JOINT COMMITTEE ON VACCINATION AND IMMUNISATION

Minutes of the Meeting held on Friday 1 May 1992,
in Room 83/84 Hannibal House, 10.30am.

PRESENT:

MEMBERS:

Professor A G M Campbell (Chairman)
Professor J E Banatvala
Dr M F H Bush
Professor G Collee
Professor G Crompton
Professor A Geddes
Professor P Grob
Dr I Jones
Professor H P Lambert
Professor R Levinsky
Professor D Miller
Mrs D Roden
Dr G Schild
Dr J B Selkon
Sir Joseph Smith

SECRETARIAT:

Dr D M Salisbury, HP(M)1
Mr L T Wilson, HP(A)3B

INVITED TO ATTEND:

Dr N T Begg, CDSC
Mr F Coleman, NHS Supplies Authority
Mr M Corr, HEA
Dr E Miller, CDSC

OGD REPRESENTATIVES, etc.:

Dr N Cumberland, MoD
Dr A Greer, DHSS (NI)
Dr T V O'Dwyer, Ministry of Health (Republic of Ireland)
Dr O A Thores, SOHHD

DEPARTMENT OF HEALTH:

Mr R M Freeman, HP(A)3B
Dr J Hilton, HP(M)1
Dr J Leese, HP(M)1
Mr W K O'Leary, HP(A)3B
Mrs S Philogene, NUR
Dr F Rotblat, MCA
Miss J StJuste, HP(A)3B

The Chairman welcomed Dr T.V. O'Dwyer from the Minstry of Health in Dublin, Mr Michael Corr from the HEA and Mr Fred Coleman from the NHS Supplies Authority to the meeting.

1) Apologies for absence.

Apologies were received from Dr Reid, Dr Lang (MRC), Dr Cooke (HEA) and Dr Rubery (Department of Health).

2) Minutes of the meeting held on 1 November 1991.

These were read and agreed as a true record, with the following amendments:

4.2 This paragraph did not accurately reflect the success in Scotland where an average overall take-up rate of 90% had been achieved; pertussis was nearly 90%. Scotland was moving towards a common denominator for data validity.
4.3 Line 5 - delete "properly".
6 Title should read "Hib" not "Hiv".
18 6 November 1992 was retained as the date for the next meeting. [For dates of further meetings, see paragraph 14.]

3) Matters arising.

Matters arising from the meeting of 1 November were:

Paragraph 2: There was no significant change in the influenza vaccine from last year; a common vaccine for the EC had been agreed as in WHO guidance. The central purchase of hepatitis B vaccine would be considered after the commencement of the national purchase of childhood vaccines.
Paragraph 4.4: Officials from the U.S.A., who had been inspecting the arrangements for the childhood immunisation programmes in several European countries, had been very flattering about the position in both Holland and the U.K..
Paragraph 5.1: A paper showing a declining incidence of pertussis notifications from 1978 to the first quarter of 1992 was tabled.
Paragraph 12: Dr Mary Warrell was in favour of the short course for rabies immunisation.

4) IMMUNISATION COVERAGE.

4.1 Regional figures for England 1990/91 (Dr Salisbury)

JCVI(92)1

Full information by DHA and by antigen was available if required. DT Polio uptake had reached 94%, MMR 91% and Pertussis 89%. Only a few regions had not yet achieved 90% or more for DT Polio uptake whilst the number of DHAs reaching the 90% target for the other antigens continued to rise. For Measles uptake, every region except the North West had improved. For Pertussis uptake

the gap was rapidly diminishing. The worst figures came mainly from the South London districts and the District Immunisation Co-ordinators for those districts would be contacted.

In Scotland, the end of 1991 had seen DT Polio immunisation uptake at 96%, Pertussis 91% and MMR 94%. There were specific problem areas caused by lack of computerisation or good data collection. Uptake in Northern Ireland was well into the 90s, even in the most deprived parts of Belfast, and Wales had also improved. Figures for the Republic of Ireland were much lower than for the U.K., partly because of the absence of a national health service. Coverage stood at about 70%. The U.K. accelerated schedule had been recently adopted in Ireland and all children received rubella at age 12 (the only country in Europe to do so).

4.2) COVER Reports (Dr Begg) **JCVI(92)2**

These figures were very encouraging; they gave an early indication of the effect of the accelerated schedule. There had been no notified fatalities from pertussis in 1991.

4.3) BMJ Article, March 1992 (Dr Begg) **JCVI(92)3**

The 95% target should be achieved comfortably although pertussis would be the most difficult to get up to that figure.

4.4) BMJ Article, March 1992 (Dr Ritchie) **JCVI(92)4**

This was noted.

4.5) Lancet Article, February 1992 (Dr Booy) **JCVI(92)5**

The article showed that tetanus vaccine, administered at 2, 3 and 4 months is not so immunogenic as it was under the old schedule. Dr Elizabeth Miller will be investigating DTP immune levels in young children and again at school entry; they were followed up up to the time of the pre-school booster. None of the children immunised at 2, 3 and 4 months had antibodies below the protective level for diphtheria or tetanus but 6 did have low levels (a cut-off point of .01 being used). The influence of maternal antibodies needed to be borne in mind.

In some studies, the use of Hib in the same syringe as DTP had been shown to lower antibody responses to DTP.

5) <u>REPORT ON VACCINE SUPPLY ARRANGEMENTS</u> (Oral report: Mr Coleman and Mr Wilson)

The Executive Letter advising the NHS of the supply changes was tabled; this detailed the interim arrangements in force until October 1992. With effect from 1 April, all childhood vaccines were supplied to all users free of charge.

In Wales, each health authority had received money to purchase its Hib vaccine; in England, funds had been 'top-sliced' for vaccine purchase.

6) INTRODUCTION OF HIB VACCINE

6.1) REPORT FROM IMPLEMENTATION GROUP

The unconfirmed minutes of the Implementation Group's Fifth Meeting were tabled. (NB: Mrs Roden was a member of the FHSA, not the District Health Authority).

6.2) REPORT OF MEETING WITH SOFTWARE PRODUCERS (Oral report: Drs Salisbury and Begg)

The software teams from England, Wales and N. Ireland met together - for the first time ever - and discussed the plans for the introduction of Hib and the needs for software for the childhood immunisation programme. Irrespective of the number of districts covered by each system, the cost would be about £20K. This had already been given to the Child Health Computer Consortium which covered 147 districts (all of Wales and N Ireland and much of England). The remaining English districts were in consortia of varying sizes and money was being set aside to help them change their software systems, although, the smaller the grouping of districts, the more the districts themselves would have to pay. The manufacturers saw no problems with adding the three dose schedule or the one dose 'catch-up' schedule to their programmes. The situation in Scotland was similar, although one district was not yet computerised at all and one was in transition.

6.3) LICENSING ARRANGEMENTS

The Committee was assured that, subject to manufacturers supplying satisfactory information, vaccines would be licensed in time for the launch. MSD's application had been received last year and the variation to that licence had now been finalised. Two other applications had been received, one of which was moving rapidly. One manufacturer would have problems meeting all the vaccine requirements and one could meet the initial large demand; NIBSC should be able to manage the batch release.

6.4) REPORT OF GLOUCESTER STUDY (Dr Begg) JCVI(92)6

The report, which was submitted to JCVI in confidence, had been submitted to the Medicines Control Agency.

247 children had been recruited for the study. MSD, Merieux and Lederle vaccines had been used and blood samples taken before vaccination and after each dose with records of reactions being kept by parents. Any children not completing the courses had dropped out because of local reactions, although none of the reactions would have met the 'Green Book' definition of a severe reaction; most reactions had been seen with Merieux vaccine.

The Committee agreed that the best antibody response profile followed the use of Merieux vaccine. Satisfactory results were seen with the Lederle but poor results occurred with the MSD product. If more than one vaccine was licensed by the launch date a single vaccine could be justified on these results. Purchasing

contracts will be on a one year basis so there will be opportunity for other manufacturers to enter the market later.

No serious adverse reactions attributable to the Hib vaccine had been reported from anywhere else in the world. Children from different ethnic groups had been looked at in Oxford and there had been no problems.

6.5) DEMONSTRATION OF CO-ORDINATOR'S MATERIALS (Dr Salisbury)

275 District Immunisation Co-ordinators had met in February. Since then a slide pack, with speaking notes, for professional education had been put together and sent out to all DICs in England, Wales and N. Ireland.

The Committee were shown the slides.

6.6) REPORT FROM HEA ON PROMOTION MATERIALS (Mr Corr) JCVI(92)7

This was a national programme and the HEA was in contact with the territorial health education bodies about information and promotion work. The Health Education Board, Scotland had received the slides, the professional and the parent material.

The immunisation schedule and catch up programme was discussed. This was designed to provide an orderly system to protect those at highest risk first. However, practices who felt they could accelerate the timetable would not be discouraged provided vaccine was available.

7) UPDATE ON MEASLES

7.1) REVIEW OF MEASLES IMMUNISATION STRATEGIES (Dr Salisbury) JCVI(92)9

Various strategies for measles elimination were presented. Whilst one dose of measles vaccine is effective, no country had eliminated measles with a one dose strategy. The use of a two dose strategy had yet to prove itself as the means of disease elimination whilst two dose strategies themselves differed from country to country.

It was agreed that there was not yet sufficient information upon which to make any decisions. The age distribution of disease was a key factor that remained to be confirmed. Elimination was unlikely through the present strategy but feasibility studies and costings would be required before the best approach for the UK could be recommended.

It was agreed that the emphasis should be upon doctors to immunise the remaining 10% not yet being immunised. There was not enough evidence to change the strategy although it should be made known that it was under review; a Chairman's letter explaining this might be helpful. There was a need for epidemiological research; the work being done already on this matter should be supported.

7.2) LETTERS FROM BMJ JCVI(92)10

These were noted.

7.3) REPORT OF MEETING ON MMR ADVERSE REACTIONS (Dr Salisbury) JCVI(92)11

and

7.4) REPORT OF NORTH HERTS IMMUNOGENICITY STUDY (Dr Elizabeth Miller) JCVI(92)12

The report of a cluster of CSF mumps virus positive cases in Nottingham had caused concern that national surveillance may have been underreporting the incidence of cases; a meeting had been held to discuss the Nottingham situation and the national data. There appeared to be no difference between the two Urabe vaccines. Appendix C showed that the rate of reporting is much higher in Nottingham (1:8,000) than in the UK in general (1:400,000) and there was concern about BPSU under-reporting. The need for more reliable information and how to decide which vaccine to use in future, based upon the relative reactogenicity and immunogenicity of the different vaccines, were also considered.

A study had been undertaken in North Herts where MSD and SKB MMR vaccines had been used before they were introduced nationally. 300 children had been traced and had their measles, mumps and rubella antibody levels measured. Preliminary ELISA results showed significant differences between vaccines for measles and mumps antibodies. Further neutralisation tests were needed to look at real markers of protection.

The Rubella results were the same in both groups. The children with low ELISA results were being revaccinated and their antibody responses measured.

Urabe appeared to be the more reactogenetic vaccine, but also the most immunogenetic; the consequences of the study could be vital and might have important implications for vaccine failure and epidemics in older children.

In Nottingham all children with febrile convulsions were lumbar punctured, unlike some other areas from where reports had been received (Preston and Ashford). There was no evidence in Preston and Ashford of laboratory-diagnosed bacterial meningitis being under detected. Thus, selection on the grounds of presenting symptoms appeared to influence the detection rate.

The Committee agreed that no conclusions could be reached until the full immunogenicity results were available as well as the full analysis of the Nottingham and other data.

7.5) RUBELLA

Rubella susceptibility in women was only 1/2% and disease incidence was now very low. Less than 20 terminations per year were as the result of rubella infection; only 2 cases of CRS had been confirmed in the last 15 months (Dr Selkon). The Oxford rubella study which began in the 1970s showed a 95% efficacy in

the vaccine although that had presumably been boosted by wild virus which had been present until 1988.

8) REPORT OF SEVENTH IMMUNISATION CO-ORDINATORS MEETINGS (Mr L T Wilson) JVCI(92)13

This meeting had again been a considerable success attended by more than 250 people.

9) MEMORANDUM "IMMUNISATION AGAINST INFECTIOUS DISEASE" 1992 JCVI(92)14

Comments on the draft Memorandum should be sent to Dr Salisbury within 10 days of the JCVI meeting. It was agreed to delete "recover" from paragraph 3.8.1. The positive changes at paragraph 4.3 onwards about contraindications for pertussis were welcomed.

INFLUENZA

Sir Joseph Smith said that the minutes of the last meeting which had been circulated needed some modifications. The addition of pneumococcal vaccine to the CMO's influenza letter had been discussed by the Influenza Sub-group and it had been agreed not to include it so as to avoid any possible confusion. The CMO's letter would recommend specific vaccines for use in children 6 months to 4 years now that two vaccines are licensed for this age group.

10) REPORT ON RECENT POLIOMYELITIS CASES (Drs N Begg and D Salisbury) JCVI(92)15

There had been media interest in the two recent vaccine-associated polio cases which had, coincidentally, been geographically and temporally close. The 21 cases identified over the past 7 years had been reviewed by PHLS. 13 had been vaccine-associated, 5 imported and 3 were unknown. The BPSU Acute Flaccid Paralysis Study was under way.

11) HEPATITIS ADVISORY GROUP

11.1) PAPER: INFECTION OF HEALTH CARE WORKERS (Dr Judith Hilton) JCVI(92)16

This was presented for information; consultation had not yet taken place. The question was raised about those health care workers in the private sector and also about teachers, social workers etc.. Dr Hilton pointed out that DH could only place requirements on staff employed in the NHS but that private hospitals would be expected to follow NHS "good practice". She pointed out that the tabled proposals would not apply to non-health care workers. Professor Banatvala confirmed that the health authorities were eagerly awaiting the guidance; the Advisory Group was looking at the position of the medical schools.

11.2) HEPATITIS A VACCINE POLICY JCVI(92)17

This vaccine had been licensed and made available sooner than expected and many aspects, eg. Item of Service fees, had yet to be addressed; a CDR article had been quickly published to provide guidance on the vaccine's use. A revised chapter had been prepared for the Green Book but two aspects required further guidance: the question of immunising those at some occupational risk, and, the use of the vaccine for travellers. In the USA, it had been found that one dose of the new vaccine had provided 100% protection but that giving HNIG at the same time reduced its efficacy. Dr Hilton said that studies using the SKB vaccine had produced slightly different results; one dose provided 97% protection and two doses were required for 100% protection. Better epidemiology was required. JCVI members agreed the revisions proposed to the text.

12) WHO EPI REPORT TO WORLD HEALTH ASSEMBLY JCVI(92)18

This paper was noted.

13) CHILDREN'S VACCINE INITIATIVE (CVI) REPORT JCVI(92)19

The administrative structure of the CVI was described. Product development groups (PDGs) had been set up for heat stable polio vaccine and single dose tetanus vaccine; a measles PDG was likely. A number of task forces had been commissioned, including one on Priority setting for new vaccines. Dr Salisbury was serving on this and on the CVI Management Advisory Committee.

14) ANY OTHER BUSINESS

There was no other business.

15) NEXT MEETING

The next meeting was confirmed as November 6 1992 as previously arranged. Other dates agreed were 30 April 1993 and 29 October 1993.