Meeting Report

Third Meeting of the Combined Subregional Committees for the Certification of Poliomyelitis Eradication and Verification of Measles Elimination in Pacific Island Countries and Areas

29 September to 1 October 2015
Nadi, Fiji

World Health Organization
Western Pacific Region

Participants of the Third Meeting of the Combined Subregional Committees for the Certification of Poliomyelitis Eradication and Verification of Measles Elimination in Pacific Island Countries and Areas
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WORLD HEALTH ORGANIZATION

REGIONAL OFFICE FOR THE WESTERN PACIFIC

RS/2015/GE/43(FJI) English only

MEETING REPORT

THIRD MEETING OF THE COMBINED SUBREGIONAL COMMITTEES FOR THE CERTIFICATION OF POLIOMYELITIS ERADICATION AND VERIFICATION OF MEASLES ELIMINATION IN PACIFIC ISLAND COUNTRIES AND AREAS

Convened by:

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC

Nadi, Fiji
29 September–1 October 2015

Not for sale

Printed and distributed by:

World Health Organization
Regional Office for the Western Pacific
Manila, Philippines

February 2016

NOTE

The views expressed in this report are those of the participants of the Third Meeting of the Combined Subregional Committees for the Certification of Poliomyelitis Eradication and Verification of Measles Elimination in Pacific Island Countries and Areas and do not necessarily reflect the policies of the conveners.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for Member States in the Region and for those who participated in the Third Meeting of the Combined Subregional Committees for the Certification of Poliomyelitis Eradication and Verification of Measles Elimination in Pacific Island Countries and Areas in Nadi, Fiji, from 29 September to 1 October 2015.

CONTENTS

Keywords:

/ Immunization / Measles-prevention and control / Poliomyelitis – prevention and control/ Pacific Islands

ABBREVIATIONS

AFP	acute flaccid paralysis
cVDVP	circulating vaccine-derived polio
IPV	inactivated polio vaccine
JRF	joint reporting form
MCV	measles-containing vaccine
MCV1	MCV dose 1
MCV2	MCV dose 2
NP-AFP	non-polio AFP
OPV	oral polio vaccine
RCC	Regional Certification Commission for Polio Eradication
RVC	Regional Verification Commission for Measles Elimination
SIA	supplementary immunization activity
SRCC	Subregional Committee for the Certification of Poliomyelitis Eradication
SRVC	Subregional Committee for the Verification of Measles Elimination
TAG	Technical Advisory Group
tOPV	trivalent OPV
VII	Vaccine Independence Initiative
UNICEF	United Nations Children's Fund
WHO	World Health Organization

SUMMARY

The Third Meeting of the Combined Subregional Committees for the Certification of Poliomyelitis Eradication and Verification of Measles Elimination in the Pacific island countries and areas (SRCC/SRVC) was convened in Nadi, Fiji from 29 September to 1 October 2015. The SRCC/SRVC serves as the expert review group to classify all cases of acute flaccid paralysis (AFP) reported in Pacific island countries and areas. The committee produces the required annual report on the status of poliomyelitis-free status for Pacific island countries and areas to be submitted to the Regional Certification Commission. The SRCC/SRVC also develops the annual report on progress towards measles elimination to be submitted to the Regional Verification Commission.

After reviewing the status of AFP and measles/rubella surveillance, routine and supplementary immunization, and outbreak preparedness and response, the SRCC/SRVC concluded that although there is no evidence of ongoing endemic measles virus transmission, measles virus surveillance is not yet verification-standard especially because acute fever and rash cases are being investigated and reported from only a few countries and reporting of the 10 core variables is not complete. In addition, measles immunity gaps persist in select populations.

The Pacific islands have remained polio-free since regional certification in 2000, but the SRCC/SRVC acknowledges the continued risk as long as poliovirus circulates anywhere in the world, while taking note of the surveillance gaps in the Pacific. In addition, polio vaccine coverage remains heterogeneous in the Pacific. Although Pacific island countries and areas are considered as one “epidemiologic” block and categorized as “low risk” for importation of polio virus, there is significant variability among the 21 countries and areas in terms of quality of surveillance, coverage, programmatic strength and external threats and emergencies.

With regard to measles/rubella the SRCC/SRVC recommends:

1) Countries and areas should achieve and sustain high coverage (more than 95%) with two doses of measles-containing vaccine (MCV) in the routine programme. Periodic measles supplementary immunization activities (SIAs) targeting susceptible age groups should be conducted to close immunity gaps and prevent large scale outbreaks following importations. To increase efficiency, measles-rubella SIAs should be integrated with other vaccines or health interventions as appropriate.
2) Solomon Islands and Vanuatu that have not yet introduced a routine second dose of measles vaccine in their national immunization programmes, should take steps to increase coverage with first dose of measles containing vaccine (MCV1) and introduce routine measles second dose. The SRVC supports the technical advisory group's (TAG's) recommendation that the second routine dose should ideally be offered in the second year of life. The SRVC recommends the use of combination measles and rubella vaccines for all routine and supplemental doses.
3) The SRVC supports implementation of policies promoting screening and immunization prior to school entry for countries that have not yet introduced school laws/policies. Care should be taken so that screening does not impose a barrier to education enrollment.
4) The United Nations Children's Fund (UNICEF) and development/technical partners are urged to mobilize resources to supplement the national buffer stocks by stockpiling the minimum levels of measles and rubella containing vaccine at the regional warehouse to assure timely responses to stock outs, outbreaks and emergencies. Minimum levels can be defined based on ongoing risk assessments.
5) To strengthen surveillance, the SRVC requests WHO and partners to organize systematic surveillance reviews in priority countries (persistently silent) to increase case identification, investigation and reporting. All countries and areas should identify surveillance focal points/national coordinators to liaise with WHO and should submit monthly surveillance data including zero reporting.

6) The SRVC requests WHO to take action to coordinate with the United States of America affiliated countries and United States and French territories to encourage case-based data reporting to WHO South Pacific. All countries and areas should investigate acute fever and rash cases including core variables on the case-based form and collect appropriate clinical specimens.
7) To increase ease of specimen collection and transportation, where applicable dried blood spots may be considered for measles and rubella testing to confirm diagnosis. In outbreaks, specimens for genotyping (nasopharyngeal or oral fluid swabs) should be collected and sent to reference laboratories as per surveillance indicator.
8) As requested by the Regional Verification Commission for Measles Elimination (RVC), countries and areas that have not yet done so, should develop costed outbreak preparedness and response plans.
9) Pacific island countries and areas should consider initiating surveillance for congenital rubella syndrome in sentinel sites.

With regard to polio the SRCC/SRVC recommends:

1) To strengthen surveillance, the SRCC requests WHO and partners to organize systematic surveillance reviews in priority countries (persistently silent) to increase case identification, investigation and reporting. All countries and areas should identify surveillance focal points/national coordinators to liaise with WHO and submit monthly surveillance data including zero reporting.
2) As requested by the RCC, countries and areas (or at least the five with populations greater than 200 000) that have not already done so, should develop costed outbreak preparedness and response plans.
3) No later than the end of 2015, countries and areas should urgently update the 2008 laboratory inventories of polioviruses (type specific and virus specific).
4) To fulfil the obligations related to polio laboratory containment, the SRCC recommends the expansion of the SRCC to include additional member(s) with expertise in laboratory science and epidemiology.
5) UNICEF and development/technical partners are urged to mobilize resources to supplement the national buffer stocks by stockpiling the minimum levels of polio vaccine (IPV and bOPV) at the regional warehouse to assure timely responses to stock outs, outbreaks and emergencies. Minimum levels can be defined based on ongoing risk assessments.
6) The SRCC requests that the risk assessment methodology be reviewed to ensure that the overall risk level does not mask vulnerabilities at country level.
7) The committee also raises attention to the ongoing threat of El Niño and its potential impact on the immunization programs, especially during the upcoming switch phase in April 2016. Development and technical partners are encouraged to assure adequate technical and operational support to relevant Pacific island countries and areas during this critical period.
8) Countries and areas still using OPV should implement switch plans and validate the withdrawal of tOPV after the switch in accordance with the global guidelines.
9) The SRCC recommends that countries and areas take steps to improve and sustain high polio vaccine coverage and annual reporting of coverage data by submitting the completed Joint Reporting Form (JRF).

1. INTRODUCTION

1.1 Meeting organization

The Third Meeting of the Combined Subregional Committees for the Certification of Poliomyelitis Eradication and Verification of Measles Elimination in the Pacific island countries and areas was convened in Nadi, Fiji from 29 September to 1 October 2015. Five of the six Subregional Committee members attended the meeting, with the sixth member represented by a colleague from the same institution. The secretariat was composed of WHO staff from the regional and Pacific subregional offices. The UNICEF subregional office for the Pacific was also invited to participate. The lines of evidence for measles were summarized and reviewed one by one. Similarly the individual components of the polio report were summarized and reviewed.

1.2 Meeting objectives

The objectives of the meeting were:

1) to review and classify all pending acute flaccid paralysis cases;
2) to draft the annual progress report on maintaining poliomyelitis-free status in Pacific island countries and areas for submission to the Regional Certification Commission at its 21st meeting in November 2015; and
3) to draft the annual report on progress towards achieving measles elimination in Pacific island countries and areas for submission to the Regional Verification Commission at its fifth meeting in 2016 (dates to be determined).

1.3 Opening session

Dr Lisi Tikoduadua, Chair of the Subregional Committee, called the meeting to order and welcomed the participants to Fiji and to the meeting. Participants introduced themselves and then the Chair reviewed the meeting objectives.

2. PROCEEDINGS OF THE SRVC

2.1 Global and regional progress in measles elimination

Dr Yoshihiro Takashima briefed on the current situation of measles elimination at global and regional levels. While six countries and one area[1] in the Region were verified by the Regional Verification Commission (RVC) to have interrupted endemic measles virus transmission for a period of at least 36 months, the Region experienced a measles resurgence in 2013–2015.[2] The increased incidence of measles virus transmission was attributed to three factors: the resurgence of ongoing transmission in endemic countries;[3] large-scale outbreaks following importation in countries with a low or no recent documented cases of measles transmission;[4] and multiple importations in countries that have achieved or are close to achieving measles elimination.[5]

2.2 First line of evidence: epidemiology of measles in the Pacific islands

Dr Jayaprakash Valiakolleri described the epidemiology of measles in the Pacific. In 2014, three Pacific island countries and areas experienced imported outbreaks. The Federated States of Micronesia reported 292 cases from three of the four states. Of these, 67% of the cases received one documented dose of measles containing vaccine. In response to the outbreak, SIAs were conducted

[1] Australia, Brunei Darussalam, Cambodia, Japan, Macao SAR (China), Mongolia and Republic of Korea
[2] The regional measles incidence per one million population significantly increased from 5.9 in 2012 to 17.7 in 2013 and 44.0 in 2014.
[3] China (H1), the Philippines (B3 has become endemic since early 2013 while D9, which was endemic in 2010 to 2012, has been not detected since early 2013) and Malaysia (D8 and D9)
[4] Viet Nam (due to H1, D8 and B3 in 2013-2014), Papua New Guinea (due to D8 imported from Indonesia in 2013 and B3 imported from the Philippines in 2014), Federal States of Micronesia (due to B3 in 2014), Solomon Islands (due to B3 imported from Papua New Guinea in 2014), Lao People's Democratic Republic (due to H1 in 2014), Mongolia (due to H1 in 2015) and Vanuatu (2013-2014)
[5] Australia, Hong Kong SAR (China), Japan, New Zealand, the Republic of Korea and Singapore

targeting people six months to 49 years in Pohnpei and Chuuk and six months to 57 years in Kosrae. In Solomon Islands 4406 cases were reported from all 10 provinces. Outbreak response SIAs were conducted targeting people six months to 30 years. The attack rate was highest among adolescents and young adults with nine measles-related deaths. The genotype was B3 in both outbreaks. In Vanuatu 10 cases were reported. Immunization mop up was conducted in highly populated areas including the capital of Port Vila. All outbreaks were controlled in 2014. However an additional outbreak was recently reported from Vanuatu in 2015.

2.3 Second line of evidence: quality of epidemiological surveillance

Dr William Schluter discussed the quality of epidemiological surveillance in the Pacific. The sensitivity of surveillance at subregional level with a non-measles non-rubella discard rate of 3.8 per 100 000 population exceeds the target (more than two per 100 000). At sub-regional level, in 2014 and 2015, suspected cases were reported from Fiji, the Federated States of Micronesia, Solomon Islands and Vanuatu, whereas suspected cases were expected from nine other countries or areas. Core variables have not been reported for any of the reported suspected cases since 2010. Although virological specimens were collected during outbreaks, collection of blood serum for measles confirmation occurred for only 11% of cases in 2014.

2.4 Second line of evidence: quality of laboratory surveillance

Ms Varja Grabovac described the quality of measles laboratory surveillance. From 2015 to date, there have been 167 suspected measles cases tested at the Fiji Centre for Communicable Disease Control (91 from Fiji and 76 from Vanuatu) with 17 laboratory-confirmed cases (one from Fiji and 16 from Vanuatu). Laboratory indicators for timeliness of reporting results (target less than 80%) within 4 days is 84% and within 7 days is 95%. Three national measles and rubella laboratories: National Centre for Scientific Services, Fiji; Institut Louis Malarde, French Polynesia; and Department of Public Health and Social Services, Guam are participating in the WHO measles and rubella annual proficiency IgM testing and achieving average scores of 95% for measles IgM and 98% for rubella IgM.

2.5 Third line of evidence: population immunity

Dr Valiakolleri summarized population immunity. Immunization services are provided through immunization sessions “on demand” on specific days. Nineteen countries administer two doses of measles-containing vaccine (MCV). Nine Pacific island countries and areas have school entry requirements for measles. Catch-up campaigns were conducted in 14 Pacific island countries and areas in 1997/1998. Different strategies in different countries have been used to increase/sustain population immunity. These include i) two doses of MCV with SIAs initially and then sustained with high coverage, ii) two doses of MCV with at least one SIA during the last five years, iii) two doses of MCV with SIAs prior to 2004 and iv) two doses of MCV only with high routine immunization coverage and v) one dose of MCV with SIAs.

2.6 Fourth line of evidence: sustainability

Dr Valiakolleri described sustainability of the immunization programmes in the Pacific as follows: MCV procurement is through a variety of mechanisms in the Pacific island countries and areas. Ministries of health in 10 Pacific island countries and areas procure their vaccines through UNICEF through the Vaccine Independence Initiative (VII). Three Pacific island countries and areas (American Samoa, Guam and the Commonwealth of Northern Mariana Islands) receive their vaccines from the United Stes of America and three countries (the Marshall Islands, the Federated States of Micronesia and Palau) through compact funding of the United States. Three French affiliated territories (French Polynesia, New Caledonia and Wallis and Futuna) are about to procure vaccines through funding from the French Government and internal resources. One United Kingdom territory (Pitcairn islands) procures though the United Kingdom but follows the New Zealand immunization schedule. Nine Pacific island countries and areas have school entry requirement for measles vaccination.

2.7 Fifth line of evidence: genotyping

Ms Varja Grabovac presented measles virus genotyping. The distribution of measles genotypes in the Western Pacific Region from 2012 to 2015 showed a clear predominance of H1 (58% in 2012; 86% in 2013; 81% in 2014 and 98% in 2015) over D8, D9, and B3 genotypes. For seven countries and areas verified as having achieved measles elimination, genotype evidence supports the interruption of endemic measles virus transmission. While the proportion of laboratory confirmed cases in the Western Pacific Region remains relatively high (96% in 2013, 85% in 2014 and 99% in 2015), the availability of genotype information is still quite low. On average only 8% of confirmed cases have genotype data (8.4% in 2013; 7.8% in 2014 and 7.1% in 2015).

3. CONCLUSIONS AND RECOMMENDATIONS OF THE SRVC

3.1 Conclusions

The SRVC concludes that although there is no evidence of ongoing endemic measles virus transmission, measles virus surveillance is not yet verification-standard especially because non-measles, non-rubella acute fever and rash cases are being investigated and reported from only a few countries, such as, Fiji, Solomon Islands and Vanuatu, and investigation and reporting of the 10 core variables is not complete. In addition, immunity gaps persist in select populations.

The SRVC notes the recent measles outbreaks in 2014 and congratulates the Federated States of Micronesia, Solomon Islands and Vanuatu for their rapid and comprehensive outbreak immunization response that was successful in interrupting the imported measles virus transmission. In addition, the SRVC congratulates the countries and areas that implemented effective measures to prevent outbreaks or widespread transmission.

3.2 Recommendations

1) Countries and areas should achieve and sustain high coverage (more than 95%) with two doses of measles-containing vaccine (MCV) in the routine programme. Periodic measles supplementary immunization activities (SIAs) targeting susceptible age groups should be conducted to close immunity gaps and prevent large scale outbreaks following importations. To increase efficiency, measles-rubella SIAs should be integrated with other vaccines or health interventions as appropriate.
2) Solomon Islands and Vanuatu that have not yet introduced a routine second dose of measles vaccine in their national immunization programmes, should take steps to increase coverage with first dose of measles containing vaccine (MCV1) and introduce routine measles second dose. The SRVC supports the technical advisory group's (TAG's) recommendation that the second routine dose should ideally be offered in the second year of life. The SRVC recommends the use of combination measles and rubella vaccines for all routine and supplemental doses.
3) The SRVC supports implementation of policies promoting screening and immunization prior to school entry for countries that have not yet introduced school laws/policies. Care should be taken so that screening does not impose a barrier to education enrollment.
4) The United Nations Children's Fund (UNICEF) and development/technical partners are urged to mobilize resources to supplement the national buffer stocks by stockpiling the minimum levels of measles and rubella containing vaccine at the regional warehouse to assure timely responses to stock outs, outbreaks and emergencies. Minimum levels can be defined based on ongoing risk assessments.
5) To strengthen surveillance, the SRVC requests WHO and partners to organize systematic surveillance reviews in priority countries (persistently silent) to increase case identification, investigation and reporting. All countries and areas should identify surveillance focal points/national coordinators to liaise with WHO and should submit monthly surveillance data including zero reporting.

6) The SRVC requests WHO to take action to coordinate with the United States of America affiliated countries and United States and French territories to encourage case-based data reporting to WHO South Pacific. All countries and areas should investigate acute fever and rash cases including core variables on the case-based form and collect appropriate clinical specimens.
7) To increase ease of specimen collection and transportation, where applicable dried blood spots may be considered for measles and rubella testing to confirm diagnosis. In outbreaks, specimens for genotyping (nasopharyngeal or oral fluid swabs) should be collected and sent to reference laboratories as per surveillance indicator.
8) As requested by the RVC, countries and areas that have not yet done so, should develop costed outbreak preparedness and response plans.
9) Pacific island countries and areas should consider initiating surveillance for congenital rubella syndrome in sentinel sites.

4. PROCEEDINGS OF THE SRCC

4.1 Global and regional update on polio including RCC and TAG recommendations

Dr Tigran Avagyan provided a briefing on polio eradication from the global and regional perspective. On 20 September 2015, the Global Commission for Certification of Eradication of Poliomyelitis confirmed global eradiation of type 2 wild poliovirus. As no cases of wild poliovirus were reported since 24 July 2014, Nigeria was removed from the list of polio-endemic countries. However, wild poliovirus transmission is ongoing in two remaining countries: Afghanistan and Pakistan. In addition, circulating vaccine-derived polio (cVDVP) cases have been reported from several countries. Both the Regional Certification Commission for Polio Eradication (RCC) and the Technical Advisory Group on Immunization and Vaccine Preventable Diseases (TAG) at their most recent meetings recommended countries to maintain high quality AFP surveillance, to achieve and sustain high level population immunity and comply with the timeline and requirements of the polio endgame strategy.

4.2 Case presentations for review and classification of AFP cases

Dr Valiakolleri presented the pending acute flaccid paralysis (AFP) cases. There was one AFP case in 2014 in Solomon Islands that was due for final classification. The case was a 10-month old male infant who developed maximum paralysis within three days of symptom onset. The paralysis was asymmetrical affecting both arms and right leg with no meningeal signs and no sensory loss. Muscle tone was reduced as were deep tendon reflexes. The clinical diagnosis was Guillain-Barre syndrome. Only one stool specimen was collected. The specimen tested negative for enterovirus by cell culture. The infant had received three doses of OPV. On follow up examination completed 60-days after symptom onset, the child had no residual paralysis. The SRCC classified the case as discarded.

4.3 AFP surveillance performance for the Pacific islands

Dr Valiakolleri presented surveillance performance for the Pacific and noted that significant variability exists among the Pacific island countries and areas with regard to the quality of AFP surveillance. AFP cases have been mostly reported from Fiji and Solomon Islands and recently cases have been reported from Vanuatu. The non-polio AFP (NP-AFP) reporting rate has been sustained at more than one per 100 000 population in most years except 2002 and 2005. In 2014, the rate was 1.5. Fiji reported eight AFP cases and Solomon Islands reported six cases for a NP-AFP rate of 3.0 and Vanuatu reported one case for a NP-AFP rate of 1.1. All other Pacific island countries and areas have not reported any cases. The cause for concern is countries with a larger population like French Polynesia, Guam and New Caledonia. Overall as a sub-region, 67% of AFP cases had adequate stool samples. All stool specimens were received in good condition in the laboratory. All inadequate cases were further investigated by conducting a 60-day follow-up examination.

4.4 Polio laboratory performance and polio virus containment

Ms Varja Grabovac described polio laboratory performance and polio virus containment in the Pacific. From 2015 to date, three AFP cases have been reported from the Pacific islands with specimens tested

at the regional reference laboratory in Australia. No poliovirus was isolated and laboratory results were reported for 71% of cases within 14 days of receipt (target 80%). Preparation for finalization of Phase I of *GAPIII: Global action plan to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of OPV use* is ongoing in the Pacific. Countries have been requested to prepare for containment, by destroying or transferring all wild poliovirus type 2 isolates to appropriate secure facilities by the end of 2015.

4.5 Polio immunization coverage in the Pacific: routine and SIAs

Dr Valiakolleri provided an overview of routine and supplemental immunization in the Pacific. A variety of polio vaccine preparations are being used in the Pacific island countries and areas. Oral poliovirus vaccine (OPV) is used in 10 Pacific island countries and areas and inactivated polio vaccine (IPV) is used in 11 Pacific island countries and areas. Kiribati added one dose of IPV in June and Solomon Islands in October. Reported coverage with three doses of polio vaccine (average over the last five years) in 12 Pacific island countries and areas is over 90%, four Pacific island countries and areas are between 85–90%, two Pacific island countries and areas are between 80–85% and two Pacific island countries and areas are under 80%. Irregular reporting of coverage is noted in three of the six United States affiliated Pacific islands. Vanuatu is conducting a measles rubella catch-up campaign and has added OPV also in the SIA.

4.6 Polio endgame implementation: (IPV introduction and switch planning): Kiribati, Samoa, Tokelau, Tuvalu, Vanuatu

Mr Nahad Sadr-Azodi described that as part of the polio endgame strategy (objective 2), UNICEF Pacific provided technical support to five Pacific island countries and areas in developing IPV introduction plans in 2014 and OPV switch plans in 2015. Kiribati was the first Pacific country using an all-OPV schedule in their routine immunization programme to introduce IPV in June 2015. The other four countries and areas are on-track and are anticipated to introduce IPV by the end of 2015. All five of the UNICEF-supported Pacific island countries and areas have submitted national tOPV-bOPV switch plans that specify the date of withdrawal and financial support needed to complete the switch activities. UNICEF's support has included in-country technical assistance, operational support (including communications and social mobilization) and one year of donated vaccines.

4.7 Polio endgame implementation: (IPV introduction and switch planning): Cook Islands, Fiji, Nauru, Solomon Islands, Tonga

Dr Valiakolleri provided an update on the five countries and areas supported by WHO. Solomon Islands will introduce one dose of IPV on 2 October 2015. Support from Gavi, the Vaccine Alliance and the Australian Government Department of Foreign Affairs and Trade (DFAT) was requested to fill the funding gap. Cook Islands will be introducing one dose of IPV in November. Fiji will introduce one dose of IPV in December. There is no funding gap as the financial support from the Polio Oversight Board (POB) was received. Nauru will introduce one dose IPV in October. Tonga will introduce one dose of IPV in November. The switch plan is finalized and a funding gap of US$ 13 000 was noted. All the five countries have finalized the switch plan and the national switch day launch is planned to occur during the 2016 regional immunization week. Support from partners is requested for the funding gap related to tOPV-bOPV switch activities in Cook Islands, Nauru and Tonga.

5. CONCLUSIONS AND RECOMMENDATIONS OF THE SRCC

5.1 Conclusions

The SRCC concludes that the Pacific islands have remained polio-free since regional certification in 2000, but acknowledges the continued risk as long as poliovirus circulates anywhere in the world. The SRCC acknowledges the successful interruption of endemic polio virus in Nigeria and the global eradication and certification of wild polio virus type 2. The SRCC extends congratulations to all polio partners involved in these achievements.

The SRCC notes the surveillance gap in the Pacific in that AFP cases have been identified, investigated and reported from only a few countries (Fiji, Solomon Islands and Vanuatu). In addition, polio vaccine coverage remains heterogeneous in the Pacific sub-region. Although the Pacific island countries and areas are considered as one "epidemiologic" block and categorized as "low risk" for importation of polio virus, the SRCC acknowledges the significant variability among the 21 countries in terms of quality of surveillance, coverage, programmatic strength and external threats and emergencies.

The SRCC congratulates Kiribati as the first all-OPV using county in the Pacific to introduce IPV as part of the polio endgame plan. The SRCC commends countries on their preparation to introduce IPV and the completion of the switch plans and wishes them well on the implementation of the endgame plan.

5.2 Recommendations

1) To strengthen surveillance, the SRCC requests WHO and partners to organize systematic surveillance reviews in priority countries (persistently silent) to increase case identification, investigation and reporting. All countries and areas should identify surveillance focal points/national coordinators to liaise with WHO and submit monthly surveillance data including zero reporting.
2) As requested by the RCC, countries and areas (or at least the five with populations greater than 200 000) that have not already done so, should develop costed outbreak preparedness and response plans.
3) No later than the end of 2015, countries and areas should urgently update the 2008 laboratory inventories of polioviruses (type specific and virus specific).
4) To fulfil the obligations related to polio laboratory containment, the SRCC recommends the expansion of the SRCC to include additional member(s) with expertise in laboratory science and epidemiology.
5) UNICEF and development/technical partners are urged to mobilize resources to supplement the national buffer stocks by stockpiling the minimum levels of polio vaccine (IPV and bOPV) at the regional warehouse to assure timely responses to stock outs, outbreaks and emergencies. Minimum levels can be defined based on ongoing risk assessments.
6) The SRCC requests that the risk assessment methodology be reviewed to ensure that the overall risk level does not mask vulnerabilities at country level.
7) The committee also raises attention to the ongoing threat of El Niño and its potential impact on the immunization programs, especially during the upcoming switch phase in April 2016. Development and technical partners are encouraged to assure adequate technical and operational support to relevant Pacific island countries and areas during this critical period.
8) Countries and areas still using OPV should implement switch plans and validate the withdrawal of tOPV after the switch in accordance with the global guidelines.
9) The SRCC recommends that countries and areas take steps to improve and sustain high polio vaccine coverage and annual reporting of coverage data by submitting the completed Joint Reporting Form (JRF).

6. CLOSING

After reviewing again the committee recommendations and conclusions, the Chair thanked the SRCC/SRVC members for their work in classifying the pending AFP cases and drafting the conclusions and recommendations for the progress reports on measles elimination and polio eradication. The Chair acknowledged the support of the WHO Secretariat and thanked WHO and UNICEF staff members for their technical support during the meeting.

ANNEXES

Annex 1. List of participants

1. SRCC & SRVC MEMBERS

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Annex 2. Meeting timetable

Time	Tuesday, 29 September 2015	Time	Wednesday, 30 September 2015	Time	Thursday, 1 October 2015
08:00–08:30 08:30–08:50 08:50–09:00 09:00–09:30 09:30–10:00	REGISTRATION Opening session • Opening remarks by the Chair of the SRCC/SRVC • Self-introduction • Administrative announcements 1. Meeting objectives 2. Global and regional progress in measles elimination 3. First line of evidence: Epidemiology of measles in the Pacific islands	08:30–09:15 09:15–10:00	11. Global and regional update on polio including RCC and TAG recommendations 12. Case presentations for review and classification of AFP cases	08:30–10:00	20. Group work to draft SRCC and SRVC reports
10:00–10:30	GROUP PHOTO AND COFFEE BREAK	10:00–10:30	COFFEE BREAK	10:00–10:30	COFFEE BREAK
10:30–11:00 11:00–11:30 11:30–12:00	4. Second line of evidence: Quality of epidemiological surveillance 5. Second line of evidence: Quality of laboratory surveillance 6. Third line of evidence: Population immunity	10:30–11:15 11:15–12:00	13. AFP surveillance performance for the Pacific islands 14. Polio laboratory performance and polio virus containment	10:30–11:15 11:15–11:45 11:45–12:00	21. Group work to draft SRCC and SRVC reports (continued) 22. Group discussion to finalize reports 23. Closing session
12:00–13:00	LUNCH BREAK	12:00–13:00	LUNCH BREAK	12:00–13:00	LUNCH
13:00–13:30 13:30–14:00 14:00–15:00	7. Fourth line of evidence: Sustainability 8. Fifth line of evidence: Genotyping 9. NVC plan	13:00–13:30 13:30–14:15 14:15–15:00	15. Polio immunization coverage in the Pacific: routine and SIAs 16. Polio endgame implementation: (IPV introduction and switch planning): Kiribati, Samoa, Tokelau, Tuvalu, Vanuatu 17. Polio endgame implementation: (IPV introduction and switch planning): Cook Islands, Fiji, Nauru, Solomon Islands, Tonga		
15:00–15:30	COFFEE BREAK	15:00–15:30	COFFEE BREAK		
15:30–16:30	10. Comments, conclusions and recommendations	15:30–16:00 16:00–17:00	18. NCC plan 19. Comments, conclusions and recommendations		

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