

Caribbean Meeting Stresses Surveillance

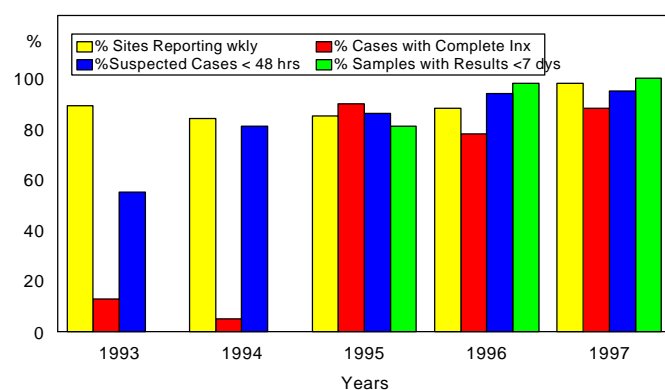
The following are some of the major conclusions and recommendations of the Fourteenth Meeting of the Caribbean EPI Managers held in Castries, Saint Lucia, from 18-20 November 1997. The meeting was officially opened by Her Excellency the Governor of Saint Lucia, Dr. Pearlette Louisy and the Honorable Minister of Health, Ms. Sara Flood delivered the keynote address.

Measles Eradication

The English-speaking Caribbean still holds the longest record in the Western Hemisphere of six years without indigenous measles transmission. Two recent importations into the Bahamas and Trinidad and Tobago stressed the danger of importations and the need for adherence to PAHO's measles eradication strategy, particularly the maintenance of high levels of immunization coverage and periodic implementation of *follow-up* campaigns. A large outbreak in Guadeloupe (please refer to page 2), in late 1996, illustrates the vulnerability of the countries to measles transmission if the strategy is not fully implemented.

The measles laboratory at the Caribbean Epidemiology Center (CAREC) provides confirmation for suspected measles cases (Figure 1). The laboratory is able to test for IgM antibodies for measles, rubella and dengue infections. Through week 44 of 1997, a total of 847 specimens had been submitted for laboratory confirmation. Of these, 2 (0.2%) were positive for measles, 276 (31.5%) were positive for rubella and 11 (1.3%) were positive for dengue. All specimens were tested and reported back to countries within seven days of receipt.

Figure 1
Measles surveillance indicators in the English-speaking Caribbean and Suriname 1993-1997*



Source: MOH Reports to EPI/CAREC

* Data as of 25 October 1997 (Epidemiological week 43)

Recommendations

- MR or MMR are the vaccines of choice for measles and rubella elimination.
- Countries that are instituting a two-dose schedule should be aware that even with such a regimen, susceptibles will accumulate because coverage with two doses will never

achieve 100% and some children will remain unvaccinated. *Follow-up* campaigns are required to maintain interruption of transmission.

- To maintain the English-speaking Caribbean and Suriname free of measles, high vaccination coverage must be maintained. Efforts need to be made to ensure that at least 95% of each birth cohort is vaccinated with measles-containing vaccine at 12 months of age.
- The possibility of combining measles and rubella surveillance should be explored.
- To prevent the accumulation of susceptible preschool-aged children from reaching dangerous levels, *follow-up* campaigns should be conducted among children 1-4 years every 4 years. Countries should plan on conducting *follow-up* campaigns in the year 2000.
- The Brazil experience suggests that certain young adults may be at risk for measles. Efforts are needed to assure measles vaccination in young adults in high-risk groups, which include students, migrant workers, health care workers and the military.
- As long as measles circulates anywhere in the world, the English-speaking Caribbean will be at risk for measles importations. Measles surveillance systems need to detect these importations in a timely manner and respond accordingly when they occur.

Poliomyelitis

Presentations on polio stressed the importance of continuing technical and political commitment to surveillance and vaccination activities to keep the region polio-free. Although progress is being made towards global eradication of polio, importations still represent the biggest threat. All English-speaking Caribbean countries were making great efforts in sending all cases with stool samples for laboratory testing, one of the surveillance indicators. However, it was noted that the other three critical surveillance indicators were not consistently being met from countries that notified cases. Periodic evaluations of surveillance for acute flaccid paralysis (AFP) were recommended at all major health facilities to see if cases are being missed.

Rubella and CRS

Since 1982 significant rubella virus activity has been recorded in many CAREC-member countries, and cases of congenital rubella syndrome (CRS) have been documented as sequelae to these outbreaks. Following a *catch-up* measles campaign (Big Bang) in 1991, very low rubella incidence (fewer than 2.0 cases per 100,000 population) was recorded between 1992 and 1995. However, since the beginning of 1995 and continuing through 1997, sizable outbreaks of rubella have occurred in Jamaica, Barbados, Trinidad and Tobago, Guyana, and Belize. In 1996, rubella incidence rates of 10.3 cases per 100,000 population were recorded. To date, more than 20 cases of CRS have been reported since 1996.

The Bahamas implemented a major campaign with MMR targeting all individuals 4-40 years old in July of this year, aimed at the interruption of rubella transmission. The lessons from this initiative will be extremely useful to all other countries that are planning to eliminate rubella and CRS.

Recommendations

- It is imperative that Ministries of Health discuss and arrive at a consensus position with regard to the objective of rubella elimination.
- There is overwhelming evidence, both from estimated figures as well as from data collected over the last year, particularly in Guyana, Barbados and a regional review presented by CAREC, that the burden of rubella and its cost, both in financial terms and human suffering, warrant efforts towards its elimination.
- The Technical Advisory Group Meeting (TAG) held in Guatemala in September, 1997 outlined the strategies for the elimination and control of rubella and CRS. These include a one-time mass vaccination of all individuals, male and female, within a certain age range that will vary from country to country, but should cover individuals up to 35 years of age. The lower level age group will be defined by the previous vaccination activities that included rubella-containing vaccine.
- During 1998, senior MOH officials and political leaders in all countries should define national policy regarding rubella and CRS elimination, aiming at a Pan-Caribbean initiative. The conference of Ministers of Health, to be held in April of 1998, their Caucus in September and the current revision of the Caribbean Cooperation in Health (CCH) represent excellent opportunities for achieving consensus on this issue.

Immunization Coverage

The average coverage rates for all 19 countries were: DPT 89%, OPV 89%, measles containing vaccine 92%, and BCG 95%. Over 90% of the infant vaccinations in the countries are administered by the public sector through a network of clinics. However, not all countries have been able to attain very high coverage, and some still show rates between 80-85%. These are due to pockets of low coverage occurring in certain geographic areas, e.g., remote rural areas and dense urban centers. A review of coverage data for the English-speaking Caribbean for the period 1994-1996, indicates that special activities need to be carried out particularly in Suriname, Grenada, Guyana and Belize to reach coverage above 90%.

Introduction of New Vaccines

Vaccines currently being discussed for introduction in the English-speaking Caribbean are hepatitis B and *Haemophilus influenzae* type b (Hib). These two vaccines are already being administered, primarily by the private sector in the English-speaking Caribbean. In 1996, the private sector bought 42,208 (20mcg) adult-dose vials of hepatitis B. Pediatric doses accounted for about 6,000, and these could only fully immunize 1.4% of the birth cohort of the Caribbean Member Countries.

Whereas four countries are using hepatitis B vaccine in the public sector (1.7% of the sub-region total birth cohort) only two are using Hib vaccine. The uptake in the private sectors is 28,128 doses of Hib vaccine, which can only vaccinate 5-9% of the region's infants (the birth cohort for 1996 was 140,311).

Recommendations

- The introduction of new vaccines into a national immunization program should not simply reflect their availability, but should follow a careful investigation of their appropriateness to that particular epidemiology, and whenever possible, evidence that their introduction into routine use would be a cost-effective use of resources.
- The extensive experience of the Caribbean in implementing immunization campaigns will be invaluable in the introduction of new vaccines for routine use. All countries in the region should strive to introduce these vaccines in the public sector within the next three years.

Booster Dose Policy

A panel discussion revealed a great variety of schedules for booster doses in children, adolescents, adults and pregnant females. Many countries are giving at least 3 boosters between 1 year and the end of school. Often, these do not provide any protection or benefit to the recipient. In many instances, too many unnecessary booster doses are being administered, particularly for TT. Therefore, it was agreed that participants conduct a thorough review of schedules and real need for boosters in the Caribbean. The removal of unneeded boosters would result in savings that could be reallocated to the introduction of new antigens or strengthening of existing routine programs. When booster doses are needed, it is important to consider schedules that make it easier for parents to comply.

Surveillance of Adverse Events

Thorough surveillance of vaccine-associated adverse events conducted during the recent mass MMR campaign in the Bahamas has provided reassuring results about the safety of the vaccine when used in older groups. These results may help other countries gain better acceptance of similar campaigns aimed at the elimination of CRS. Draft guidelines for implementing a surveillance system for adverse events following immunizations were developed and presented by PAHO. Participants noted that it was extremely encouraging to see that many Caribbean countries had already developed such surveillance systems.

Surveillance Priorities at CAREC

CAREC has redefined its communicable disease priorities, which will continue to include measles, polio, rubella/CRS, diphtheria, pertussis, tetanus and tuberculosis. In addition, CAREC will work with national EPIs to develop surveillance systems for other diseases that are becoming targets of national immunization programs, such as Hib and hepatitis B. CAREC will also continue fostering partnerships with the private sector to strengthen their participation and use of disease data, including the establishment of a private physician sentinel surveillance system.