THE PAEDIATRIC SOCIETY OF NEW ZEALAND

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cc: Chair of Immunisation Subcommittee to Pharmac, Dr Stuart Dalziel
Pat Tuohy, Ministry of Health

To whom it may concern

Re: Proposal to amend listings in the National Immunisation Schedule 2017

Thank you for the opportunity to feedback on the most recent consultation document relating to provisional agreements for the supply of vaccines for the New Zealand National Immunisation Schedule. The document was circulated both through our general membership email and through our smaller email group of the Infection and Immunisation special interest group.

Overall the feedback has been very positive for the majority of suggested changes. Comments have been summarised below:

- Members were very supportive of the initiative to use Gardasil 9valent vaccine in an expanded programme to include boys in addition to girls including the reduced number of required doses for those 14 years and under.

- Members were generally happy with the change from a 3 dose to a 2 dose schedule of the rotavirus vaccine in view of the equivalent effectiveness and adverse event data on both vaccines.

- Members were very supportive of the introduction of universal varicella vaccine – one dose schedule with offer of catch up at 11yrs

  Several members commented on the severe complicated varicella which they commonly see in New Zealand hospitals; this will likely be prevented with universal varicella vaccination.

  Members commented specifically on concerns about a single dose programme which although effective against severe varicella would not reduce outbreaks and breakthrough varicella. A two dose varicella vaccine schedule would provide greater effectiveness against all varicella to prevent milder, breakthrough disease and severe disease. It was noted that the United States has changed from a single dose varicella schedule to a two dose schedule due to the high observed rates of breakthrough disease. Breakthrough occurs more when wild type varicella remains circulating therefore a two dose schedule would be most effective early in the introduction of the programme to rapidly decrease circulating varicella.

  Members were supportive of the offer of catch-up vaccine at 11 years to prevent an increase in non-immune adolescents and adults who would be at risk of more severe varicella. Some comments were made how this catch up would need to be offered systematically and with good education through school programmes to help ensure good uptake. Another possibility is to have a very broad catch-up throughout school years, which in the context of a single dose schedule may help prevent some of the larger school outbreaks that are likely to continue amongst the unvaccinated school and toddler cohorts.

- PCV13 to be replaced by PCV10
  Members expressed some concern around change to PCV with lower coverage of invasive pneumococcal disease serotypes. Members commented that IPD was now a rare disease in vaccinated infants and young children and that any increase in IPD rates in the vaccinated population would need close monitoring. Close surveillance of emergent serotypes would be needed.

  It was noted that in the era of universal vaccination with PCV10 in NZ, the commonest serotype causing invasive disease continued to be 19A (ESR report 2014). Serotype 3 which is also contained in PCV13 and not the PCV10 was the third most common cause of IPD in 2014. With the introduction of PCV13 there had been notable decreases in serotypes 19A and 3 (both PCV13 serotypes) in <2yr age group by end of 2015 (ESR quarterly report Dec 2015). However, it is important to note this involved a very small total number of cases in 2015 (16 cases IPD in <2 years olds).

  In 2014, 13 cases of IPD due to serotype 19A occurred in children aged <5 years who had received 3 or 4 doses of PCV10. Although there is evidence of cross-protection against this serotype with PCV10 in the international literature, the NZ data demonstrates breakthrough disease from this serotype can continue to happen. A recent publication from NZ children aged <3 years demonstrated 19A to be the most commonly carried serotype amongst PCV10 vaccinated population of children aged <3 years with middle ear disease and a matched control group (Best et al. Vaccine 2016).

For children and adults at highest risk of invasive pneumococcal disease (such as splenectomised, certain immunecompromise groups etc) we would like reassurance that PCV13 will continue to be funded. Members also commented that implementation of a high risk vaccination programme with PCV13 to run alongside a different conjugate vaccine on the national schedule has hurdles in implementation needing clear national guidelines, ongoing communication and education.

The national surveillance of IPD (2014) also demonstrated rates of IPD for Maori and Pacific to be 3-4 times higher than for Pakeha. Of 34 cases reported in children aged <2 years in 2014, 22 were Māori or Pacific ethnicity. With repeatedly documented rates of higher IPD in indigenous groups around the world including in New Zealand, if PCV13 is to be supplied to high risk groups will this also include Maori and Pacific infants?

Finally, this proposal has wide reaching implications for the National Immunisation Schedule. Feedback from our organisation required time for dissemination and collation of replies. We are concerned that the consultation time was too short.

Thank you for the opportunity.

Yours sincerely

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References

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