Minutes from the Ministry of Health Expert Advisory Group (EAG), 10 September 2019

Members:

Prof Stuart Dalziel, Assoc Prof Lance Jennings, Assoc Prof Karen Hoare, Dr Osman Mansoor, Prof Peter McIntyre, Dr Ramon Pink, Dr William Rainger, Dr Sally Talbot, Dr Anja Werno, Dr Ayesha Verrall, Assoc Prof Tony Walls

In attendance:

PHARMAC:	Andrew Oliver, Lindsay Ancelet
ESR:	Dr Jill Sherwood
Ministry of Health:	Tom Kiedrzynski, Dr Caroline McElnay, Dr Niki Stefanogiannis, Dr Natasha White

Apologies:

Dr Sean Hanna, Prof Cameron Grant, Dr Stephen Munn, Dr Edwin Reynolds, Dr Michael Tatley, Assoc Prof Nikki Turner, Prof Michael Baker

Purpose:

The purpose of the meeting of this expert group is to provide advice to the Ministry of Health on the implementation of:

- an immunisation response to reduce the incidence of Men W in New Zealand
- a measles immunisation catch up campaign to address known immunity gaps

1.0 Update on EAG recommendations from 3 September

Recommendation 4:

PHARMAC provided an update on the current and projected MMR vaccine supply in New Zealand. The current stock is being carefully managed to ensure supply across Auckland to support the outbreak vaccination response in Auckland and maintain the childhood schedule in Auckland and elsewhere.

PHARMAC advised that a further 52,000 doses will be available from this weekend onwards with a further 70,000 doses arriving in the New Year. PHARMAC are continuing to look at other supply but at this stage it appears that the 52,000 doses will have to last till the next stock arrives in the New Year. PHARMAC advised that to maintain the normal usage (childhood schedule plus others) 12-13,000 MMR vaccines are required per month. Over a 3 month period this equates to 36,000-39,000.

The EAG considers that earlier MMR1 at 12 months is desirable. However in view of short-term vaccine supply issues, the EAG agreed that this not be implemented now and updated recommendation 4 to:

- Outside Auckland MMR1 should continue to be offered at 15 months. However, MMR1 can be given from 12 months but children aged 12-14 months need not be actively recalled at this time.

2.0 Addressing meningococcal disease due to serogroup W in New Zealand

The EAG reviewed the data provided in the background papers and advised that a long-term programme with both a Men ACWY and Men B vaccine on the routine immunisation schedule was needed. EAG also asked PHARMAC how this proposed outbreak response could affect the potential funding of meningococcal vaccines on the schedule. PHARMAC clarified that although a decision had been made not to currently fund routine meningococcal vaccines on the schedule for infants and adolescents, these vaccines remain on PHARMAC's list for funding and that they can potentially still be funded for the schedule.

The EAG also noted that Men B rates, after decreasing to an historic low in 2014, had returned to 2011 levels in 2017. Although the incidence decreased in 2018, the number of cases was trending upwards in 2019, and still higher than ACWY, making consideration of vaccine response to B important.

Recommendations:

2.1 That an outbreak response to meningococcal disease should target 14/15 to 24 year olds and 12 month olds with a catch up for children from 13 to 60 months.

- It was noted that these two groups are the groups with the highest rate of disease.
- In international studies, adolescents and young adults aged up to 24 years have the highest rates of carriage. Although not conclusive, there is some evidence that immunising with ACWY vaccine reduces carriage rate (rates in over 25 year olds also decreased in Scotland after introduction of ACWY vaccine - reference to be provided)
- Although targeting 0 to 24 year olds would be ideal, it was noted that the capacity to deliver an immunisation campaign to this broad group would have greater costs but relatively less impact compared to targeting two discrete groups. However, clear messages will be needed on why the immunisation response would not directly target 5 – 12 year olds or infants under 12 months. EAG advised that this is due to the lower disease incidence rates in the first group and the need for multiple doses in the latter.
- It was noted that limiting the upper age to the 20th birthday would also reduce costs given the challenge of reaching those aged 20 to 24.
- EAG advised that the infant dose can be given at either the 12 or 15 month immunisation visit with a catch up programme for 1-4 year olds.
- Further analyses and disease modelling are needed, including cost-benefit analyses, particularly in relation to the timeframe over which this response to be undertaken.
- PHARMAC agreed that their health economists could assist the Ministry of Health by providing details and outputs from their cost effectiveness model. It was noted that since this model attempts to capture the costs and impact of vaccination, based largely on direct vaccine effects and assuming current epidemiology, it may not provide a good estimate of indirect (herd) effects that are observed with other meningococcal conjugate vaccines, and a crucial part of the proposed programme.

If the model assumes current meningococcal incidence it may also underestimate the cost effectiveness of vaccination when rates increase, as they have done in W outbreaks elsewhere"

- It was suggested that this work could be presented at the October PHARMAC immunisation subcommittee meeting
- The implementation plan needs to consider how to ensure equity of access and monitor for disparities in uptake.
- It was noted that meningococcal vaccines can be given at the same time as an MMR and other scheduled vaccines.

3.0 Improving measles immunity across New Zealand in 2019 to prevent future measles outbreaks

Recommendations:

3.1 Given the current and projected vaccine supply the childhood immunisation schedule must be maintained and not be compromised

- Across the Auckland region
  - MMR1 should continue to be offered at 12 months with active recall.
  - MMR2 should continue to be offered at 4 years old with active recall.
- Primary care should continue to recall those under 5 years who are overdue, as per business as usual practice.
- Outside Auckland
  - MMR1 should continue to be offered at 15 months. MMR1 can be given from 12 months but infants should not be actively recalled at this time.
  - MMR2 should continue to be offered at 4 years old with active recall.
  - Primary care should continue to recall those under 5 years who are overdue, as per business as usual practice.

3.2 Outside Auckland, regions who are experiencing outbreaks with a high risk of community spread should bring the 15 month MMR 1 forward to 12 months

- It was noted that further work is urgently required to define when there is a high risk of community spread. Suggestions made included when there are two or more cases with no obvious link in place or person within the same DHB.

3.3 Planning for a national catch up campaign should commence as soon as possible with a view to implementing when vaccine supply is secured. The priority group for this catch up campaign should be 15-29 year olds.

- Targeting 15 – 29 year olds focusses on a known gap in population immunity, reinforced by recent case presentations. This approach will facilitate breaking the chains of transmission and hence preventing spread.
- Although the seroprevalence survey from 2014/15 suggests that 30-39 year olds have a low immunity level this age group is not currently experiencing many cases.
- It was agreed that prioritising certain groups within adolescents and young adults could also be helpful, for example: settings where people in this age group are likely to congregate with opportunity for more intensive transmission (tertiary institutions, workplaces), Māori and Pacific populations, and postnatal women.
- Checking of MMR1 status via the NIR and incorporation of MMR catch up into school programmes is a feasible initiative with assured high coverage and should be strongly recommended and appropriately resourced for all DHBs to implement.
- Delivery of a programme to those not in school is an important issue but lack of good records and difficulties in access and motivation are problematic. Entry into courses of further education in 2020 and the possibility of targeting mothers at the 6 week check merit further consideration.

- Implementation approaches should be informed by focus groups with the key target groups to determine drivers for action and best pathways for improving access to vaccination.
- The NIR is a useful tool for identifying those who have not been vaccinated and so should be used where possible, especially for the younger age groups. However, it was noted that there is limited value in following up decliners, so efforts should be directed at overcoming access barriers.
- Steps need to be taken to ensure equitable delivery of any supplementary immunisation activity. This should include ensuring communications as well as services are developed and implemented with involvement and engagement of Maori and Pacific communities.

3.4 Strong, clear and consistent messages are needed for health professionals and the public on who should seek immunisation and where, along with who should not actively seek immunisation.

- It was noted there is some inconsistency of messages currently.
- Any communications campaign should include considering social media channels and engaging influencers to reach the target audience of adolescents and young adults.
- It was suggested that clear messaging is needed specifically addressing vaccine hesitancy.
- To maintain vaccine confidence, it was suggested that consistent messaging outlining how measles can present in an immunised person would be helpful.

3.5 Any supplementary measles immunisation activities should focus on reaching target populations with one dose of MMR.

3.6 The catch up campaign needs to have a monitoring and surveillance plan in place before implementation.

- It was noted that a follow up seroprevalence survey may be of limited value.

3.7 Any second phase of an MMR catch up campaign could be aligned with rollout of a meningococcal outbreak response aiming to target the same age groups.

Additional comments for consideration were made by the EAG:

- There is limited international evidence around effective supplementary measles immunisation activities for adolescents and young adults outside of school age in countries like New Zealand with verified measles elimination status. EAG members had no suggestions for additional evidence that could inform a campaign approach.
- There is a need to facilitate new mechanisms of vaccine delivery nationally as 15-29 year olds are a group which may not regularly access general practice. Possible options include utilising pharmacies and workplaces e.g. through pharmacist vaccinators and occupational health nurse vaccinators.
- There is a potential role for schools in reviewing and supporting compulsory documentation of immunisation status that should be explored with the Ministry of Education.

- Non-immune pregnant women in the 15–29 year group could be identified if measles serology was added to the antenatal tests as these currently only measure rubella immunity status. MMR could then be given to non-immune mothers after delivery and potentially at 6 weeks post-natal with their infant's first immunisation.