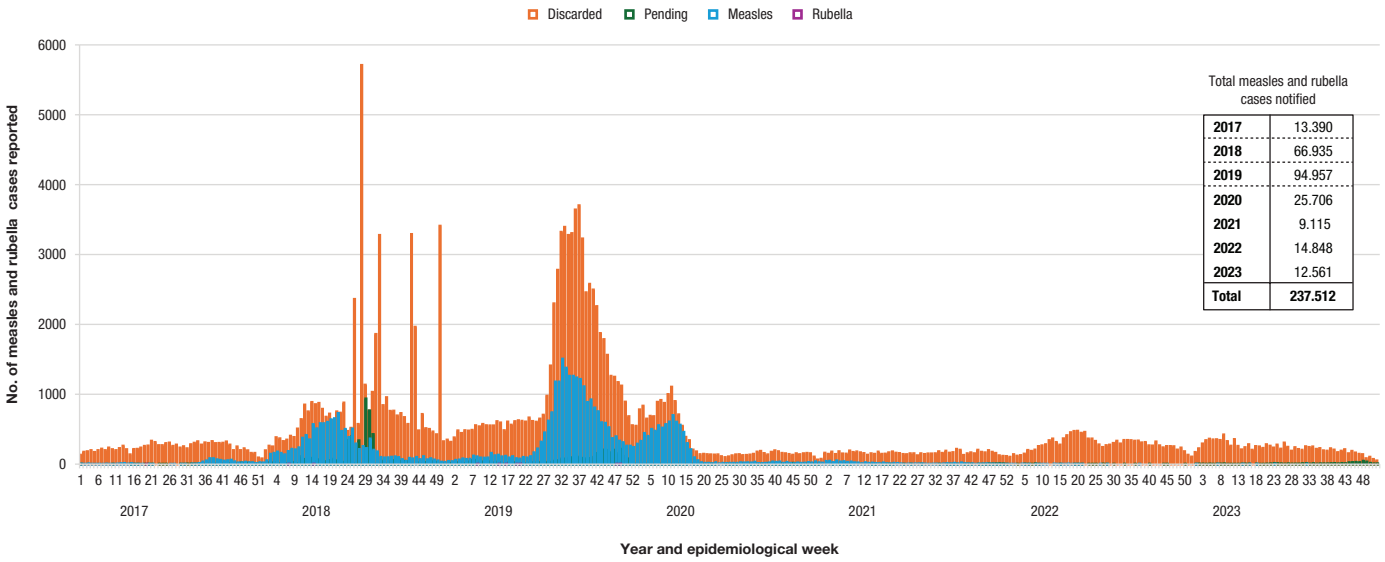
- Function as an independent commission and report to the Director of PAHO.
- Monitor the sustainability status of measles and rubella elimination in each PAHO Member State.
- Re-verify measles and rubella elimination independently for countries and for the Region (after national verification committees submit their reports).
- Work and advocate with national independent expert bodies and other stakeholders engaged in monitoring and re-verification processes.
- Document the effect of the elimination initiative on strengthening national health systems.

FIGURE 1. Reported measles cases by WHO region, 2018–2023



Source: World Health Organization.

FIGURE 2. Notification of measles and rubella cases by epidemiological week and final classification, Region of the Americas, 2017–2023



Source: Surveillance weekly reports storage at the Immunization Data Warehouse of the Pan American Health Organization.

Importantly, the specific lines of evidence used by both the regional verification commissions to determine the status of a particular country focus on the population immunity, quality of surveillance, and rapid response capacity. The analysis of such evidence led the newly formed MRE-RVC to revoke Brazil's measles-free status on 5 February 2019. The WHO policy requires that measles-free countries stop transmission of importations within 1 year; otherwise, they lose their measles-free status, as had previously happened with the Bolivarian Republic of Venezuela on 1 July 2018.

LEVERAGING THE WORK OF THE MRE-RVC TO SUSTAIN ELIMINATION

Since its formation, the MRE-RVC has been faced with serious challenges – not just the resurgence of measles, but the need to rapidly revitalize the "institutional memory" of all stakeholders to re-address the measles and rubella elimination goals. Many public health authorities responsible for national programs considered that the elimination goals had long been achieved and were finished with. Why would any additional effort be

required beyond what was being done? To that end, expert members of the MRE-RVC and the PAHO secretariat made substantial effort to encourage all stakeholders to reprioritize the need to sustain success, as well as to return to the high-level governance required by the MRE-RVC to function effectively.

Although the setbacks – measles outbreaks beginning in 2017, the continued decline in vaccination coverage beginning in 2011 (Figure 3), and the decline in political commitment that would have otherwise sustained previous levels of success – led to rethinking the closure of the first Regional Verification Commission, the initial proposal in late 2018 was for PAHO to create a post-elimination working group that would report to the PAHO Technical Advisory Group on Vaccine Preventable Diseases. Among several concerns considered was the fact that the designation of a post-elimination working group would not overcome the requirement for high-level political commitment to correct the backsliding of the program.

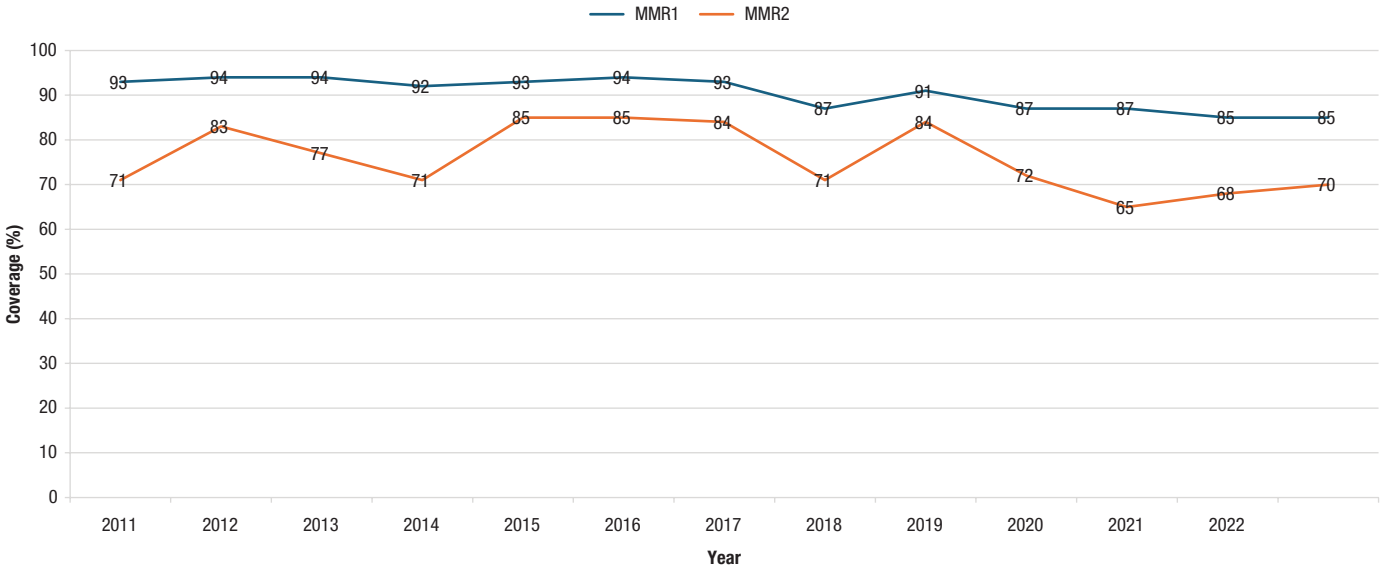
The Assistant Regional Director of PAHO at that time, Dr Jarbas Barbosa (now Regional Director), supported the creation of the PAHO MRE-RVC in the Americas and its first meeting was held in January 2019 before the COVID-19 pandemic. This newly formed post-elimination commission was held accountable to the highest levels of PAHO governance to help mitigate the challenges of sustaining political commitment of all countries to protect the achievements and react quickly to any program slippage. Among the responsibilities of the MRE-RVC was advocacy and new terms of reference that were essential for revitalizing efforts in the Region. The workload to course correct to the accomplishments of the previous Regional Verification Commission was considerable, especially during the COVID-19 pandemic. This work did not just focus on the absence of cases, but also included rigorous reviews of the functionality of the national verification committees, the quality of surveillance (both epidemiological and laboratory), the results of risk assessments, and the adequacy and performance of the national workforce, among others. To that end, in the first year of operation, the post-elimination MRE-RVC met seven times, and eight times in the second year.

The MRE-RVC was also tasked with high-level advocacy to galvanize and sustain political commitment for measles and rubella elimination in the Region. Most of the evidence used, as with the first commission, continues to be data to demonstrate population immunity and performance of epidemiological and laboratory surveillance. Successful recovery of smooth, streamlined operations with a focus on comprehensive annual country reports and one annual meeting of the MRE-RVC, although difficult during the COVID-19 pandemic, has been achieved, and is still a priority of the Commission. An important lesson learnt from this experience is that the highest level of authority must empower the MRE-RVC to advocate at the highest levels of governance within the Region.

DRAWING ON LESSONS LEARNT

Among the many early lessons learnt, perhaps the most important was the critical need to increase political commitment that had waned in the previous decade. This political commitment had to be coupled with an adequate budget, allowing for effective management of all stakeholders, including the communities themselves, to achieve the best scientific and operational deployment of strategies (4). This focus on commitment and excellence in scientific and operational deployment provided impetus for countries to achieve the measles and rubella elimination target. Many of these lessons have been described elsewhere (4, 13), especially the important need to sustain the highest levels of population immunity through essential immunization services, supplemented with follow-up vaccination campaigns every 4–5 years. Therefore, we highlight here a few other key observations in no particular order of importance.

FIGURE 3. Trends in MMR-1 and MMR-2 vaccination coverage, Region of the Americas, 2010–2022



MMR, measles, mumps, and rubella.
Source: Country reports through the electronic World Health Organization/United Nations Children's Fund Joint Reporting Form.

Best practices to control outbreaks must be shared between countries in every relevant meeting, especially to inform countries that have not seen cases of measles and rubella since verification. These countries are also at risk of outbreaks due to their immunity and surveillance gaps. Measures exist and must be shared to mitigate the extent of transmission after an imported case occurs. For example, some countries provide the second measles-containing vaccine at school entry. Lowering the age of the second measles–rubella-containing vaccine dose to the second year of life is a strategy to improve population immunity among the most vulnerable children, while providing an opportunity to catch up on all other vaccines for children not vaccinated in the first year of life. Such an approach also potentially offers other comprehensive services, including nutritional growth monitoring and prevention and control of pneumonia, diarrhea, and malaria. Creative, targeted strategies to reach indigenous populations using community leaders can be used most everywhere with modifications. Accordingly, the transparent and high-quality annual presentations from Brazil and Venezuela (Bolivarian Republic of) to the annual meeting of the MRE-RVC in November 2023 clearly reflected their high-level commitment to achieving national re-verification status, while providing valuable information for the other countries and impetus not to lower their guard. Each country provided a detailed response to all recommendations of the MRE-RVC from the previous year and to requests for additional data when asked by Commission members.

PAHO data suggested that over the post-elimination 10-year period (2010 to 2020), more than 300 importations of the measles virus occurred in countries of the Americas from outside the region. The United States, for example, was no longer challenged with importations of measles and rubella from Latin America because of the success of their measles and rubella elimination strategies. Most importations of measles to the Region came from Europe and southern Asia (14). When measles importation occurs, the response and control efforts are resource intensive (15). For example, in the United States, the median cost per measles outbreak was US$ 152 308 (range US$ 9862 to US$ 1 063 936). The median cost per case was US$ 32 805 (range US$ 7396 to US$ 76 154), and the median cost per contact was US$ 223 (range US$ 81 to US$ 746). Such experience, when shared in high-level technical meetings, serves as a warning for countries to maintain the more cost-effective, high-impact public health measures of sustaining the highest levels of vaccination coverage and highest quality of surveillance.

While these imported cases were occurring during 2010–2020, measles–rubella vaccination coverage steadily declined to its lowest levels in 2020 (Figure 3). Of the six WHO regions, only the African Region had lower levels of vaccination coverage than the Americas. This marks another important lesson. Well coordinated rapid response to imported cases and outbreaks enabled many countries to sustain elimination even with slipping vaccination coverage. The notable exceptions were Brazil and Venezuela (Bolivarian Republic of), which failed to do so largely because their response was not rapid enough to contain virus spread early on (11). In all other countries, rapid response through strategic leadership and timely deployment of strategies succeeded in containing the spread of the viruses, despite declining population immunity. Although rapid response is vital, this situation cannot be sustained indefinitely without ensuring high levels of population immunity and addressing surveillance performance. In other words, a country with vaccination coverage <95% can use rapid response measures with optimal surveillance to stop transmission and convince the MRE-RVC that transmission has been stopped. However, to expect this situation to continue over a long period of low vaccination coverage raises serious concerns about the sustainability of efforts of national authorities to maintain high levels of population immunity in all communities and excellent surveillance in a country. The MRE-RVC must hold the country accountable in that regard.

This experience highlights the great challenge the MRE-RVC faces during times of substandard vaccination coverage. Assessments and conclusions must be balanced using all the lines of evidence. For example, if the national verification committee is not meeting regularly with a strong agenda and documented note for the record of specific recommendations and follow-up for low-performing communities, the role of the MRE-RVC is compromised.

The high sensitivity of surveillance based on PAHO and WHO guidelines on case definitions spurred rapid action to contain the spread of imported cases. However, many of the larger countries had suboptimal surveillance in large areas, especially the reporting rate of suspected cases (target >2 per 100 000 population in all municipalities). To compound the situation, the MRE-RVC guidelines require countries to use the standard case definition of rash and fever for suspected cases which ensures the highest sensitivity of surveillance (Table 1) and to report on active search efforts in low-performing areas. If a country does not use the PAHO approved suspected case definition, the MRE-RVC must be convinced that other measures are being implemented to account for the drop in the sensitivity of surveillance. The United States and Canada are examples of countries not using the PAHO recommended suspected case definition. Hence, active searches become critically important. Such searches must be well documented for review by the MRE-RVC and include active searches in health care settings such as clinics and hospitals, laboratories, and communities. The occurrence of a "gap" in surveillance performance, such as a decline in the rates of reporting suspect cases, requires rigorous, documented efforts to ensure that no cases are missed. Only then can the MRE-RVC conclude that cases would not be missed if they were to occur.

The epidemiological investigations are supported by state-of-the-art laboratory techniques and leadership. The laboratory network was built from the infrastructure started by polio surveillance, but is now more aligned with the global health security agenda. New diagnostics on the horizon will be crucial additions to this support. Similarly, public–private partnerships to enhance transportation of diagnostic specimens help countries meet surveillance targets, while ensuring such capacity is ready to respond to the next emerging threat.

As acknowledged, the absence of homogenous, high levels of coverage makes sustaining elimination in the Americas very challenging, until other parts of the world achieve measles and rubella elimination. The use of geo-mapping of population immunity has helped to visualize high-risk areas. If managed properly, the measles and rubella elimination program has the potential to increase coverage of all childhood vaccinations and facilitate the introduction of new measures such as COVID-19 vaccines. A fundamental approach in PAHO has been to link

TABLE 1. Distribution of countries/territories using PAHO recommended suspected case definition for measles and rubella cases

Country	Case definition for suspected measles and rubella case
Argentina Bolivia (Plurinational State of) Costa Rica Dominican Republic Ecuador El Salvador English-speaking Caribbean Guatemala Haiti Honduras Nicaragua Panama Paraguay Peru Venezuela (Bolivarian Republic of)	The following countries are using the rash and fever definition for suspected cases as recommended by PAHO for maintaining high sensitivity of surveillance.
Brazil Canada Chile Colombia Cuba French Overseas Departments Mexico United States of America Uruguay	The following countries use a modified rash and fever definition for suspected cases, making it more specific. Countries often justify this approach because they are frequently overwhelmed with non-measles and non-rubella causes of rash and fever, such as large dengue outbreaks.

PAHO, Pan American Health Organization.
Source: Prepared by the authors.

measles and rubella elimination with the strengthening of essential immunization and other primary care services (16). The MRE-RVC considers these to be important elements of the sustainability of elimination efforts. It therefore requests extensive feedback in a country's annual report on progress in all these areas of work, thereby building on lessons learnt, while supporting PAHO's vision of universal health coverage.

Importantly, the MRE-RVC facilitated the revitalization of national verification committees which supported renewed efforts to address gaps in performance of the execution of the strategies as they prepared updates in their annual reports and sustainability plan. Strong independent national verification committees are fundamental to sustaining efforts within countries. As with the MRE-RVC, these national committees are tasked with making local site visits and advocating for the performance and documentation needed for a successful MRE-RVC review. Without strong national verification committees, the quality of the Commission's work is severely compromised. Finally, the MRE-RVC should not be disbanded prematurely, at least not until a global target for measles and rubella elimination is reached.

FURTHER EVOLUTION OF THE TERMS OF REFERENCE

The initial role of the MRE-RVC was the recovery and revitalization of the independent review process, including the national verification committees. In the first 2 years of operation, the Commission met 15 times, most of which were virtual meetings over the course of the COVID-19 pandemic. The meetings covered important issues related to the programmatic backsliding in the quality of surveillance since the last meeting of the first Regional Verification Commission in 2016 and maintenance of population immunity. Several members of the MRE-RVC conducted site visits to countries in urgent need of support and reported their findings on national progress to the Commission.

By November 2021, the MRE-RVC transitioned from simply a "frantic responder" to unexpected events occurring throughout the Region to a more formalized independent assessor and motivator as indicated in the advocacy component of its terms of reference. The country annual report template was streamlined and input into a time-bound process leading to individual country assessments by the independent members of the MRE-RVC. The third such formalized annual meeting was held in Brazil in November 2023. In advance of the meeting, reviewers had the opportunity to dialogue with countries to clarify questions they had with the data presented in the country report. This dialogue with national health authorities before the meeting greatly contributed to the quality of the deliberations at the MRE-RVC meeting.

In addition, the MRE-RVC site visit to Brazil 3 months before the meeting also helped produce a more robust and transparent report from national authorities. The MRE-RVC saw first hand how Brazilian authorities in only a few months of assuming leadership were launching a recovery process grounded in

health with scien**ce.** Despite these improvements in the recovery process, the MRE-RVC still considered that it did not have enough evidence to re-verify Brazil as having sustained measles and rubella elimination, which led to the final recommendation in the meeting report of "pending" for Brazil. The Brazil example highlights how the overall process – site visit by members of the MRE-RVC, ongoing local PAHO technical cooperation, dialogue between the MRE-RVC reviewers and national authorities about specific issues in the annual report, and the discussions in the formal meeting of the Commission – greatly contributed to Brazil accepting its status as pending, while knowing and embracing what needed to be done before the next meeting of the MRE-RVC. What better way to sustain efforts?

Other lessons to fine-tune the MRE-RVC work include the following actions.

- Conduct annual meetings in countries with the greatest need to heighten local and regional visibility.
- Provide opportunities for longer online presentations by struggling countries at least 1 month before the scheduled annual meeting of the MRE-RVC.
- Provide the ministries of health of countries with the reviewers' feedback on annual national reports at least 1 month before the annual meeting of the MRE-RVC to allow the countries to address concerns of the reviewers and report to the meeting.
- Meet with national health authorities of the country hosting the annual meeting of the MRE-RVC 1 day before the meeting to allow for more informal dialogue of potential solutions to challenges country may be facing.
- Conduct ad hoc country site visits by members of the MRE-RVC to assess independently national progress.

CHALLENGES GOING FORWARD

Failure to re-verify measles elimination in only a few countries can lead to a sense of failure across the Region. Without a global target for measles and rubella elimination, backsliding because of the occurrence of imported cases is inevitable. Achieving a global commitment to a global target will clearly help regional and national efforts.

The MRE-RVC supports a country classification scheme consistent with WHO guidelines to help sustain national efforts to regain measles-free status (re-verification). However, the lack of sufficient data in annual national reports makes it difficult for the MRE-RVC to make definitive recommendations on the status of certain countries. To that end, a classification of "indeterminate" was created for whenever a country's annual report does not show sufficient population immunity and surveillance data to allow a clear decision on the country's classification.

Imposing the indeterminate classification on countries when data are insufficient is challenging. Indeterminate classification does not mean a failed program, but one that needs to correct certain remaining gaps in vaccination coverage and surveillance.

Countries must sustain political commitment to ensure adequate resources to implement a rapid response to any imported cases. These efforts ideally would also be supported by a global target. A global target could potentially lead to improved synchronization of campaigns across countries and regions that would lead to interruption of endemic transmission. Numerous examples from early polio campaigns, such as operation MECACAR, provide important lessons for accelerating progress among and between regions (18). These experiences should show us that acting collectively to prevent and rapidly respond to the spread of the measles and rubella viruses is very possible and will alleviate much suffering in the world.

CONCLUSION

The current PAHO MRE-RVC is committed to using its advocacy role to galvanize further political commitment to create and realize a global target. Despite the lack of a global target, however, the Region must never stop its efforts. Among the many reasons to sustain efforts, the three most striking are: the measles vaccine saves more lives than any of the other vaccine used in national immunization programs; congenital rubella syndrome is still the leading cause of infectious disease birth defects in the world; and measles vaccination performance remains a tracer for national capacity to maintain health security in response to future infectious disease threats. Direct inter-regional collaboration is an opportunity not to be missed. The MRE-RVC strongly concurs that such an approach is ethical, necessary as a best buy in public health, and very feasible (4). Setting a global target for measles and rubella elimination is crucial.

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Mantenimiento de la eliminación del sarampión y la rubéola mediante la Comisión Regional de Monitoreo y Reverificación en las Américas

RESUMEN En el 2015 y el 2016, la Comisión Regional de Verificación de la Organización Panamericana de la Salud (OPS) verificó, respectivamente, la eliminación de la transmisión endémica de la rubéola y el sarampión en la Región de las Américas. Una vez alcanzado este logro, se disolvió esta comisión. Poco después, en la etapa posterior a la eliminación, la Región tuvo que hacer frente a una serie de desafíos, en especial en cuanto a la respuesta y la detención de la transmisión de casos importados de sarampión. Como consecuencia de esta situación, Brasil y Venezuela (República Bolivariana de) perdieron su condición de países libres de sarampión en febrero del 2019 y julio del 2018, respectivamente. Estos acontecimientos motivaron que la OPS creara la Comisión Regional de Monitoreo y Reverificación de la Eliminación del Sarampión y la Rubéola (MRE-RVC, sigla en inglés), cuya finalidad es reverificar la situación en estos dos países y llevar a cabo evaluaciones intensivas de todos los países en relación con sus medidas para mantener la eliminación. Se encomendó a la MRE-RVC la tarea de promover la revitalización del compromiso político necesario para proporcionar recursos suficientes a fin de mantener la eliminación del sarampión y la rubéola en la Región de las Américas. A pesar de desafíos como la circulación mundial de los virus de estas dos enfermedades en otros lugares, es importante mantener la eliminación del sarampión y la rubéola en la Región. En este documento se describen las actividades de la MRE-RVC para hacer frente a los desafíos, y las enseñanzas extraídas, a la vez que se proporciona información sobre cómo mantener los logros alcanzados. Las principales razones para mantener estas actividades son las siguientes: la vacuna contra el sarampión salva más vidas que cualquier otra vacuna; el síndrome de rubéola congénita sigue siendo la principal causa de anomalías congénitas producidas por enfermedades infecciosas en el mundo; y los resultados de la vacunación contra el sarampión siguen siendo un indicador de la capacidad nacional para mantener la seguridad sanitaria y brindar una respuesta oportuna frente a futuras amenazas debidas a enfermedades infecciosas. Es imprescindible fijar un objetivo mundial para la eliminación del sarampión y la rubéola.

Palabras clave: Sarampión; rubéola (sarampión alemán); síndrome de rubéola congénita; vacunación; Américas.

Manutenção da eliminação do sarampo e da rubéola por meio da Comissão Regional de Monitoramento e Reverificação nas Américas

RESUMO Em 2015 e 2016, respectivamente, a Comissão Regional de Verificação da Organização Pan-Americana da Saúde (OPAS) verificou a eliminação da transmissão endêmica da rubéola e do sarampo na Região das Américas. Depois desse êxito, a Comissão foi dissolvida. Pouco tempo depois, na era pós-eliminação, a Região enfrentou vários desafios, principalmente para responder a casos importados de sarampo e interromper sua transmissão. Como resultado, o Brasil e a Venezuela (República Bolivariana da) perderam o status de países livres de sarampo em fevereiro de 2019 e julho de 2018, respectivamente. Esses eventos estimularam a OPAS a formar a Comissão Regional de Monitoramento e Reverificação da Eliminação da Rubéola e do Sarampo (MRE-RVC, na sigla em inglês), com o objetivo de verificar novamente a situação desses dois países e fazer avaliações intensivas dos esforços de todos os países para manter a eliminação. Coube à MRE-RVC fazer atividades de conscientização a fim de ajudar a revitalizar o compromisso político necessário para oferecer recursos suficientes para sustentar a eliminação do sarampo e da rubéola nas Américas. Apesar de desafios como a circulação mundial dos vírus do sarampo e da rubéola em outros lugares, é importante manter a eliminação do sarampo e da rubéola na Região. Este artigo descreve as atividades da MRE-RVC para resolver os desafios e as lições aprendidas, além de apresentar informações sobre como manter os ganhos. Os principais motivos para manter os esforços são: a vacina contra o sarampo salva mais vidas do que qualquer outra vacina; a síndrome da rubéola congênita continua sendo a principal causa de defeitos congênitos por doenças infecciosas no mundo; e o desempenho da vacinação contra o sarampo continua sendo um indicador da capacidade nacional de manter a segurança sanitária e uma resposta oportuna a futuras ameaças de doenças infecciosas. É fundamental ter uma meta global para a eliminação do sarampo e da rubéola.

Palavras-chave: Sarampo; rubéola (sarampo alemão); síndrome da rubéola congênita; vacinação; América.