EIGHTH 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

26–28 May 2020
Virtual meeting
Eighth 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

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MEETING REPORT

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NOTE

The views expressed in this report are those of the participants of the Eighth 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, a virtual meeting held from 26 to 28 May 2020, 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 Eighth 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 from 26 to 28 May 2020.
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**Keywords:**

Immunization programs / Immunization / Measles / Rubella / Poliomyelitis / Regional health planning / Pacific Islands
SUMMARY

The Eighth 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 as a virtual meeting from 26 to 28 May 2020. 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 while there continues to be no evidence of ongoing endemic measles or rubella transmission in PICs, recent outbreaks in American Samoa, Fiji, Samoa and Tonga highlighted the vulnerability PICs to importation of measles virus, while measles remains a globally endemic disease. Both affected and unaffected PICs are to be commended for mounting coordinated and capable responses for conducting proactive and comprehensive preparedness activities to prevent uncontrolled spread. The ongoing coronavirus disease 2019 (COVID-19) pandemic may threaten the performance of routine immunization services, which may result in rapid accumulation of susceptible children if proactive measures are not taken to ensure missed children are vaccinated. The SRVC should prepare evidence to present to the Regional Verification Commission for verification of measles and rubella elimination in the 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 underperforming AFP surveillance, the risk of outbreaks remains high due to emergence or importation of circulating vaccine-derived polioviruses (cVDPVs). Regarding routine polio immunization, the supply of one dose of inactivated polio vaccine (IPV) in 2021 is confirmed for PICs using oral polio vaccine (OPV) – and these countries will be able to introduce a second dose of IPV starting 2021. The SRCC noted that performance of AFP surveillance remains variable in the subregion with persistent suboptimal performance in several PICs. The Committee acknowledged that the timely shipment of stool specimens to the respective reference laboratories might be affected by restricted travel due to the COVID-19 pandemic.
1. INTRODUCTION

1.1 Meeting organization

The Eighth 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 as a virtual meeting from 26 to 28 May 2020. Five of seven Committee members attended the meeting and Secretariat staff from the World Health Organization (WHO) Regional Office for the Western Pacific and the WHO Representative Office in the South Pacific. Staff from the Pacific Community (SPC), the United Nations Children’s Fund (UNICEF) Pacific and the United States Centers for Disease Control and Prevention (US CDC) also attended as observers. 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 2020;

(2) in view of the recent measles outbreak and emergence of circulating vaccine-derived poliovirus (cVDPV), to assess progress in implementing recommendations from the previous meeting and recommend actions for the next year, for maintaining polio-free status and towards achieving measles and rubella elimination in Pacific island countries and areas (PICs); and

(3) to draft the annual progress reports: (i) on maintaining polio-free status in PICs for submission to the Regional Certification Commission meeting in November 2020; and (ii) on progress towards achieving measles and rubella elimination in PICs for submission to the Regional Verification Commission meeting, planned for September 2020.

1.3 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 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.

2. PROCEEDINGS OF THE SRVC

2.1 Measles outbreaks in PICs, and overview of major issues and challenges in the Pacific

PICs experienced a number of importation-related measles outbreaks in 2019 and early 2020. The largest outbreak occurred in Samoa, after a large immunity gap accumulated during 2018–2019 due to a 10-month suspension of the measles–rubella immunization programme beginning July 2018. The programme was suspended after two user-error related fatal adverse events following immunization, or AEFIs. This resulted in coverage with measles-containing-vaccine second-dose (MCV2) in 2018 of 13%. Anti-vaccination messaging also may have contributed to decreased uptake of vaccination after the vaccination programme was restarted. The outbreak in Samoa had 5707 cases between September 2019 and January 2020. Cases occurred across a very wide age range up to and beyond 60 years, but most cases were in children under 3 years, consistent with the known age gap in immunization
coverage. The response to the outbreak involved a massive coordinated effort from the Government of Samoa and partners. Mass vaccination with measles–rubella vaccine was implemented for all Samoans aged 6 months to 60 years, with overall coverage of 93%. The response also included physical distancing, closing schools and even shutting down the government to assist with outbreak response.

Massive international support included assistance from specialists and needed medical equipment. There were 86 deaths and a large number of hospitalizations requiring rehydration and some ventilation. Samoa’s 2019 experience demonstrates the rapid accumulation of susceptible children when an immunization programme is interrupted, as we are currently experiencing due to the coronavirus disease 2019 (COVID-19) outbreak.

In Tonga, an outbreak occurred after a high school rugby team became infected in New Zealand during an international tournament. A total of 665 cases were reported; only 21 were hospitalized and all recovered. The population of Tonga is highly vaccinated overall through routine and supplementary immunization and was thought to be at low risk of an outbreak. The outbreak predominantly occurred among older adolescent and young adults and among infants aged under 1 year. A very high proportion of cases had complete documentation of two measles vaccine doses. Measles immunoglobulin G (IgG) avidity testing is ongoing with support from the Victorian Infectious Diseases Reference Laboratory, or VIDRL, to determine to what extent vaccine failure may have contributed to the outbreak. A nationwide mass vaccination campaign was conducted for age groups 10–24 years and a zero dose for those aged 6–11 months was started. Booster doses were also given to children aged 1–9 years. Overall supplementary immunization activity (SIA) coverage was 94% nationwide.

Fiji experienced an outbreak with 31 confirmed cases within the Central Division. The outbreak predominantly affected children aged under 5 years and adults over 19 years. There was limited community spread after affected schools were closed.

Like Tonga, Fiji is overall a highly vaccinated population with a small, expected immunity gap based on historical routine immunization and SIA coverage. A high proportion of cases had at least one documented dose of measles vaccine. A well represented task force was set up in response to the measles outbreak in the Pacific before it reached Fiji. This allowed for coordination and organization that led to a quick and aggressive response to the imported cases, including well-coordinated response teams at division and subdivision levels, which kept pace with the case investigations, and a nationwide SIA delivering more than 200,000 doses, targeting children aged 6 months–5 years and adults aged 19–39 years, with 95% coverage nationwide of children aged under 5 years and 91% among adults aged 19–39 years. The response also included physical distancing measures, including school closures, targeted immunization to boost immunity and rapid case follow-up to contain the outbreak with only 31 cases and no deaths.

Both Fiji and Tonga experienced outbreaks disproportionately affecting vaccinated individuals. The possibility of waning immunity to measles after vaccination, leading to increased cases of breakthrough infections among vaccinated individuals, will require further research and strategic thought to guide countries in preventing, preparing for and responding to new outbreaks among immunized individuals. Significant investment in preventing nosocomial transmission of measles will be needed. Finally, achieving measles and rubella elimination will require a much broader view towards elimination strategies, including greater coordination and synchronization of immunization interventions and clarity and agreement on the use of mechanisms relating to the International Health Regulations (2005), known as IHR (2005), for measles notification and coordinated responses.

American Samoa reported 12 laboratory-confirmed cases, and Kiribati reported three confirmed cases. Both were contained without nationwide SIAs.
2.2 Acute fever and rash surveillance, laboratory and genotype issues for verification

The Regional Reference Laboratory in Australia received 391 samples from 377 patients for measles testing. The transit for samples was delayed due to measles outbreaks, and limited data were available due to confidentiality issues. The results showed 166 (44%) with confirmed measles (IgM+/PCR+), 56 (15%) did not indicate acute measles and 60 (16%) showed evidence of past infection or vaccination. Interestingly, 54 (14%) indicated very early infection (IgM-/PCR+) and an unspecified number indicated breakthrough infection (IgM-/IgG+/PCR+). Nine (2%) were IgM+/PCR-, indicating later early infection, and 5 (1%) had no evidence of measles infection. Genotyping data detected two genotypes during these outbreaks: Fiji and Tonga (D8) and Samoa (B3). These strains were circulating throughout the region in 2019–2020. The Laboratory received 14 serum samples for rubella testing: 10 indicated past infection or vaccination and four were acute infection or possibly a cross-reaction. No PCR samples or clinical symptoms were provided, and follow-up samples were requested.

2.3 Lines of evidence for measles and rubella elimination in PICs

**Epidemiology:** 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 in French Polynesia, which experienced a small 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 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 promptly responded to the outbreaks, and they were interrupted within five months. In 2015, Vanuatu experienced another outbreak with 20 cases, and the outbreak was interrupted within eight months. No outbreaks occurred until 2019, when an outbreak in New Zealand spread to Samoa, Tonga, Fiji, American Samoa and Kiribati, as described in the preceding section.

**Immunity:** Overall, routine immunization coverage with first-dose (MR1) and second-dose (MR2) measles–rubella vaccine has been stable in the Pacific islands, achieving 84% MR1 and 59% MR2 coverage. All PICs except Vanuatu have introduced MR2 into the routine programme. Vanuatu plans to introduce MR2 this year. Eight countries use measles–rubella (MR) vaccine, while 12 use measles–mumps–rubella (MMR) vaccine, and one (French Polynesia) uses measles–mumps–rubella–varicella (MMRV) vaccine. In 1997/98, 13 PICs conducted synchronized catch-up SIAs. The six PICs affiliated with the United States of America did not participate; neither did Wallis and Futuna. The coverage was 90% and above in eight countries, between 80% and 89% in four and less than 80% in one (French Polynesia, 77%). Since 2014, 10 preventive campaigns have been implemented in PICs: Fiji in 2017; the Federated States of Micronesia in 2017, 2018 and 2019; Kiribati in 2019; the Commonwealth of the Northern Mariana Islands in 2018; Samoa in 2017; Vanuatu in 2015 and 2019; and the Marshall Islands in 2019. A total of 10 outbreak response SIAs have been conducted since 2014, including two in 2014 (Solomon Islands and Federated States of Micronesia) and eight in 2019, including unaffected countries and areas (American Samoa, Fiji, the Marshall Islands, the Commonwealth of the Northern Mariana Islands, Nauru, Tonga and Samoa). Campaigns were planned in the Federated States of Micronesia in 2020 and Vanuatu in 2021. The outbreak response immunization activities in both affected and unaffected countries greatly strengthened population immunity in PICs and advanced measles and rubella elimination efforts.

**Surveillance:** Traditional surveillance performance indicators are not well suited to the unique situation of the PICs. In 2020, PICs achieved 13.4 discarded non-measles, non-rubella cases per 100 000 population at the national level (target at least 2.0 per 100 000 population), but only 10% of individual countries met the target discard rate (target at least 80%). Of suspected cases, 87% had adequate blood specimens, which met the target of 80%. Although 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. WHO in the region has developed draft alternative lines of evidence for measles and rubella elimination in the PICs, in particular including an alternative approach to demonstrating surveillance capability. A strength of the Pacific subregion is the collaborative communication between islands, which can serve as a surveillance safety net when individual countries and areas may not have adequate individual surveillance capacity. This outbreak demonstrated that PICs are capable of detecting imported cases, particularly when sensitivity and awareness is alerted due to outbreaks among other PICs. Additionally, most islands that detected confirmed cases were able to obtain genotype data through the Regional Reference Laboratory network.

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 SPC and WHO coordination. 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 gatherings 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, and HBAS now functions as a sentinel system for acute fever and rash, or AFR, illnesses. Challenges include: inconsistent information sharing and joint risk assessment between surveillance and EPI officers (6 of 19 immunization managers enrolled in PacNet); inconsistent application of case definitions within and between PICs; reliance on offshore testing for measles and rubella diagnosis; limited surveillance for congenital abnormalities; and limited human resources in under-immunized areas.

**Sustainability:** Available data on gross national income (GNI) per capita for selected PICs based on World Bank classification show Solomon Islands, Kiribati, Vanuatu and the Federated States of Micronesia are in the lower middle-income group, Fiji, the Marshall Islands, Samoa, Tonga, American Samoa, Tuvalu and Nauru in the upper middle-income group, and the Commonwealth of the Northern Mariana Islands, Palau, French Polynesia, Guam and New Caledonia in the high-income group. The six USA-associated Pacific countries get their vaccines through the USA. Vaccines in New Caledonia, French Polynesia, and Wallis and Futuna need to meet European standards. The remaining 11 countries procure all the traditional vaccines, including polio vaccine, through the UNICEF Vaccine Independence Initiative (VII) financial mechanism and funds for traditional vaccines are from government funds. 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.

### 2.4 Conclusions and recommendations

#### 2.4.1 Conclusions

The SRVC noted that reporting of coverage data through the WHO–UNICEF Joint Reporting Form is continuously lacking by American Samoa.

The SRVC concluded the following:

- While there continues to be no evidence of ongoing endemic measles or rubella transmission in the PICs, outbreaks in American Samoa, Fiji, Samoa and Tonga in 2019–2020 highlighted the vulnerability of Pacific island communities to importation of measles virus, while measles remains a globally endemic disease.
- Outbreaks in the PICs were all successfully contained without leading to endemic spread across the islands, demonstrating the capacity to sustain elimination within the subregion.
• The epidemiology and age distribution of the outbreaks varied significantly between affected PICs, reflecting the history of their immunization programme as well as distinct issues and challenges in each country or area.

• The large outbreak of measles in Samoa in 2019 occurred after a rapid accumulation of susceptible children during the 10-month period of paused routine measles and rubella immunization following two immunization error-related deaths. This illustrates the importance of identifying and taking proactive steps to fill known immunity gaps through catch-up or non-selective mass vaccination activities.

• The outbreak in Samoa had a high case fatality, which may have been in part due to an overwhelmed health-care system and a shortage of vitamin A.

• The response to the outbreak in Samoa was supported by a massive collaborative effort from multiple international partners to conduct epidemiological analysis, vaccinations and clinical care.

• Outbreak cases in Tonga had a very high proportion of breakthrough infection among fully vaccinated children and young adults associated with a boarding school, demonstrating that even highly vaccinated populations may have unknown immunity gaps and may be at risk of outbreaks after importation. This finding gives greater urgency to accelerate measles elimination globally.

• Outbreak cases in Tonga had a very low rate of hospitalization, reflecting a massive public education effort as well as the high rate of cases among fully vaccinated people, which is known to cause less severe disease.

• Both affected and unaffected PICs are to be commended for mounting coordinated and capable responses to suspected and confirmed measles cases, and for conducting proactive and comprehensive preparedness activities to prevent uncontrolled spread. This included implementation of zero-dose immunization policies for infants aged 6–11 months in several PICs and mass vaccination activities in Fiji, Kiribati, the Marshall Islands, the Federated States of Micronesia, Nauru, the Commonwealth of the Northern Mariana Islands, Samoa, Tonga and Vanuatu. These activities have filled immunity gaps and significantly strengthened the subregion’s capacity to prevent and respond to future measles outbreaks.

• Public health and physical distancing measures to respond to the ongoing COVID-19 pandemic may threaten the performance of routine immunization services, which may result in rapid accumulation of susceptible children if proactive measures are not taken to ensure missed children are vaccinated.

• Although there was a low overall proportion of laboratory-confirmed cases, imported laboratory-confirmed cases were detected in multiple PICs and most islands had some genotype data. There was a delay in the shipment of samples from the PICs to regional reference laboratories due to a measles outbreak in New Zealand. PIC specimens were forwarded from New Zealand to Australia for testing as the laboratory in New Zealand does not have reference laboratory status for measles and was overwhelmed by domestic specimens for measles testing.

• The Mataika House measles and rubella national laboratory in Fiji is congratulated for introducing the capacity for molecular detection of measles in 2019 and passing the proficiency test. The laboratory will undergo the WHO accreditation process to add this capacity to its programme.

• Following the initial detection of an outbreak in Samoa, both affected and unaffected PICs intensified surveillance activities to detect acute fever and rash and conducted preparedness and pre-emptive response activities. This demonstrated the capacity of the subregion to communicate and collaborate as a region to detect and contain measles outbreaks. However, timeliness of these activities should be improved when risk of importation is high from countries outside the subregion, such as from New Zealand.
• The SRVC should prepare evidence to present to the Regional Verification Commission for verification of measles and rubella elimination in the PICs.

2.4.2 Recommendations for Member States

The SRVC encouraged Member States to consider the following:

1) Maintain an intensified level of surveillance to detect imported measles cases and to prevent outbreaks among children whose vaccination was delayed or missed due to programme interruption related to the ongoing COVID-19 pandemic.

2) Continue to maintain a collaborative approach to measles and rubella surveillance and outbreak preparedness by rapidly notifying WHO and other PICs of newly detected measles cases.

3) Develop plans and policies for when disasters and outbreaks (such as the ongoing COVID-19 pandemic) impact immunization programme performance to: assess immunity gaps; track, follow up and vaccinate those individuals having missed vaccinations; and re-establish community demand for vaccines.

4) Encourage the collection of virological samples during investigation of suspected measles and rubella cases, to allow tracking of imported virus genotype and lineage.

5) Ensure that suspected congenital rubella syndrome (CRS) is a disease of mandatory notification in each country or area and work with WHO to identify an appropriate case definition for suspected CRS in the local context.

6) For countries with national capacity for rubella serology, consider adding rubella serological testing to antenatal screening and provide rubella vaccine to seronegative mothers after delivery.

7) Review national vaccination schedules and consider changing the timing of the second dose of measles and rubella containing vaccine, or MRCV, 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) For countries with uncertainty about immunization coverage or level of immunity among specific population groups (for example where large-scale population movement may have occurred), consider working with WHO and partners to implement serological surveys to map population immunity. These serological surveys may assess multiple antigens through techniques such as microscopic bead assay, or MBA, and may be simplified for remote island settings through the use of dried blood spot sample collection methods.

9) Work with WHO to conduct the previously planned surveillance assessment for measles and rubella and develop a collaborative framework for detecting imported cases and documenting measles elimination.

10) Work with WHO to strengthen the capacity of national laboratories to conduct antibody and polymerase chain reaction, or PCR, testing for measles and rubella case detection, and establish clear referral relationships with one of the regional reference laboratories in the Western Pacific for confirmatory testing.

11) Work with WHO and UNICEF to ensure the availability of measles and rubella containing vaccines and supplies, including contingency resources for outbreak responses.

Further, the SRVC urged Vanuatu to introduce a second dose of measles and rubella containing vaccine in the second year of life, as soon as possible, and to seek technical assistance from WHO, if needed.
2.4.3 Recommendations for WHO

The SRVC requested that WHO fill an EPI vacancy in the WHO Representative Office in the South Pacific in Fiji to ensure continuous technical support to the PICs, which is critical for the subregion in addressing immunity gaps.

The SRVC requested that WHO consider the following:

1) Continue to work with PICs to explore expanding national laboratory capacity for measles and rubella case confirmation.

2) Work with priority countries and areas to identify and address challenges to reporting immunization coverage via the WHO–UNICEF Joint Reporting Form and case-based surveillance data to the WHO Regional Office.

3) Support PICs to conduct CRS surveillance by conducting 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 the investigation and final classification of suspected cases.

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

5) Continue to 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 the PICs against the continued threat of measles and rubella importation from endemic areas.

3. PROCEEDINGS OF THE SRCC

3.1 Global and regional update on polio including Regional Certification Commission and Technical Advisory Group recommendations

The global polio programme is facing challenges due to the COVID-19 pandemic. The situation remains concerning with increasing number of wild poliovirus cases in Pakistan and Afghanistan and continuous outbreaks due to circulating vaccine-derived polioviruses type 1 and 2 globally. On a positive note, the African Regional Certification Commission may announce in August 2020 the of eradication of wild polioviruses in the African Region. Novel OPV2 is expected to be available for outbreak response later in 2020. An increased global stockpile of IPV will allow countries using OPV in their routine immunization schedule to introduce the second dose of IPV starting in 2021. The key priorities for the global polio eradication programme for the next six months include sustaining AFP and environmental surveillance, planning for resumption of SIAs, keeping the focus on novel OPV2, and continuing support for the COVID-19 response.

The Western Pacific Region has successfully maintained its polio-free status since 2000. Most Member States maintain over 90% coverage with three doses of polio vaccine and high-quality, sensitive AFP surveillance. In December 2019, an outbreak of cVDPV1 in Papua New Guinea was officially closed and the IHR Emergency Committee removed Papua New Guinea from the list of countries infected with cVDPV1. In 2019, outbreaks of cVDPV type 1 and 2 were confirmed in the Philippines and Malaysia. Funding from the Global Polio Eradication Initiative to the Western Pacific Region is expected to continue decreasing even further.

3.2 Informal consultation on polio vaccination strategies in the Western Pacific Region

To review the current and future polio vaccination strategies in the Western Pacific Region, WHO convened an informal consultation in February 2020, which was attended by world-renowned experts with wide knowledge and extensive experience in the global and regional polio eradication initiatives.
The objectives of the consultation included: reviewing the current global and regional situation regarding cVDPV outbreaks; identifying and evaluating the risks related to cessation of OPV use in the Western Pacific Region in advance of certification of global polio eradication; and discussing the strategic directions in the polio vaccination schedule in the Region in 2021–2030. In the course of the consultation, the experts reviewed: the global and regional polio eradication situation; the global supply status of IPV; the implications of the new strategy of Gavi, the Vaccine Alliance, for the Member States; deliberations and recommendations of the Strategic Advisory Group of Experts, or SAGE, polio working group; and possible risks to be considered as well as similar plans in other WHO regions, such as the Region of the Americas. The expert group recommended that WHO present the outcomes of the consultation to the members of the Western Pacific Region Technical Advisory Group for their review and recommendations and continue close cooperation with other polio-free regions on this issue.

3.3 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 examination findings of the 2019 and 2020 AFP cases that are pending final classification. Three of 22 AFP cases from 2019 were pending final classification. After deliberations by the Committee members, one case was discarded as Discard-3 and two cases as Discard-4. Two cases from 2020 were discussed. After deliberations by the Committee members, one case was discarded as Discard-4. As the critical information for the second case was missing, the SRCC members concluded that the case could not be finally classified at the time of the meeting. Further information will be requested from the reporting country (Solomon Islands) for the SRCC to be able to proceed with the final classification of that case.

3.4 AFP surveillance performance for the Pacific islands

The non-polio AFP reporting rate in the PIC epidemiological block is maintained above 1 per 100 000 population less than 15 years of age. However, many of the PICs do not report or report fewer than expected cases. The 22 AFP cases reported in 2019 were from three countries: Fiji (13), Solomon Islands (6) and New Caledonia (2) with a non-polio AFP reporting rate of 1.91. The annualized non-polio AFP reporting rate for the PICs in 2020 as of 19 May was 0.52, with Fiji and Solomon Islands reporting two cases. All surveillance indicators had improved in 2019 compared to significant drops in 2018. The specimen adequacy rate was 52% as compared to 38% in 2018. Eight cases had specimens reaching the reference laboratory within 72 hours. For six AFP cases, stool specimens were not collected; for eight cases, stool specimens reached the reference laboratory between four and seven days. The 60-day follow up indicator compared to 2018 dropped from 89% to 67%.

3.5 Polio immunization coverage in the Pacific: routine and supplementary immunization activities

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 four PICs in 2019 (Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, Samoa 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 SIAs in 2019. The reported polio 3 (three doses of polio vaccine) coverage for each of the 20 countries and areas was also reviewed and discussed.
3.6 Polio laboratory containment and completion of national inventory for potentially infectious materials

Worldwide, there are currently 30 countries planning to retain type 2 poliovirus in 66 designated poliovirus-essential facilities (PEFs), including 17 PEFs in five countries in the Western Pacific Region: Australia, China, Japan, the Republic of Korea and Viet Nam. There is significant delay globally with the implementation of 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, or GAPIII, both with certification of PEFs as well as with completion of national inventories to identify potentially infectious materials, or PIMs, that may contain Sabin 2 in all biomedical laboratories. As of May 2020, six out of 21 PICs have completed national inventories and submitted country reports. It is expected to collect all remaining country reports from PICs by the end of August and to consolidate them in an SRCC report to submit to WHO by 1 September.

3.7 Conclusions and recommendations

3.7.1 Conclusions

The SRCC noted that reporting of coverage data through the WHO–UNICEF Joint Reporting Form is continuously lacking by American Samoa.

The SRCC reviewed and classified four out of five AFP cases reported in 2019 and 2020. Further information on the fifth AFP case reported from Solomon Islands in 2020 is required for the SRCC to make a final classification of the case. The SRCC, having reviewed programme performance in implementing surveillance for AFP and ensuring population immunity against poliovirus, concluded that PICs have continued to maintain polio-free status.

The SRCC concluded the following:

- Immunity gaps against polio remain in Guam, the Marshall Islands, the Federated States of Micronesia, the Commonwealth of the Northern Mariana Islands, Samoa, Solomon Islands and Vanuatu.
- The risk of outbreaks remains high due to emergence or importation of cVDPVs in countries with suboptimal population immunity against poliovirus and underperforming AFP surveillance. This is evidenced by ongoing multiple outbreaks of cVDPVs in the Western Pacific Region.
- The supply of one dose of IPV in 2021 is confirmed for PICs using OPV.
- Countries using OPV will be able to introduce a second dose of IPV starting in 2021.
- Performance of AFP surveillance remains variable in the subregion with persisting suboptimal performance in several PICs.
- Further advocacy with PICs is required to raise awareness of clinical staff on reporting AFP cases and taking stool specimens for further testing in the respective reference laboratories.
- The timely shipment of stool specimens to the respective reference laboratories might be affected by restricted national and international travel due to the COVID-19 pandemic.

3.7.2 Recommendations for Member States

The SRCC encouraged Member States to consider the following:

1) All PICs to achieve and maintain more than 90% of coverage with three doses of polio vaccine at the national level.
2) Countries using OPV:
3.7.3 Recommendations for WHO

The SRCC also requested that WHO fill an EPI vacancy in the WHO Representative Office in the South Pacific in Fiji to ensure continuous technical support to the PICs, which is critical for the subregion in addressing immunity and AFP surveillance gaps.

The SRCC requested that WHO consider the following:

1) Support PICs using OPV in preparing for the introduction of the second dose of IPV.

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

3) Develop a template for the polio outbreak preparedness and response plan (in consultation with the SRCC) and support the countries in developing national plans.

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. Meeting programme

EIGHTH 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

26 to 28 May 2020, a virtual meeting

## TIMETABLE

<table>
<thead>
<tr>
<th>Time</th>
<th>Tuesday, 26 May 2020</th>
<th>Time</th>
<th>Wednesday, 27 May 2020</th>
<th>Time</th>
<th>Thursday, 28 May 2020</th>
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<tbody>
<tr>
<td>08:00-08:30</td>
<td>Opening session</td>
<td>08:00-08:30</td>
<td>11. Global and regional update on polio including RCC and TAG recommendations</td>
<td>08:00-10:00</td>
<td>22. Group work to finalize conclusions and recommendations</td>
</tr>
<tr>
<td>08:00-08:30</td>
<td>1. Meeting objectives</td>
<td>08:30-08:50</td>
<td>12. Discussion</td>
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<tr>
<td>08:30-08:40</td>
<td>1. Meeting objectives</td>
<td>08:50-09:10</td>
<td>13. Informal consultation on polio vaccination strategies in WPR</td>
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<tr>
<td></td>
<td>2.1. Fiji (10 min)</td>
<td>09:30-10:00</td>
<td>15. Case presentations for review and classification of AFP cases</td>
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<td>2.2. Samoa (10 min)</td>
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<td>2.3. Tonga (10 min)</td>
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<td>09:10-09:20</td>
<td>3. Overview of major issues/lessons of each outbreak for elimination in the Pacific</td>
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<td>09:20-09:50</td>
<td>4. Discussion</td>
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<tr>
<td>09:50-10:20</td>
<td>BREAK</td>
<td>10:00-10:30</td>
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<tr>
<td>10:20-10:35</td>
<td>5. AFR surveillance, laboratory and genotype issues for verification</td>
<td>10:30-10:45</td>
<td>16. AFP surveillance performance for the Pacific islands</td>
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<td>10:35-10:50</td>
<td>6. Discussion</td>
<td>10:45-11:00</td>
<td>17. Discussion</td>
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<tr>
<td>10:50-11:05</td>
<td>7. Immunity line of evidence (MR coverage, update on recent and planned SIAs)</td>
<td>11:00-11:15</td>
<td>18. Polio immunization coverage in the Pacific: routine and SIAs</td>
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<tr>
<td>11:35-12:00</td>
<td>10. Discussion</td>
<td>11:45-12:00</td>
<td>21. Discussion</td>
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