

Summary of WHO position paper on Meningococcal A conjugate vaccine: updated guidance, February 2015

Background

A position paper on meningococcal vaccines was published in 2011 and its recommendations remain valid. This update adds to the previous recommendations specifically concerning routine immunization of infants and young children in the African meningitis belt with meningococcal A conjugate vaccine.

Since publication of the meningococcal vaccine position paper, preventive mass campaigns in 17 of the 26 countries in the African meningitis belt have been, or are in the process of being, implemented, and over 217 million persons have received monovalent MenA conjugate vaccine.¹ A study in Chad provides evidence of the impact of the MenA conjugate vaccine on the incidence of serogroup A invasive disease and carriage.

Two licensed formulations of the vaccine are available: MenAfriVac, containing 10 µg of purified meningococcal A polysaccharide antigen conjugated with tetanus toxoid (PsA-TT) for use in those aged 1–29 years, and MenAfriVac 5 µg, containing 5 µg of PsA-TT for use in infants and children aged 3–24 months.

Current evidence on schedule and dosing

Two double-blind randomized controlled studies of monovalent MenA conjugate vaccine have been conducted in Ghana and Mali that show that both formulations of MenA conjugate vaccine are immunogenic in a 1-dose schedule for those aged 9–24 months or in a 2-dose schedule for those aged 3–9 months. Duration of protection beyond 27 months after the final dose is unknown.

The reactogenicity profile of MenA conjugate vaccine given concomitantly with routinely administered vaccines was shown to be similar to that of the concomitantly-given routine vaccines alone, with a comparable safety profile. Both clinical studies provide evidence that the two MenAfriVac formulations were well tolerated and safe.

WHO updated recommendations

WHO emphasizes the importance of completing mass vaccination campaigns in individuals aged 1–29 years in all countries in the African meningitis belt, and the need to conduct high quality surveillance and vaccine programme evaluation in those countries. The following recommendations are additional to those in the 2011 position paper.

- WHO recommends that countries completing mass vaccination campaigns introduce meningococcal A conjugate vaccine into the routine childhood immunization programme within 1–5 years following campaign completion, along with a one-time catch-up campaign for birth cohorts born since the initial mass vaccination and which would not be within the age range targeted by the routine immunization programme. In areas where coverage with meningococcal A conjugate vaccine is less than 60%, periodic campaigns could be

¹ Meningitis Vaccine Project. (<http://www.meningvax.org/index.php>, accessed December 2014).

considered to complement routine vaccination, as herd protection may not be sufficient to protect those who are not immunized.

- WHO recommends a 1-dose schedule with vaccine administration by deep intramuscular injection, preferably in the anterolateral aspect of the thigh at 9–18 months of age based on local programmatic and epidemiologic considerations. Any children who miss vaccination at the recommended age should be vaccinated as soon as possible thereafter. If in a specific context there is a compelling reason to vaccinate infants younger than 9 months, a 2-priming dose infant schedule should be used starting at 3 months of age, with doses at least 8 weeks apart. MenAfriVac 5 µg should be used for routine immunization of those 3 to 24 months of age. MenAfriVac 10 µg should be used for catch-up and periodic campaigns from 12 months of age onwards unless bridging studies have been conducted and show that MenAfriVac 5 µg can be used in older age groups. The need for a booster dose has not been established.
- Data on co-administration with other vaccines has been evaluated and found to be acceptable for diphtheria toxoid, tetanus toxoid, whole cell pertussis, hepatitis B, *Haemophilus influenzae* type b, oral poliovirus, yellow fever, measles and rubella vaccines. No evidence exists for co-administration with rotavirus vaccine, pneumococcal conjugate vaccine or inactivated polio vaccine; however, absence of data should not discourage co-administration.
- Vaccination of pregnant women is safe, as assessed in a well-conducted observational study, and they should be vaccinated if in the age range targeted by the mass vaccination campaigns.