Immunisation Subcommittee of PTAC
Teleconference held 23 September 2013

(minutes for web publishing)

Immunisation Subcommittee minutes are published in accordance with the *Terms of Reference for the Pharmacology and Therapeutics Advisory Committee (PTAC) and PTAC Subcommittees 2008*.

Note that this document is not necessarily a complete record of the Immunisation Subcommittee meeting; only the relevant portions of the minutes relating to Immunisation Subcommittee discussions about an Application or PHARMAC staff proposal that contain a recommendation are generally published.

The Immunisation Subcommittee may:

(a) recommend that a pharmaceutical be listed by PHARMAC on the Pharmaceutical Schedule and the priority it gives to such a listing;
(b) defer a final recommendation, and give reasons for the deferral (such as the supply of further information) and what is required before further review; or
(c) recommend that PHARMAC decline to list a pharmaceutical on the Pharmaceutical Schedule.

These Subcommittee minutes were reviewed by PTAC at its meeting on 7 November 2013, the record of which will be available in February 2014.

Record of the Immunisation Subcommittee teleconference 6 September 2013

1. Hepatitis A vaccine for Ashburton

1.1. The Subcommittee noted the current hepatitis A outbreak in Ashburton, as presented in the strategy report prepared by the Canterbury District Health Board. Members commended the quality of this report.

1.2. The Subcommittee noted that the outbreak was an ongoing issue since 26 April 2013, and considered that the current intervention of immunising close contacts, and of three pre-schools, had not been effective.

1.3. The Subcommittee considered that the aim of a hepatitis A vaccination programme for the current Ashburton outbreak would be to reduce transmission in the community sufficient to arrest the local epidemic, rather than provide those vaccinated with long term protection. Members felt that a single dose strategy (outbreak control), as opposed to a two dose strategy (long term immunity), would be more cost effective in any cost utility analysis. Members also noted an unpublished Argentinean study (Vizzotti et al, Impact of the Single Dose Immunization Strategy against Hepatitis A in Argentina, http://www.who.int/immunization/sage/meetings/2012/april/1_C.Vizzotti_SAGE_Ginebra.pdf) indicating that a single dose was effective in reducing community transmission in outbreak settings. As such, members considered that a single vaccination would be sufficient to meet the above aim, although patients would need to be informed and educated to ensure they were aware of the purpose and limitations of a single dose. Members considered that in general, providing a single dose to many people would be preferable to extensive efforts to provide two doses, with the latter strategy having the trade-off of fewer people being protected.

1.4. Members discussed who should receive the hepatitis A vaccine, and which populations would receive the greatest benefit from being vaccinated. The Subcommittee considered that the under-4 year age group is an important group to treat, as they largely remain asymptomatic and are more likely to spread the virus. The Subcommittee considered while the vaccine should be provided to children aged 1-9 years inclusive, it would be appropriate to vaccinate any child who attends a school where primary-school-aged children attend. The Subcommittee considered that in smaller schools in rural communities, it is more likely that children will interact with those of different age groups. Members noted that children who come in to Ashburton to attend school from the surrounding districts should be included in the programme. Members also considered that adults working as food handlers should be vaccinated, as they are in a prime position to spread the virus, given the two-week period of communicability before the onset of symptoms.

1.5. The Subcommittee noted that the hepatitis A vaccine should be available in pre-schools that have not previously been vaccinated and that children under 1-9 years should be able to be vaccinated at their general practice. Members also considered that pre-school and school teachers would be at risk and should also be vaccinated.

1.6. Members discussed whether vaccination should be limited to the Ashburton township, or whether it should be extended to the Methven and Rakaia districts. Members considered that the intervention should be targeted to the Ashburton township at this time as this would

likely have the greatest benefit, however this should include all children who attend schools and preschools in Ashburton, regardless of where they reside, as these children will also benefit from protection.

1.7. The Subcommittee discussed how the program should be implemented and funded. Members considered that a preschool and school-based program would be suitable, but supplemented by the vaccine being available at GPs in Ashburton. The Subcommittee noted the school-based meningococcal vaccine programme in Northland, where uptake was lower than expected. Members considered that the vaccine should also be available through GPs, for children such as those who are home-schooled or were away when the vaccination program visited their school. The Subcommittee noted that with only nine general practices in Ashburton, it would be feasible to run an education campaign with those GPs so that they could properly provide the vaccine.

1.8. The Subcommittee noted the information provided by the Ministry of Health that DHBs under the DHB Operational Policy Framework DHBs are to cover the cost of additional services purchased in response to a major incident. The Subcommittee noted that if the vaccine was funded then PHARMAC and the Ministry of Health would work with Canterbury DHB regarding implementation.

1.9. The Subcommittee discussed the different hepatitis A vaccines currently available. Members noted that, following the Immunisation Request For Proposal, PHARMAC had proposals from both GSK and Sanofi Pasteur. Members noted that the vaccine from Sanofi Pasteur was indicated only for ages 2 years and over, while the GSK vaccine was suitable for ages 1 and over. Members considered that it was important that those aged between 12 and 23 months are vaccinated, and that these infants should receive the GSK vaccine. Members considered that it would be feasible in practice to use two vaccines.

1.10. The Subcommittee **recommended**, with a high priority, and rapid implementation, funding one dose of a hepatitis A vaccine for one year, to the following people:

Children, aged 1–9 years inclusive, residing in Ashburton

Children, aged 1–9 years inclusive, who attend a preschool or school in Ashburton;

Children, aged older than 9 years, who attend a primary school in Ashburton;

Adults who work in food handling premises located in Ashburton; and

Adults who work in preschools and primary schools located in Ashburton.

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