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

14–16 May 2019
Manila, Philippines
MEETING REPORT

SEVENTH 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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NOTE

The views expressed in this report are those of the participants of the Seventh 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 Seventh Meeting of the Combined Subregional Committees for the Certification of Poliomyelitis Eradication and Verification of Measles Elimination in Pacific Island Countries and Areas in Manila, Philippines from 14 to 16 May 2019.
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SUMMARY

The Seventh 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 Manila, Philippines, from 14 to 16 May 2019. 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 (PICs). The SRCC produces the required annual report on the polio-free status for PICs to be submitted to the Regional Certification Commission. The SRVC develops the annual report on progress towards achieving measles elimination to be submitted to the Regional Verification Commission.

After reviewing the status of measles/rubella surveillance, routine and supplementary immunization, and outbreak preparedness and response, the SRVC concluded that there continues to be no evidence of ongoing endemic measles or rubella transmission in PICs, and overall measles and rubella population immunity through vaccination are high across broad age groups. Traditional quality and sensitivity indicators for verification-standard measles and rubella case-based surveillance may not be appropriate for the PIC context to describe the capacity to detect significant endemic or imported measles and rubella transmission. The SRVC should prepare evidence tailored to the unique context of PICs to present to the RVC for verification of measles and rubella elimination in PICs.

After reviewing the status of AFP surveillance and population immunity against poliovirus, the SRCC concluded that the PICs have maintained polio-free status. However, due to variable coverage with routine polio vaccines and no supplementary immunization activities since polio-free certification in 2000, it is estimated that one or two birth cohorts in PICs might be susceptible for polio. Diverse formulations of polio vaccines and national vaccination schedules among countries make it difficult to synchronize the national vaccination schedules for polio vaccines. The SRCC noted also that performance of AFP surveillance varies among countries, and further efforts to increase awareness of and knowledge on AFP surveillance among health-care workers is required.
1. INTRODUCTION

1.1 Meeting organization

The Seventh 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 Manila, Philippines, from 14 to 16 May 2019. Six of seven Committee members and the chair of the Regional Commission for Certification of Poliomyelitis Eradication in the Western Pacific attended the meeting. The Secretariat was composed of World Health Organization (WHO) staff from the Regional Office for the Western Pacific and the WHO Representative Office in the South Pacific. The lines of evidence for measles and the individual components of the poliomyelitis (polio) report were summarized and reviewed.

The list of participants is available in Annex 1 and the meeting timetable in Annex 2.

1.2 Meeting objectives

The objectives of the meeting were:

1) to review and classify all acute flaccid paralysis (AFP) cases pending final classification as of May 2019;
2) to review progress in implementing recommendations from the previous meeting, and to recommend actions for maintaining polio-free status and progressing towards achieving measles and rubella elimination in Pacific island countries and areas (PICs); and
3) to draft annual progress reports: (i) on maintaining polio-free status in PICs for submission to the Regional Certification Commission (RCC) for Poliomyelitis Eradication in the Western Pacific at its 25th meeting in 2019; and (ii) on progress towards achieving measles and rubella elimination in PICs for submission to the Regional Verification Commission (RVC) for Measles and Rubella Elimination at its eighth meeting, planned for September 2019.

2. PROCEEDINGS OF THE SRCC

2.1 Opening session

Dr Ilisapeci Tuibeqa, Chair of the Combined Subregional Committees, called the meeting to order and welcomed the participants. Dr Yoshihiro Takashima, Coordinator of the Expanded Programme on Immunization (EPI) of the WHO Regional Office, delivered opening remarks and presented to the meeting participants the current and anticipated challenges related to vaccine-preventable diseases in the Western Pacific Region and the actions taken and planned by WHO to respond to these challenges. Dr Nobuhiko Okabe, Chair of the Regional Commission for the Certification of Poliomyelitis Eradication in the Western Pacific, in his opening remarks addressed the current challenges related to global and regional polio eradication efforts.

2.2 Global and regional update on polio including RCC and Technical Advisory Group recommendations

Although the number of AFP cases due to wild poliovirus has been decreasing every year, the number of cases due to circulating vaccine-derived polioviruses (cVDPVs) globally is still high. In 2018, there were 33 wild poliovirus cases and 105 cVDPV cases globally. The spread of wild poliovirus and cVDPV remains a public health emergency of international concern. The Global Polio Eradication Initiative (GPEI) has adopted a new five-year strategy (2019–2023) on polio eradication, integration and certification.

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 vaccine, and AFP surveillance performance varies notably among the countries and areas. The regional polio laboratory
network plays a crucial role in monitoring the presence of poliovirus, confirmation of results of AFP cases, and documentation of the elimination of type 2 polioviruses following the switch of oral polio vaccine (OPV) from trivalent to bivalent. Implementation of polio laboratory containment is ongoing in the Region, but with some operational impediments.

In June 2018, the authorities in Papua New Guinea declared an outbreak of type 1 cVDPV. The Government, supported by partners and donors, immediately initiated a comprehensive response to the outbreak involving enormous financial and human resources. In all, more than 10 million children ranging in age from below 1 year up to 15 years were immunized with polio, measles/rubella and other vaccines. Further strengthening the current level of performance in the next six months is important for the outbreak to be declared closed.

The biggest current risk related to poliovirus in polio-free regions/countries still using OPV in their routine immunization schedules is the emergence and circulation of vaccine-derived polioviruses. EPI in the Region has started preparation for OPV use cessation in the Region and switch to an immunization schedule using only inactivated polio vaccine (IPV) in advance of the global eradication of polio.

2.3 Case presentations for review and classification of AFP cases

The SRCC reviewed the clinical notes, results of investigations including stool specimens, and 60-day follow-up (60 DFU) examination findings of the 2018 and 2019 AFP cases pending classification. Eight of the 13 AFP cases from 2018 were pending classification. After deliberations by the Committee members, four were discarded as Discard-3 and three as Discard-4. For the eighth case, which was from Solomon Islands, no 60 DFU could be done, though attempts were made to trace the child twice. The Committee requested to advise the country to make one more attempt to trace the child before concluding that the case is lost to follow-up and further deliberating classification.

Four cases from 2019 were discussed. Since the age of one AFP case was 15 years, and the clinician did not suspect polio, it was concluded that the case would not be included for calculating surveillance indicators. One case was discarded as Discard-5 and a second with 60 DFU as Discard-4. During a follow-up of the fourth case, an inadequate case not due yet for 60 DFU, the child was normal and there was no residual paralysis. From the detailed clinical notes and investigation reports, the Committee concluded that the case could be discarded as Discard-4 and 60 DFU to be completed when due.

2.4 AFP surveillance performance in the PICs

Though the non-polio AFP (NP-AFP) reporting rate at the PIC epidemiological block level is being sustained at around 1 per 100 000 population less than 15 years of age, many of the PICs do not report, or reported cases are few and irregular. The 13 AFP cases reported in 2018 were from four countries: Solomon Islands (7), Fiji (4), Vanuatu (1) and Tonga (1) with a NP-AFP rate of 1.2. The annualized NP-AFP rate for 2019 as of 30 April was 1.4 with Solomon Islands, New Caledonia and Fiji reporting a total of six cases. All surveillance indicators had dropped significantly in 2018 as compared to 2017. The specimen adequacy rate was 38% as compared to 63% in 2017. Only one of the 13 cases had specimens reaching the reference laboratory within 72 hours, with more than 50% of the specimens shipped from the national level reaching the laboratory after 10 days or more.

2.5 Polio immunization coverage in the Pacific: routine and SIAs

There is variety in the polio vaccine-containing formulations and immunization schedules being used in the PICs. An all-IPV schedule is used in 12 countries, and eight countries are using bivalent OPV with one dose of IPV. These eight countries switched from trivalent to bivalent OPV during the global switch period in April/May 2016. Though immunization coverage in many PICs has been high over the last years, coverage has been suboptimal in at least three PICs (Commonwealth of the Northern
Mariana Islands, the Federated States of Micronesia and the Marshall Islands). Further, it was noted with concern that American Samoa had not submitted coverage data since 2011 despite repeated follow-up. None of the PICs have conducted non-selective polio supplementary immunization activities (SIAs) except Vanuatu in 2016 along with a measles–rubella catch-up campaign. The reported polio 3 (three doses of polio vaccine) coverage for each of the 20 countries and areas was also reviewed and discussed.

2.6 Progress in laboratory containment of polioviruses

Five countries in the Western Pacific Region have designated poliovirus-essential facilities (PEFs) to handle and store wild poliovirus, vaccine-derived poliovirus, oral polio vaccine and Sabin type 2 poliovirus: Australia, China, Japan, the Republic of Korea and Viet Nam. Globally, there are 78 PEFs located in 28 countries. At the World Health Assembly in May 2018, a resolution on containment was endorsed, urging Member States to complete inventories for poliovirus type 2, to destroy unneeded type 2 materials, and to begin inventories and destruction of unneeded type 1 and 3 materials. The WHO Guidance to Minimize Risks for Facilities Collecting, Handling or Storing Materials Potentially Infectious for Polioviruses (PIM Guidance) was developed to assist facilities to assess the risk of poliovirus potentially infectious materials in their possession and to implement appropriate risk-reduction strategies consistent with the WHO Global Action Plan to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of oral polio vaccine use (GAPIII). The Global Commission for the Certification of the Eradication of Poliomyelitis set the deadline for completion of the inventories for 30 April 2019 (one year after the publication of the WHO guidance). The survey of facilities that may store potentially infectious materials in PICs is ongoing and expected to be completed by mid-August.

2.7 Conclusions and recommendations of the SRCC

2.7.1 Conclusions

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

The SRCC noted the following:

- Dr Adi Lisikoveni Vesikula Tikoduadua had retired from the SRCC/SRVC, and the Committee acknowledged her 21 years of exceptional leadership and dedication as Chair of the Subregional Committees.
- Vaccine hesitancy in PICs is increasing.
- Coverage with three doses of polio vaccine is high overall, although some countries and areas report coverage below 80%.
- Quality of AFP surveillance in PICs is sustained at a high level for most key performance indicators.
- National definitions of paediatric age differ significantly among PICs, from 12 years old in Solomon Islands and Samoa to 18 years old in Guam.
- Shipment of stool samples from AFP cases is challenging for some countries.
- Solomon Islands and Fiji submit monthly zero-reports on vaccine-preventable disease surveillance, and New Caledonia and Guam submit quarterly reports; Samoa includes AFP in weekly syndromic surveillance; and Cook Islands regularly shares its syndromic surveillance report with the immunization programme report.
- The deadline (30 April 2019) for country reporting on the survey to identify poliovirus potentially infectious materials was missed by PICs. Only Guam has submitted its report. Fiji has completed its audit, and Tonga and French Polynesia are nearing completion.
The SRCC concluded the following:

- Due to variable coverage with routine polio vaccines and no supplementary immunization activities since polio-free certification in 2000, it is estimated that one or two birth cohorts in PICs might be susceptible for polio.
- Diverse formulations of polio vaccines and national vaccination schedules among countries make it difficult to synchronize the national vaccination schedules for polio vaccines.
- Performance of AFP surveillance varies among countries, and further efforts to increase awareness of and knowledge on AFP surveillance among health-care workers is required.
- More detailed analysis of low stool adequacy rates in PICs in 2018 is required to identify the reasons and plan mitigating measures.
- Maintenance of reverse cold chain during shipment of stool specimens might be improved by using temperature-monitoring electronic data loggers.

2.7.2 Recommendations

**Recommendations for Member States**

The SRCC made the following recommendations:

1) Members of the SRCC are requested to sensitize responsible officers and health workers in their respective countries on AFP surveillance, routine immunization and laboratory containment and to advocate allocating more resources to the national immunization programmes.

2) Regular polio risk assessments, including detailed analysis of vaccination coverage at the subnational level, to be conducted with support from the WHO Secretariat.

3) PICs are requested to plan and implement actions to close immunity and AFP surveillance gaps.

4) PICs still using OPV in their routine immunization schedules are encouraged to consider switching to an IPV-only schedule after careful consideration of vaccine supply and relevant programmatic aspects.

5) PICs are requested to timely notify the polio regional reference laboratory at Victorian Infectious Diseases Reference Laboratory (VIDRL) and WHO on the expected shipment of stool specimens from AFP cases to facilitate the process of shipment, clearance and ensure timely processing of samples.

6) PICs are requested to develop polio outbreak preparedness and response national plans.

7) PICs are requested to complete their national inventories of potentially infectious materials and to share the results with WHO EPI by 1 August 2019.

8) PICs are requested to complete Form 2 of the PIM Guidance and submit it to the subregional containment coordinator at the WHO Division of Pacific Technical Support (DPS) office by mid-August 2019.

9) The SRCC to submit the consolidated Form 2 of the PIM Guidance to the WHO Regional Office by 1 September 2019.

**Recommendations for WHO**

The SRCC requested that WHO do the following:

1) Develop a communications strategy/tool to address vaccine hesitancy in the countries.

2) Revise the syndromic reporting system and synchronize it with hospital-based surveillance in countries where these are separate.

3) Support PICs still using OPV to estimate the feasibility and associated cost of switching to an IPV-only schedule.

4) Support implementation of reverse cold chain monitoring.

5) Request the polio regional reference laboratory (VIDRL) to share laboratory testing results with the WHO Division of Pacific Technical Support in Fiji.

6) Develop and provide a schedule of country visits and teleconferences to support countries in completing containment reports.

7) Develop the template for the polio outbreak preparedness and response plan (in consultation with the SRCC) and support the countries in developing national plans.
3. PROCEEDINGS OF THE SRVC

3.1 Global and regional progress in measles and rubella elimination including RVC and Technical Advisory Group recommendations

Globally, 2018–2019 has seen a resurgence in measles, with measles incidence doubling in 2019 compared to 2018. Coverage of measles-containing vaccine first dose (MCV1) has made little progress globally: 86% in 2018; 55 countries achieved coverage of ≥80% in every district. Coverage of measles-containing vaccine second dose (MCV2) is increasing: now at 69% globally and 171 countries have introduced MCV2 as of 2018. Rubella vaccine has been introduced in 168 countries as of the end of 2018.

The Western Pacific Region is experiencing an increase in measles transmission during 2018–2019, including increased importation of the virus from endemic countries to many Member States in the Region. In addition, rubella cases have increased dramatically in China and Japan. However, the Region continues to make encouraging progress towards measles and rubella (MR) elimination. A second dose of measles-containing vaccine (MCV) has been introduced in all Member States except Vanuatu, and the overall two-dose MCV coverage is 94% region-wide, but there is still wide variation in coverage among Member States. Nationwide SIAs were conducted in 13 countries during 2010–2019, including a nationwide MR-OPV campaign in Papua New Guinea in June–July 2019. The new WHO Regional Strategy and Plan of Action for Measles and Rubella Elimination in the Western Pacific Region (2018) was developed to guide the Region’s response to newly identified challenges during the measles resurgence of 2013–2016 and incorporate lessons learnt. Four countries have used this document to develop new final or draft national action plans for measles and rubella elimination. As of September 2018, nine countries and areas have been verified as having eliminated measles and five as having eliminated rubella.

3.2 Special challenges in verification of PICs: experience from PAHO in verifying MR elimination in the Caribbean

In the Region of the Americas, there are 25 English- and Dutch-speaking Caribbean countries and territories. A collective decision was made to conduct coordinated mass speed-up rubella campaigns in each country, beginning September 1998. Verification of measles and rubella elimination occurred during 2011–2016, but the English Caribbean countries eliminated measles in 1991. The primary challenges faced by the Caribbean in verification of measles and rubella elimination were: timeliness of submission of reports; collation of reports from 22 countries and territories into one Caribbean subregional report; lack of authority to receive reports from the Dutch and French territories; varying quality and standards of surveillance for measles and rubella among countries; and challenges with documentation to verify vaccination coverage data, especially for delayed doses given to older cohorts. To overcome surveillance quality issues, active and retrospective search for congenital rubella syndrome (CRS) and coordination with dengue/Zika surveillance were used to document absence of measles, rubella and CRS cases. Further challenges in sustaining elimination include: complacency after achieving elimination; declining coverage due to increasing vaccine hesitancy and refusal due to ongoing myths and role of so-called anti-vaxxers; false sense of security with high national coverage despite low-coverage districts; challenges with achieving >95% coverage for both doses of measles–mumps–rubella (MMR) vaccine, but especially so for MMR2; and maintaining quality surveillance in the context of increasing outbreaks of arbovirus infection with similar clinical presentation to measles and rubella, with a focus on testing for dengue, Zika, chikungunya virus during outbreaks without consideration of measles or rubella.

3.3 Overview of MR surveillance in the PICs (syndromic and case-based MR surveillance in PICs, status of CRS as a notifiable disease, syndromic CRS testing)

The Pacific Public Health Surveillance Network (PPHSN) is a voluntary network of PICs and organizations dedicated to the promotion of public health and response in the Pacific. It was created in
1996 under joint coordination by the Pacific Community and WHO. Target diseases include dengue (vector-borne diseases), measles, rubella, influenza, leptospirosis and typhoid fever. These data are disseminated via email to the network via PacNet, including weekly summaries of: the Pacific Syndromic Surveillance System; Hospital-based Active Surveillance (HBAS) system; routine surveillance; mass-gathering events; and outbreak monitoring reports. The HBAS system was established in 1997 by WHO under the PPHSN framework towards global polio eradication and includes 61 sites in 20 PICs. This system is comprehensive for detecting all AFP cases in the Pacific and is the basis of certification of polio-free status. Suspected measles and neonatal tetanus (NT) were later added towards integrated EPI surveillance. The HBAS system now functions as a sentinel system for acute fever and rash (AFR) illnesses. Challenges include: inconsistent information sharing and joint risk assessment between surveillance officers and EPI (six of 19 immunization managers enrolled in PacNet); inconsistent application of case definitions within and between PICs; reliance on offshore testing for MR diagnosis; limited surveillance for congenital abnormalities; and limited human resources in under-immunized areas.

3.4 AFR surveillance, laboratory and genotype issues for verification

The standard for measles and rubella should be nationwide, population-based, case-based surveillance of all suspected cases, with descriptions of core variables and laboratory confirmation, including genotyping, classification of cases by type of confirmation and source of infection. Rubella and measles surveillance should be integrated: (i) use AFR as suspected cases definition for both diseases; and (ii) conduct laboratory testing for measles and rubella in parallel or in series. Standard performance indicators are well defined to assess level of sensitivity, representativeness and quality of investigation.

Measles and rubella surveillance in the PICs does not meet most requirements and performance indicators, although it has improved over time. Only 30% of PICs report having CRS surveillance. To improve performance, coordination with syndromic surveillance may be necessary to ensure that reported AFR cases without confirmation for other more frequent differential diagnoses are adequately investigated. Laboratory testing algorithms for measles, rubella and other pathogens (for example arboviruses) should be established. Alternative indicators to assess performance could be considered, such as: capacity to detect imported cases, presence of active surveillance, awareness of health staff about measles and rubella case definitions, and risk of importation and import-related outbreaks.

CRS should be notifiable in all PICs, with suitable case definitions. The WHO Regional Office could serve remotely as a review panel of reported CRS suspected cases and support the cost of laboratory investigations. In 2019–2020, WHO will conduct a project to review measles and rubella surveillance in selected PICs to identify most suitable implementation mechanisms for recommendations issued by the SRVC and RVC.

The measles and rubella laboratory network in the Western Pacific Region consists of 385 laboratories that are available as global specialized, regional reference, national, subnational and prefecture-level laboratories, including four national laboratories in the PICs. The laboratories in the network sustain a high quality of performance with experienced and skilled staff, implementing quality management system and standardized data reporting. Quality laboratory surveillance with genotype information will be needed to verify elimination of transmission of endemic measles in the PICs. Both serological (blood) and virological (throat or nasopharyngeal swab) specimens should be collected for laboratory testing and genotype information for verification purposes. The quality of specimens received for testing is often not good, and timely transportation is frequently an issue in the PICs. To support the efforts to achieve verification, it is recommended to consider simultaneous testing for prevalent (endemic) diseases such as dengue or chikungunya that can mimic measles and rubella due to their low prevalence in elimination settings.
3.5 Immunity line of evidence (MR coverage, update on recent and planned SIAs)

Except Vanuatu, all PICs have introduced two doses of measles- and rubella-containing vaccine (MRCV). Eight countries use MR vaccine, while 12 countries use MMR and French Polynesia uses MMRV (measles, mumps, rubella and varicella). In 1997/98, 13 PICs conducted synchronized catch-up SIAs. The six USA-affiliated PICs and Wallis and Futuna did not participate. The coverage in eight countries was 90% or more, four between 80–89% and one less than 80% (French Polynesia 77%). Different immunization strategies over the past years were detailed. An update on SIAs since 2017 includes the one conducted in Fiji in 2017 with a reported coverage of more than 95%, the ongoing MMR SIAs in Chuuk state in the Federated States of Micronesia, and the planned ones in Kiribati and Solomon Islands for 2019.

The measles and rubella susceptibility profiles of 15 countries were reviewed. Profiles were not done for the remaining countries because of insufficient information on coverage data and SIAs. The limitations of the susceptibility profiles were also reviewed.

3.6 Epidemiology line of evidence

Large-scale outbreaks were common in PICs prior to 1997. Since the synchronized catch-up campaign in 13 PICs in 1997/98, outbreaks were interrupted in these PICs except French Polynesia, which experienced a small-scale outbreak in 2001 and 2002. Guam experienced outbreaks in 2002 and 2003, the Marshall Islands in 2003 and Fiji in 2006. There were no outbreaks in PICs after that until 2014 when three PICs experienced imported outbreaks. The Federated States of Micronesia and Solomon Islands experienced large-scale outbreaks, affecting three of the four states in the Federated States of Micronesia and all 10 provinces of Solomon Islands. Vanuatu also experienced an outbreak with 10 cases in the capital. All countries carried out a prompt response, and outbreaks were interrupted within five months. In 2015, Vanuatu experienced another outbreak with 20 cases, and the outbreak was interrupted by eight months later. Most of the surveillance performance indicators have not been met and need strengthening. Alternate performance indicators may need to be developed to assess performance and verification for elimination. Though the rate of discarded non-measles cases at the PIC block level has been met, many countries that are expected to report cases yearly do not report cases, though zero reports are received from some. Cases with adequate investigation have dropped in 2018.

3.7 Sustainability (VII programme, procurement, cold-chain etc)

Following the World Bank classification, based on available gross national income per capita data, Solomon Islands, Kiribati, Vanuatu and the Federated States of Micronesia fall in the lower middle-income group, while Fiji, the Marshall Islands, Samoa, Tonga, American Samoa, Tuvalu and Nauru fall in the higher middle-income group, and the Commonwealth of the Northern Mariana Islands, Palau, French Polynesia, Guam and New Caledonia are classified in the high-income group. The six USA-associated PICs receive their vaccines through the United States of America. Vaccines for New Caledonia, French Polynesia, and Wallis and Futuna need to meet European standards. The remaining 11 countries procure all traditional vaccines, including polio vaccine, through the United Nations Children’s Fund (UNICEF) Vaccine Independence Initiative (VII) mechanism with funds for traditional vaccines coming from the Government. VII is structured around a revolving fund, which acts as a line of credit for the Government, allowing it to pay for vaccines at a later time, after receipt of the order. Each country has a credit ceiling with a total of US$ 1.9 million for the PICs.
3.8 Conclusions and recommendations of the SRVC

3.8.1 Conclusions

The SRVC noted the following:

- Dr Adi Lisikoveni Vesikula Tikoduadua had retired from the SRCC/SRVC, and the SRVC acknowledged her 21 years of exceptional leadership and dedication as Chair of the Subregional Committees.
- Vaccine hesitancy in PICs is increasing.
- No measles outbreak has been reported in PICs since 2015, incidence of imported measles in 2018 was less than 1 per 1 million population, and no rubella outbreak has been reported in PICs since 2012.
- Sporadic imported measles cases have been successfully detected in Fiji and New Caledonia, indicating that surveillance is able to quickly detect importations, despite not meeting the standard surveillance performance indicators.
- Although PICs have successfully achieved zero endemic measles and rubella incidence for several years as well as high immunization coverage, they are still vulnerable to outbreaks due to imported virus. Global momentum towards elimination of the virus has weakened, leading to a global resurgence of measles that has greatly increased the risk to PICs.
- Many PICs use the recommended syndromic “acute fever and non-vesicular rash” surveillance definition for case-based surveillance, but many still use a clinical case definition to identify suspected measles and rubella cases.
- Reporting of coverage through the WHO/UNICEF Joint Reporting Form (JRF) has improved, but there are still some gaps: surveillance data are not reported by several countries with a population large enough to expect at least two discarded measles–rubella cases per year (French Polynesia, Guam, Kiribati, New Caledonia, Samoa and Tonga).
- There is a need to improve coordination and cooperation between surveillance officers and immunization managers to ensure that surveillance data are quickly integrated, interpreted and used to guide programmatic response.
- Fiji has changed its national vaccination schedule to give the second dose of MRCV during the second year of life in order to better protect young children against the increased risk of imported measles and rubella virus.
- Vanuatu remains the last PIC to introduce a two-dose MCV schedule.
- Measles and rubella SIAs were conducted in the Marshall Islands and the Federated States of Micronesia in 2018 and are planned to be conducted in Kiribati, Solomon Islands and Vanuatu in 2019.
- Samoa has restarted MMR vaccination and is congratulated for taking important steps to rebuild public confidence in vaccinations following recent challenges related to adverse events following immunization (AEFI).

The SRVC commended New Caledonia for its strong policy requiring measles- and rubella-containing vaccination of all adults who have contact with children or immunocompromised individuals.

The SRVC congratulated Solomon Islands for having introduced a second dose of MRCV in 2018.

The SRVC concluded the following:

- There continues to be no evidence of ongoing endemic measles or rubella transmission in PICs, and overall measles and rubella population immunity through vaccination are high across broad age groups.
- Some countries may still have discrete immunity gaps among adolescents and young adults, which present a risk for outbreaks after importation, including risk for CRS cases if outbreaks
occur among women of childbearing age and risk for infants below the age of vaccination eligibility who are vulnerable to infection during outbreaks.

- Traditional quality and sensitivity indicators for verification-standard measles and rubella case-based surveillance (in particular the indicator for rate of discarded non-measles, non-rubella cases at the subnational level) may not be appropriate for the PIC context to describe the capacity to detect significant endemic or imported measles and rubella transmission.
- The SRVC should prepare evidence tailored to the unique context of PICs to present to the RVC for verification of measles and rubella elimination in PICs.

### 3.8.2 Recommendations

**Recommendations for Member States**

The SRVC made the following recommendations:

1) PICs are requested to develop national plans of action for measles and rubella elimination, including plans and contingency resources for outbreak preparedness and response, and special immunization policies to protect vulnerable individuals during outbreaks (for example zero-dose vaccination of infants older than 6 months who are below the age of MCV1 routine immunization, and immunization of adult and adolescent close contacts of infants).

2) PICs are requested to strengthen and streamline processes for identifying and reporting cases that meet the suspected measles and rubella case definition in order to ensure imported cases can be detected and responded to quickly.

3) PICs are requested to encourage collection of virological samples during investigation of suspected measles and rubella cases, to allow tracking of imported virus genotype and lineage.

4) PICs are requested to develop strategies to identify and vaccinate adolescents and adults who may be susceptible to measles and rubella based on review of programme history. This may be done through SIAs for a wide age range, or through opportunistic strategies to vaccinate high-risk occupational groups, who might be exposed to measles and rubella through visitors, work in health-care settings or international travel.

5) PICs are requested to conduct data quality assessments or immunization coverage surveys, to improve estimation of immunization coverage, particularly in PICs that report discrepant administrative and official immunization coverage data, and/or have discrepancies between national data and WHO and UNICEF Estimates of National Immunization Coverage (WUENIC).

6) PICs are requested to ensure that suspected CRS is a disease of mandatory notification in each country or area, and to work with WHO to identify an appropriate case definition for suspected CRS in the local context, including cases identified through existing congenital anomaly surveillance programmes.

7) PICs are requested to review national vaccination schedules and consider changing the timing of the second MRCV dose to occur during the second year of life, if appropriate and feasible, in order to better protect young children from imported measles and rubella virus.

8) PICs are requested to develop strategies to strengthen demand and acceptance of vaccination in the general population, in addition to specific groups experiencing lowered vaccine acceptance.

9) Vanuatu is urged to introduce a second dose of MRCV in the second year of life, as soon as possible, and to seek technical support from WHO if needed.

10) American Samoa, the Commonwealth of Northern Mariana Islands, the Marshall Islands, the Federated States of Micronesia, Nauru, Palau, Pitcairn Islands, and Wallis and Futuna, in response to official communication from the WHO Regional Office in 2015, are requested to nominate national focal points for completing national inventory to identify potentially infectious materials by the end of June 2019.

**Recommendations for WHO**

The SRVC requested that WHO do the following:

1) Develop a communications strategy/tool to address vaccine hesitancy in the countries.

2) Revise the syndromic reporting system and synchronize it with hospital-based surveillance in countries where these are separate.
3) Work to identify and address challenges in reporting immunization coverage via the WHO/UNICEF Joint Reporting Form and case-based surveillance data to the WHO Regional Office.

4) Conduct an evaluation of vaccine-preventable disease surveillance in multiple PICs to identify practical recommendations for:
   - strengthening surveillance sensitivity and quality in individual countries and areas;
   - strengthening existing surveillance networks such as PacNet and PPHSN;
   - processes to incorporate measles and rubella laboratory testing in existing arbovirus surveillance;
   - enhancing collaboration between syndromic and case-based surveillance systems, and between surveillance and immunization officers to improve linkage to data interpretation and use for action; and
   - a proposed evidentiary standard for MR surveillance quality in PICs, to be agreed upon by the SRVC and submitted to the RVC, in support of a request for verification of measles and rubella elimination in PICs.

5) Prepare guidance for PICs on: appropriate laboratory sample collection and testing procedures for suspected measles and rubella cases, including use of dried blood spot (DBS); collection of virological samples; and sample collection and testing during outbreaks.

6) Support PICs to conduct CRS surveillance through diagnostic testing of serological and virological samples from suspected CRS cases, and by serving as an expert committee to guide individual countries and areas in investigation and final classification of suspected cases.

7) Provide PICs with tools to support demand generation, support clinicians to educate their patients and respond effectively to misinformation.

8) Continue to work with UNICEF and other partners to support PICs in sustaining routine vaccination.

9) Advocate strongly to the international community and to immunization partners for a new global commitment to achieving measles and rubella eradication, and a vastly increased mobilization of resources and expertise in support of this goal, to protect PICs against the continued threat of measles and rubella importation from endemic areas.

4. 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.

5. ACKNOWLEDGEMENTS

The members of the SRCC/SRVC gratefully acknowledge the support of the WHO Secretariat and thank WHO staff members for their technical support during the meeting.
ANNEXES

Annex 1. List of participants

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. Timetable

<table>
<thead>
<tr>
<th>Time</th>
<th>Tuesday, 14 May 2019</th>
<th>Time</th>
<th>Wednesday, 15 May 2019</th>
<th>Time</th>
<th>Thursday, 16 May 2019</th>
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</thead>
<tbody>
<tr>
<td>09:00–09:15</td>
<td>REGISTRATION</td>
<td>08:30–09:00</td>
<td>9. Global and regional progress in measles and rubella elimination including RVC and TAG recommendations</td>
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<tr>
<td>09:15–09:45</td>
<td>Opening session</td>
<td>09:00–09:30</td>
<td>10. Special challenges in verification of PICS: experience from PAHO in verifying MR elimination in the Caribbean</td>
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<td></td>
<td>• Opening remarks by EPI Coordinator</td>
<td>09:30–10:00</td>
<td>11. Overview of MR surveillance in the PICs (syndromic and case-based MR surveillance in PICs, status of CRS as a notifiable disease, syndromic CRS testing)</td>
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<td></td>
<td>• Opening remarks by the Chair of the SRCC/SRVC</td>
<td>10:00–10:30</td>
<td>12. Discussion</td>
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<td></td>
<td>• Opening remarks by the Chair of the RCC</td>
<td>09:45–10:15</td>
<td>GROUP PHOTO AND COFFEE BREAK</td>
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<td></td>
<td>• Self-introduction</td>
<td>10:30–11:00</td>
<td>COFFEE BREAK</td>
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<td></td>
<td>• Administrative announcements</td>
<td>10:00–10:30</td>
<td>COFFEE BREAK</td>
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<td>09:45–10:15</td>
<td>GROUP PHOTO AND COFFEE BREAK</td>
<td>10:00–11:00</td>
<td>20. Polio risk assessment model</td>
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<td>10:20–11:00</td>
<td>2. Global and regional update on polio including RCC and TAG recommendations</td>
<td>11:30–12:00</td>
<td>22. Group work to draft SRCC and SRVC reports</td>
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<td>11:00–12:00</td>
<td>3. Case presentations for review and classification of AFP cases</td>
<td>13:00–13:30</td>
<td>23. Group work to draft SRCC and SRVC reports (continued)</td>
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<td>12:00–13:00</td>
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<td>13:00–13:45</td>
<td>4. AFP surveillance performance for the Pacific islands</td>
<td>13:00–13:30</td>
<td>15. Epidemiology line of evidence</td>
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<td>14:15–15:00</td>
<td>6. Progress in laboratory containment of polioviruses</td>
<td>13:50–14:10</td>
<td>17. Sustainability (VII programme, procurement, cold-chain etc.)</td>
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<td>15:00–15:30</td>
<td>COFFEE BREAK</td>
<td>14:10–14:40</td>
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<td>15:30–16:15</td>
<td>7. NCC plan</td>
<td>14:40–15:15</td>
<td>18. NVC plan</td>
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<td>16:15–17:00</td>
<td>8. Comments, conclusions and recommendations</td>
<td>15:15–16:00</td>
<td>19. Comments, conclusions and recommendations</td>
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<tr>
<td>17:30–18:30</td>
<td>Regional Director's Reception</td>
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