Meeting Report

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

9–11 May 2017

Noumea, New Caledonia

World Health Organization
Western Pacific Region

Participants of the Fifth 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

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Convened by:

WORLD HEALTH ORGANIZATION
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Noumea, New Caledonia
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NOTE

The views expressed in this report are those of the participants of the Fifth 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 Fifth Meeting of the Combined Subregional Committees for the Certification of Poliomyelitis Eradication and Verification of Measles Elimination in Pacific Island Countries and Areas in Noumea, New Caledonia from 9 to 11 May 2017.

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Keywords:
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SUMMARY

The Fifth Meeting of the Combined Subregional Committees for the Certification of Poliomyelitis Eradication and Verification of Measles Elimination in Pacific Island Countries and Areas (SRCC/SRVC) was convened in Noumea, New Caledonia from 9 to 11 May 2017. 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 SRCC produces the required annual report on the poliomyelitis-free status for Pacific island countries and areas to be submitted to the Regional Certification Commission. The SRVC also develops the annual report on progress towards achieving 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 of verification standard, especially because performance varies in the countries and measles immunity gaps persist in select populations. Further collaborative efforts between regional and international partners as well as governments are required to achieve and maintain certification standards. The SRCC/SRVC supported the recommendation of the Technical Advisory Group (TAG) on Immunization and Vaccine-Preventable Diseases to offer the second routine dose of measles-containing vaccine in the second year of life and considered 2022 a reasonable target year for measles and rubella elimination in the Western Pacific Region.

The SRCC/SRVC concluded that the Pacific islands have maintained polio-free status, but noted that although the number of wild poliovirus cases in endemic countries is steadily decreasing the risk of international spread of poliovirus still represents a public health emergency of international concern. No stock-out of inactivated polio vaccine (IPV) due to the global shortfall was projected for Pacific island countries and areas in 2017. The SRCC/SRVC commended the Pacific island countries and areas on completion of the first part of phase 1 of the third edition of the Global Action Plan (GAP III) for polio laboratory containment.

The SRCC/SRVC recommended the following:

1) Although flaws in Demographic and Health Surveys (DHS) implementation may explain the discrepancy with reported coverage in some countries, an analysis of the quality and reliability of the administrative reports on vaccination coverage should be conducted.

2) Immunization staff should be closely involved in the planning and implementation of future DHS and immunization coverage surveys to maximize the quality and representativeness of the coverage estimates.

With regard to measles/rubella, the SRCC/SRVC recommended the following:

3) Countries and areas should achieve and sustain high coverage (more than 95%) with two doses of measles and rubella-containing vaccine (MRCV) in the routine programme.

4) Based on the analysis of coverage and surveillance data, as well as outbreaks, the most appropriate strategies (e.g. supplementary immunization activities, targeted social mobilization and communication activities, enhanced microplanning) targeting susceptible age groups should be identified and implemented to close immunity gaps and prevent large-scale outbreaks following importations.

5) To increase efficiency, measles and rubella supplementary immunization activities should be integrated with other vaccines or health interventions as appropriate.

6) Countries and areas are encouraged to use combination measles and rubella vaccines for all routine and supplementary doses.

7) National immunization programme staff should be closely involved in the planning and implementation of future DHS and immunization coverage surveys to maximize the quality and representativeness of the coverage estimates.

8) Countries that have not yet introduced school laws/policies are encouraged to implement policies promoting screening of immunization status and vaccination requirements at all levels, including preschool. Care should be taken so that screening does not impose a barrier to education enrolment.

9) All countries and areas should identify surveillance focal points/national coordinators to liaise with the World Health Organization (WHO). They should investigate acute fever and rash cases including core variables on the case-based form, collect appropriate clinical specimens and submit monthly surveillance data, including zero reporting.

10) Pacific island countries and areas are encouraged to consider initiating surveillance for congenital rubella syndrome in sentinel sites and to integrate within the existing surveillance system.

11) Countries are recommended to collect adequate specimens for serological (blood sample) and molecular testing (throat or oral fluid swab) from acute fever and rash cases whenever possible. However, only blood specimens would be considered sufficient. To facilitate specimen collection and transportation, where applicable, dried blood spots may be considered for measles and rubella testing to confirm diagnosis.

12) In countries with high incidence of diseases characterized by acute fever and rash (e.g. dengue, chikungunya, Zika), in order to optimize laboratory resources, laboratory testing for measles and rubella could be performed on samples testing negative for other pathogens.

13) As requested by the Regional Verification Commission for Measles Elimination, countries and areas that have not yet done so should develop costed outbreak preparedness and response plans.

14) Based on immunity profiles and/or measles virus transmission, the SRVC recommends Fiji, Kiribati and Samoa to consider implementation of supplementary immunization activities by the end of 2017 and Solomon Islands by the end of 2018.

15) Solomon Islands and Vanuatu, which have not yet introduced a routine second dose of measles vaccine in their national immunization programmes, should take steps to increase coverage with the first dose of measles-containing vaccine (MCV1) and introduce routine measles second dose in 2018.

16) To identify possible missed measles and rubella cases, New Caledonia and French Polynesia are encouraged to consider conducting a retrospective study of the blood samples from acute fever and rash cases collected during the last three years that tested negative for dengue/chikungunya/Zika virus, with WHO providing the necessary technical and financial support.

17) SRVC meetings are requested to continue to be convened in countries that benefit from the SRVC advocacy role to increase awareness and commitment towards measles and rubella elimination efforts.

18) Measles and rubella elimination updates are requested to be included in the agenda of the next meeting of Pacific immunization programme managers.

19) The United Nations Children's Fund (UNICEF) and development/technical partners are requested to continue mobilizing resources to supplement the national buffer stocks by stockpiling the minimum levels of MRCV at the regional warehouse to assure timely responses to stock-outs, outbreaks and emergencies. Minimum levels can be defined based on ongoing risk assessments.

20) WHO is requested:
    a. to organize systematic surveillance reviews in priority countries to increase case identification, investigation and reporting;
    b. to collaborate with SPC in exploring possibilities to support synergistic use of different surveillance systems in the countries;
    c. to collaborate with regional and international partners in continuing technical support to ensure regular reporting of AFR surveillance and vaccination coverage rates from the Pacific island countries and areas;
    d. to provide guidelines on congenital rubella syndrome surveillance;
    e. to solicit feedback from the countries and areas on the status of development of costed outbreak preparedness and response plans and provide technical support if required; and
    f. to invite priority countries such as Kiribati, the Federated States of Micronesia and the Marshall Islands to participate in future meetings.

With regard to polio, the SRCC/SRVC recommended the following:

21) Countries are encouraged to consider implementation of two-dose fractional IPV schedule as a mechanism to increase the number of children who can be vaccinated with limited vaccine supplies, provided resources for training and logistics are made available by the partners.

22) Countries are urged to comply with the requirements of the second part of GAP III phase 1 and identify, appropriately handle and store materials that are infectious or potentially infectious with oral polio vaccine containing the type 2 component (OPV2) and OPV2-like as well as Sabin 2 and Sabin2-like viruses when the global guideline is finalized and available.

23) SRCC meetings are requested to continue to be convened in countries that benefit from the SRCC advocacy role to increase awareness and commitment towards sustaining polio-free status.

24) A polio eradication update is requested to be included in the agenda of the next meeting of the Pacific immunization programme managers.

25) WHO as well as regional (Pacific Community) and international (United States Centers for Disease Control and Prevention) partners are requested to continue technical support to achieve regular reporting of AFP and vaccination coverage data/information in the Pacific island countries and areas.

1. INTRODUCTION

1.1 Meeting organization

The Fifth Meeting of the Combined Subregional Committees for the Certification of Poliomyelitis Eradication and Verification of Measles Elimination (SRCC/SRVC) in Pacific Island Countries and Areas was convened in Noumea, New Caledonia from 9 to 11 May 2017. All seven Subregional Committee members attended the meeting. The secretariat was composed of World Health Organization (WHO) staff from the Regional Office for the Western Pacific and Pacific subregional office. Observers from the Pacific Community, the United States Centers for Disease Control and Prevention (US CDC) and the United Nations Children's Fund (UNICEF) in the Pacific attended the meeting. The lines of evidence for measles and the individual components of the poliomyelitis (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 (AFP) cases;
(2) to draft the annual progress report on maintaining polio-free status in Pacific island countries and areas for submission to the Regional Certification Commission at its 23rd meeting in November 2017; 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 sixth meeting in September 2017.

1.3 Opening session

Dr Lisi Tikoduadua, Chair of the Subregional Committees, called the meeting to order and welcomed the participants to New Caledonia 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 joined the meeting via Skype to remotely deliver a presentation on global and regional progress in measles and rubella elimination. He summarized (1) achievements and challenges in measles and rubella elimination by the WHO regions, (2) progress and achievements in the Western Pacific Region, (3) challenges and issues in the Western Pacific Region, and (4) response by WHO to challenges and issues.

Progress and achievements in measles and rubella elimination in the Western Pacific Region include: (1) introduction of the second dose of measles-containing vaccine (MCV2) into the national immunization programme; (2) improvement of MCV1 and MCV2 coverage; (3) significant reduction of regional measles incidence from 2008 to 2012 with achievement of a historically low level in 2012; (4) establishment of regional measles and rubella laboratory network; (5) establishment of case-based measles and rubella surveillance; (6) development of a regional mechanism and process for verification of measles elimination; (7) introduction of rubella-containing vaccines into the national immunization programme; (8) significant reduction of regional rubella incidence from 2011 to 2016; and (9) establishment of a foundation of regional rubella elimination.

Challenges and issues in measles and rubella elimination in the Western Pacific Region are:

(1) changing measles epidemiology (e.g. increased measles virus transmission among adolescents and young adults not targeted by the present immunization strategy and among infants too young to be vaccinated (e.g. < 9 months of age); repeated outbreaks among minority groups and special populations (migrant workers, urban slum dwellers, etc.); becoming more diverse within countries with large populations, etc.);
(2) changing rubella epidemiology (e.g. the proportion of people of reproductive age infected with rubella has been significantly increasing in several countries of the Western Pacific Region); immunization system not yet strong enough to achieve and maintain elimination (planning at subnational levels, cold chain and vaccine management, etc.);
(3) insufficient capacity of national measles and rubella laboratory to conduct serological testing in a timely manner during a large-scale outbreak;
(4) delayed outbreak investigation, insufficient outbreak response, insufficient case management and nosocomial transmission; and
(5) weak involvement of local governments, private sectors, societies, communities, etc. in partnership and collaboration.

To address these issues and challenges and achieve and sustain the regional measles and rubella elimination in the Western Pacific, the *Measles and Rubella Elimination in the Western Pacific: Regional Strategy and Plan of Action* was drafted through a series of consultations with Member States, members and partners of the Technical Advisory Group (TAG) on Immunization and Vaccine-Preventable Diseases in response to the 2015 and 2016 TAG recommendations.

2.2 Summary of the lines of evidence

Dr Jayaprakash Valiakolleri described the criteria necessary for verification of measles and rubella elimination as absence of endemic transmission of measles for a period of more than 36 months in the presence of high-quality surveillance and genotyping evidence supporting interruption of endemic transmission.

The five lines of evidence are:

(1) a detailed epidemiology of measles, rubella and congenital rubella syndrome (CRS) and description of the epidemiology, including programmatic changes;
(2) population immunity presented as a birth cohort analysis, with the addition of evidence related to any marginalized and migrant groups per birth cohort;
(3) details and indicators of the quality of laboratory and epidemiological surveillance systems for measles, rubella and CRS;
(4) sustainability of the national immunization programme and resources for mass campaigns in order to sustain elimination; and
(5) evidence from circulating genotypes that measles and rubella virus transmission is interrupted. The progress made and the status in the Pacific island countries (PICs), including the indicators, were also presented.

2.3 Proposed strategies on measles and rubella elimination in the Western Pacific

Dr Roberta Pastore presented a summary of the proposed strategies on measles and rubella elimination in the Western Pacific Region. Following the 2015 TAG recommendation, the WHO Regional Office developed the draft *Measles and Rubella Elimination in the Western Pacific: Regional Strategy and Plan of Action* that will be submitted to the sixty-eighth session of the WHO Regional Committee for the Western Pacific in October 2017. The strategies and activities proposed to reach the operational targets by 2020 and to achieve the strategic objectives were presented to inform the SRVC members and discuss possible challenges for their implementation in the PICs. The presentation of the strategies followed the order of the eight strategic areas in the draft document: (1) overall planning and immunization system; (2) immunization; (3) epidemiologic surveillance; (4) laboratory support; (5) programme review and risk assessment; (6) outbreak preparedness and

response; (7) partnership, advocacy, information, education and communication (IEC), and social mobilization; and (8) progress monitoring and verification of elimination.

2.4 Update on rubella elimination in PICs

Dr Jayaprakash Valiakolleri updated on the progress of rubella elimination in the PICs. By 2015, all PICs had introduced the rubella-containing vaccine. The last two countries to do so were Solomon Islands in 2013 and Vanuatu in 2015. The reported routine immunization coverage in 2015 ranged from 65% to 100%. Rubella surveillance is integrated with measles surveillance in all countries where rubella surveillance is established. Rubella is not a notifiable disease in many countries and reporting of cases is limited to a few countries. Most of the cases are reported from Fiji and Solomon Islands. Three Pacific island laboratories are participating in an annual external quality control programme for testing measles and rubella antigen (IgM), and all of them have passed proficiency testing. Outbreaks of rubella since 2000 have occurred in 2002 (Tonga and Fiji), 2003 (Samoa, spreading to Tokelau), 2011 (Fiji) and 2012 (Solomon Islands). Young adult males (21–30 years) were predominantly affected in the 2011 outbreak in Fiji. An increase in CRS cases was observed in Solomon Islands following the 2012 rubella outbreak. CRS surveillance is weak or non-existent and there is widespread lack of awareness of CRS among clinicians.

2.5 Update on consultation on regional measles and rubella elimination

Dr Lisi Tikoduadua summarized the consultation outcomes. One conclusion was that all countries and areas should urgently address the disease burden due to CRS through increased efforts to achieve progress towards rubella elimination and that it is critical to establish the earliest achievable regional target year for rubella elimination. The consultation further concluded that while many countries can achieve rubella elimination by 2020, some countries with particular challenges such as large and diverse populations will require a phased approach and need a slightly longer period to interrupt endemic rubella virus transmission. Further collaboration and coordination by WHO and partners were recommended to achieve and sustain measles elimination in the region. It was advised to set a regional target year for rubella elimination as soon as possible to urgently address immunity gaps among current adolescents and young adults. The consultation also suggested that the TAG consider proposing a regional target year for rubella elimination to be discussed in the upcoming meeting to determine the final proposed target year.

2.6 Conclusions and recommendations of the SRVC

2.6.1 Conclusions

The SRCC/SRVC noted the following:

(1) Convening the SRCC/SRVC meetings in priority countries represents an important advocacy opportunity for the committee members as well as regional and international partners. It also provides an opportunity for immunization staff from the host government to attend and receive updates on latest progress and strategies to reach/sustain elimination goals and to maintain polio-free status.
(2) Recent Demographic and Health Surveys (DHS) coverage estimates differ substantially from vaccination coverage reported using administrative data, with DHS suggesting significantly lower coverage in some countries and areas.
(3) The introduction of new vaccines represents a good opportunity for strengthening routine immunization programmes, including activities targeting measles and rubella elimination.

The SRVC concluded that, although there is no evidence of ongoing endemic measles virus transmission, measles virus surveillance is not yet of verification standard, especially because discarded non-measles/non-rubella cases are being reported from only a few countries and areas, such as Fiji, Guam, Nauru and Solomon Islands. Further, investigation of suspected cases is still suboptimal as the 10 core variables are not completely recorded. In addition, immunity gaps persist in selected populations.

The SRVC acknowledged the recommendations from the regional measles and rubella consultation and considered 2022 a reasonable target year for the elimination of measles and rubella in the Western Pacific Region.

The SRVC supported the TAG recommendation that the second routine dose of measles-containing vaccine should be offered in the second year of life.

2.6.2 Recommendations

The SRVC made the following recommendations:

1) Countries and areas should achieve and sustain high coverage (more than 95%) with two doses of MRCV in the routine programme.

2) Based on the analysis of coverage and surveillance data, as well as outbreaks, the most appropriate strategies (e.g. supplementary immunization activities, targeted social mobilization and communication activities, enhanced microplanning) targeting susceptible age groups should be identified and implemented to close immunity gaps and prevent large-scale outbreaks following importations.

3) To increase efficiency, measles and rubella supplementary immunization activities should be integrated with other vaccines or health interventions as appropriate.

4) Countries and areas are encouraged to use combination measles and rubella vaccines for all routine and supplementary doses.

5) National immunization programme staff should be closely involved in the planning and implementation of future DHS and immunization coverage surveys to maximize the quality and representativeness of the coverage estimates.

6) Countries that have not yet introduced school laws/policies are encouraged to implement policies promoting screening of immunization status and vaccination requirements at all levels, including preschool. Care should be taken so that screening does not impose a barrier to education enrolment.

7) All countries and areas should identify surveillance focal points/national coordinators to liaise with WHO. They should investigate acute fever and rash cases including core variables on the case-based form, collect appropriate clinical specimens and submit monthly surveillance data, including zero reporting.

8) Pacific island countries and areas are encouraged to consider initiating surveillance for CRS in sentinel sites and to integrate within the existing surveillance system.

9) Countries are recommended to collect adequate specimens for serological (blood sample) and molecular testing (throat or oral fluid swab) from acute fever and rash cases whenever possible. However, only blood specimens would be considered sufficient. To facilitate specimen collection and transportation, where applicable, dried blood spots may be considered for measles and rubella testing to confirm diagnosis.

10) In countries with high incidence of diseases characterized by acute fever and rash (e.g. dengue, chikungunya, Zika), in order to optimize laboratory resources, laboratory testing for measles and rubella could be performed on samples testing negative for other pathogens.

11) As requested by the Regional Verification Commission for Measles Elimination, countries and areas that have not yet done so should develop costed outbreak preparedness and response plans.

The SRVC made the following recommendations for selected Pacific island countries and areas:

12) Based on immunity profiles and/or measles virus transmission, the SRVC recommends Fiji, Kiribati and Samoa to consider implementation of supplementary immunization activities by the end of 2017 and Solomon Islands by the end of 2018.

13) Solomon Islands and Vanuatu, which have not yet introduced a routine second dose of measles vaccine in their national immunization programmes, should take steps to increase coverage with the first dose of measles-containing vaccine (MCV1) and introduce routine measles second dose in 2018.

14) To identify possible missed measles and rubella cases, New Caledonia and French Polynesia are encouraged to consider conducting a retrospective study of the blood samples from acute fever and rash cases collected during the last three years that tested negative for dengue/chikungunya/Zika virus, with WHO providing the necessary technical and financial support.

The SRVC made the following recommendations for WHO and partners:

1) SRVC meetings are requested to continue to be convened in countries that benefit from the SRVC advocacy role to increase awareness and commitment towards measles and rubella elimination efforts.

2) Measles and rubella elimination updates are requested to be included in the agenda of the next meeting of Pacific immunization programme managers.

3) UNICEF and development/technical partners are requested to continue mobilizing resources to supplement the national buffer stocks by stockpiling the minimum levels of MRCV at the regional warehouse to assure timely responses to stock-outs, outbreaks and emergencies. Minimum levels can be defined based on ongoing risk assessments.

4) WHO is requested:
   a. to organize systematic surveillance reviews in priority countries to increase case identification, investigation and reporting;
   b. to collaborate with the Pacific Community in exploring possibilities to support synergistic use of different surveillance systems in the countries;
   c. to collaborate with regional and international partners in continuing technical support to ensure achieve regular reporting of AFR surveillance and vaccination coverage rates from the Pacific island countries and areas;
   d. to provide guidelines on CRS surveillance;
   e. to solicit feedback from the countries and areas on the status of development of costed outbreak preparedness and response plans and provide technical support if required; and
   f. to invite priority countries such as Kiribati, the Federated States of Micronesia and the Marshall Islands to participate in future meetings.

3. PROCEEDINGS OF THE SRCC

3.1 Global and regional update on polio including Regional Certification Commission and TAG recommendations

Dr Tigran Avagyan described that as of 1 May 2017 only five cases of wild poliovirus were reported from two endemic countries. However, the spread of wild and circulating vaccine-derived poliovirus remains a public health emergency of international concern. The Western Pacific Region has remained polio-free since certification in 2000. However, there are still countries and areas with immunity gaps due to suboptimal coverage with polio vaccines, and AFP surveillance performance varies notably among the countries and areas. The regional polio laboratory network plays a crucial role in the monitoring of the presence of poliovirus, confirmation of results of AFP cases, and documentation of the elimination of type 2 polio viruses following the switch from trivalent to bivalent oral poliovirus vaccine (OPV). No type 2 polio isolates have been detected from AFP cases and environmental surveillance samples since September 2016. Implementation of polio laboratory containment is ongoing in the Region, but with some operational impediments. A polio post-certification strategy is being developed to establish the high-level technical standards that are needed to sustain a polio-free world after global certification of polio eradication.

3.2 Case presentations for review and classification of AFP cases

Dr Valiakolleri presented AFP cases for 2016 and 2017 that were pending for classification. For 2016, there were four pending cases (one each from Fiji, Solomon Islands, Samoa and New Caledonia). No specimens were taken for any of the four cases. Three were classified as non-polio and discarded by the committee (Discard-3). For the fourth case, the committee wanted more information on the immunization status of the case before the case could be classified and the secretariat was requested to liaise with the country. Three cases in 2017 were pending classification (two from Solomon Islands and one from Fiji). One case from Solomon Islands did not have any residual paralysis during the 60-day follow-up and was discarded based on this (Discard-3). The remaining two cases were classified as non-polio and discarded (Discard-3) based on the clinical findings, investigations and immunity profile.

3.3 AFP surveillance performance for the Pacific islands

Dr Valiakolleri presented the surveillance performance for the Pacific. The non-polio AFP (NP-AFP) reporting rate for the last 10 years has been sustained at more than 1 per 100 000 population except in 2012 (0.6) and 2013 (0.8). In 2016, a total of 20 AFP cases were reported from four countries: Fiji (5 cases), Solomon Islands (13 cases), Samoa (1 case) and New Caledonia (1 case) with a NP-AFP rate of 2.0. It was noted that significant variability exists among the PICs with regard to quality of AFP surveillance. Most of the AFP cases in the last five years have been reported from Solomon Islands and Fiji and occasionally from Vanuatu, New Caledonia and Samoa. For 2017, the annualized NP-AFP rate is 1.5 with Fiji and Solomon Islands reporting four cases each. The stool adequacy rate has been 65% and 40% for 2016 and 2017 respectively. All the cases for 2016 and 2017 were investigated within 48 hours after notification and 60-day follow-up reports were received for all cases.

3.4 Polio immunization coverage in the Pacific: routine and supplementary immunization activity

Dr Valiakolleri gave an overview of routine and supplementary immunization in the Pacific. A variety of polio vaccine preparations are being used in the PICs. An all inactivated polio vaccine (IPV) schedule is used in twelve countries and eight countries are using OPV with one dose of IPV. These eight countries switched from trivalent to bivalent OPV during the global switch period in April/May 2016. The average reported coverage with three doses of polio vaccine over the last five years in eleven PICs is over 90%, in two PICs between 86% and 90%, in four PICs between 80% and 85%,

and in three PICs between 50*% and 79%. Irregular reporting of coverage is noted in American Samoa, the Commonwealth of the Northern Mariana Islands, and Wallis and Futuna. In 2016, Vanuatu conducted a measles–rubella catch-up campaign and OPV was added in the supplementary immunization activity. The reported immunization coverage from 2000 of each of the countries and areas was also presented.

3.5 IPV supply situation and implications

Dr Avagyan noted that the Strategic Advisory Group of Experts on Immunization reviewed available data on fractional dose IPV and concluded that regional and national immunization TAGs should recommend two fractional doses of IPV in national routine immunization schedules, where feasible. Countries interested in exploring this approach are encouraged to discuss it with their National Immunization Technical Advisory Groups. Countries moving to fractional dose IPV will be prioritized for IPV supply. OPV will continue to be used for approximately four years after the last case of polio. Once OPV is withdrawn, vaccination with IPV will continue for at least 10 years. Once OPV is withdrawn, the Strategic Advisory Group of Experts recommends giving at least two either full or fractional doses of IPV to all children – the first dose at 14 weeks or after and the second dose at least 4 months after the first dose.

The IPV supply situation remains constrained at the global level, but it is expected to improve sufficiently in 2018. The available supply continues to be allocated based on risk.

3.6 Conclusions and recommendations of the SRCC

3.6.1 Conclusions

The SRCC, having reviewed programme performance in implementing AFP surveillance and ensuring population immunity against poliovirus, concluded that the Pacific island countries and areas have continued to maintain polio-free status.

The SRCC noted:

(1) that performance varies in the countries and further collaborative efforts between regional and international partners as well as governments are required to achieve and maintain certification standards;
(2) that the number of wild poliovirus cases in endemic countries is steadily decreasing and the tremendous ongoing efforts in these countries is commendable;
(3) that the risk of international spread of poliovirus still represents a public health emergency of international concern;
(4) the support of WHO and the countries for the review and classification of the pending AFP cases;
(5) that no stock-out of IPV due to the global shortfall is expected in Pacific island countries and areas in 2017; and
(6) the availability of a global stockpile of monovalent oral polio vaccine type 2 (mOPV2) to be used for responding to polio type 2 outbreaks/events.

The SRCC commended the Pacific island countries and areas on completion of the first part of phase 1 of the third edition of the Global Action Plan (GAP III) for polio laboratory containment.

3.6.2 Recommendations

The SRCC made the following recommendations:

1) Countries are encouraged to consider implementation of a two-dose fractional IPV schedule as a mechanism to increase the number of children who can be vaccinated with limited vaccine supplies, provided resources for training and logistics are made available by the partners.

2) Countries are urged to comply with the requirements of the second part of GAP III phase 1 and identify, appropriately handle and store materials that are infectious or potentially infectious with OPV2 and OPV2-like as well as Sabin 2 and Sabin2-like viruses when the global guideline is finalized and available.

The SRVC made the following recommendations for WHO and partners:

3) SRCC meetings are requested to continue to be convened in countries that benefit from the SRCC advocacy role to increase awareness and commitment towards sustaining polio-free status.

4) A polio eradication update is requested to be included in the agenda of the next meeting of the Pacific immunization programme managers.

5) WHO as well as regional (Pacific Community) and international (US CDC) partners are requested to continue technical support to achieve regular reporting of AFP and vaccination coverage data/information in the Pacific island countries and areas.

4. HOSPITAL VISIT

On the third day of the meeting, the SRCC/SRVC members, observers and secretariat staff visited the Centre Hospitalier Territorial Gaston-Bourret to gain a better understanding of AFP and measles/rubella surveillance performance and laboratory capacity. Several aspects of AFP surveillance and measles/rubella laboratory investigation and confirmation were discussed with the respective focal points. The visit was important to identify the possibilities for further improving the reporting of AFP and acute fever and rash cases.

5. CLOSING

After reviewing 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.

6. ACKNOWLEDGEMENTS

The members of the SRCC/SRVC wish to express their sincere appreciation to the Government of New Caledonia for hosting the meeting in Noumea, as well as for organizing follow-up and arranging the hospital/laboratory visits (e.g. advocacy visit to the Centre Hospitalier Territorial Gaston-Bourret), which were most enlightening. Members gratefully acknowledge the support of WHO for their technical support during the meeting and towards the appointment of two new committee members representing New Caledonia and Samoa, as well as making it possible for representatives from the Pacific Community and US CDC to attend the meeting.

ANNEX 1

LIST OF MEMBERS OF THE SUBREGIONAL COMMITTEES FOR THE CERTIFICATION OF POLIOMYELITIS ERADICATION (SRCC) AND VERIFICATION OF MEASLES ELIMINATION (SRVC) IN PACIFIC ISLAND COUNTRIES AND AREAS, OBSERVERS AND MEMBERS OF THE SECRETARIAT

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ANNEX 2

FIFTH MEETING OF THE COMBINED SUBREGIONAL COMMITTEES FOR THE CERTIFICATION OF POLIOMYELITIS ERADICATION AND VERIFICATION OF MEASLES ELIMINATION IN PACIFIC ISLAND COUNTRIES AND AREAS
9 to 11 May 2017, Noumea, New Caledonia

24 April 2017
English only

TIMETABLE

Time	Tuesday, 9 May 20176	Time	Wednesday, 10 May 2017	Time	Thursday, 11 May 2017
07:30–09:00	**Final set up of the meeting room (WHO secretariat)**	**08:30–09:15**	**10. Global and regional update on polio including RCC and TAG recommendations**	**08:30–10:00**	**17. Group work to draft SRCC and SRVC reports**
09:00–09:15	**REGISTRATION**				
09:15–09:30	**Opening session** • Opening remarks by the Chair of the SRCC/SRVC • Self-introduction • Administrative announcements	**09:15–10:15**	**11. Case presentations for review and classification of AFP cases**		
09:30–10:00	**GROUP PHOTO AND COFFEE BREAK**	**10:15–10:45**	**COFFEE BREAK**	**10:00–10:30**	**COFFEE BREAK**
10:00–10:10	**1. Meeting objectives**	**10:45–11:30**	**12. AFP surveillance performance for the Pacific islands**	**10:30–11:15**	**18. Group work to draft SRCC and SRVC reports (continued)**
10:10–10:55	**2. Global and regional progress in measles and rubella elimination**	**11:30–12:00**	**13. Polio immunization coverage in the Pacific: routine and SIAs**		
10:55–11:40	**3. Summary of the lines of evidence**			**11:15–11:45**	**19. Group discussion to finalize reports**
11:40–12:00	**4. Discussion**			**11:45–12:00**	**20. Closing session**
12:00–13:00	**LUNCH**	**12:00-13:00**	**LUNCH**	**12:00–13:00**	**LUNCH**
13:00–14:30	**5. Proposed strategies on measles and rubella elimination in the Western Pacific**	**13:00–13:45**	**14. IPV supply situation and implications**		
14:30–14:45	**6. Update on rubella elimination in PICs**	**13:45–14:30**	**15. NCC plan**		
14:45–15:15	**COFFEE BREAK**	**14:30–15:00**	**COFFEE BREAK**		
15:15–15:30	**7. Update on consultation on regional measles and rubella elimination**	**15:00–15:45**	**16. Comments, conclusions and recommendations**		
15:30–16:15	**8. NVC plan**				
16:15–17:00	**9. Comments, conclusions and recommendations**				

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