

Global eradication of poliomyelitis

Reports of the:

Fourth meeting of the Global Technical Consultative Group for
Poliomyelitis Eradication,
Geneva, 1-2 June 1999

Global Commission for the Certification of the Eradication of
Poliomyelitis,
Geneva, 2 June 1999



**DEPARTMENT OF VACCINES AND
BIOLOGICALS**



*World Health Organization
Geneva
1999*

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List of abbreviations

AFP	acute flaccid paralysis
AFRO	WHO Regional Office for Africa
IPV	inactivated polio vaccine
NID	national immunization day
OPV	oral polio vaccine
SNID	sub-national immunization day
TCG	Technical Consultative Group
UNICEF	United Nations Children's Fund
VVM	vaccine vial monitor
WHO	World Health Organization

1.

Report of the Fourth meeting of the Global Technical Consultative Group for Poliomyelitis Eradication, Geneva, 1-2 June 1999

1.1 Introduction

From 1-2 June 1999, the fourth meeting of the Technical Consultative Group (TCG) on the Global Eradication of Poliomyelitis was convened at the World Health Organization in Geneva. The TCG reviewed the current status of global polio eradication and made recommendations on how to accelerate the initiative towards its goal of final eradication of poliomyelitis by the year 2000, as well as the progress towards eventual bio-containment of polioviruses and the certification of global polio eradication, anticipated by the year 2005.

The meeting was opened by Dr M. Scholtz, Executive Director, Health Technology and Pharmaceuticals Cluster of the World Health Organization (WHO) in Geneva. In welcoming participants, Dr Scholtz emphasized that, only one week earlier, the World Health Assembly unanimously endorsed the resolution of WHO's Executive Board in January 1999 to accelerate the polio eradication initiative. This resolution further commits WHO Member States to ensuring that the goal for global polio eradication and wild poliovirus containment is attained.

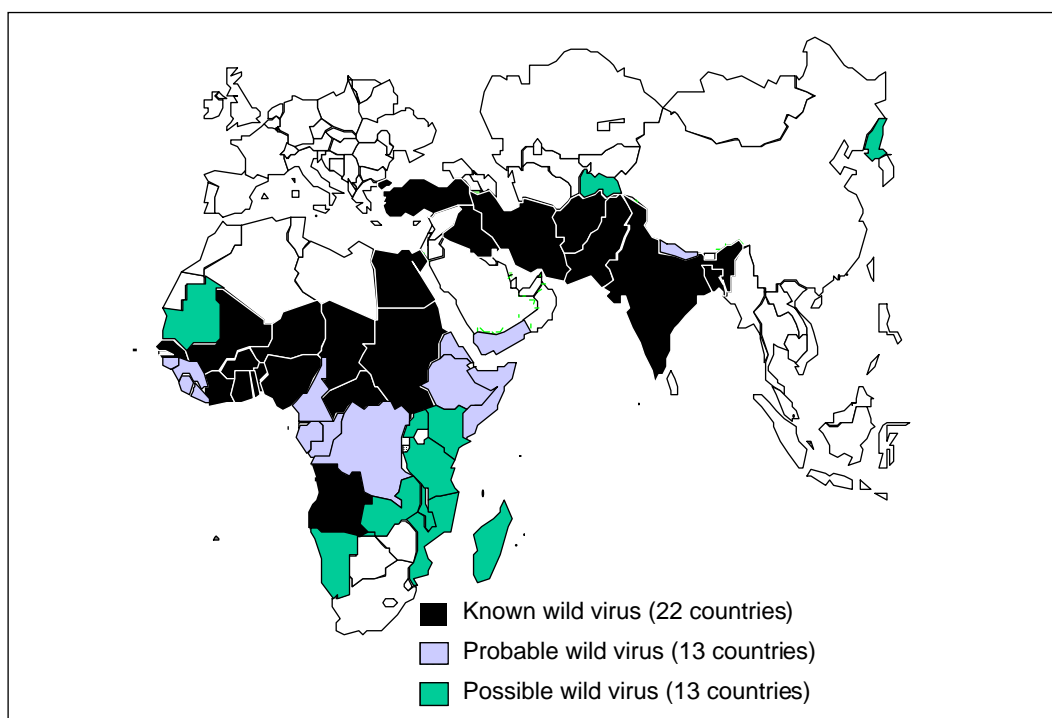
Dr Scholtz expressed his hope that the TCG would provide technical guidance on how to best accelerate the initiative, with emphasis on the major poliovirus reservoir countries and countries affected by conflict. He also noted the specific need to improve the quality of some poliovirus laboratories within the global poliovirus laboratory network, particularly in the African Region. The urgent need to accelerate surveillance for acute flaccid paralysis (AFP), especially in conflict-affected countries, was stressed.

Dr W. Orenstein of the Centers for Disease Control and Prevention of the United States of America served as chairman of the meeting, with Dr P. Figueroa of the Ministry of Health, Jamaica, as rapporteur. This report summarizes the technical deliberations of the third meeting of the TCG and contains the main recommendations of the TCG.

1.2 Status and coordination of the global polio eradication initiative

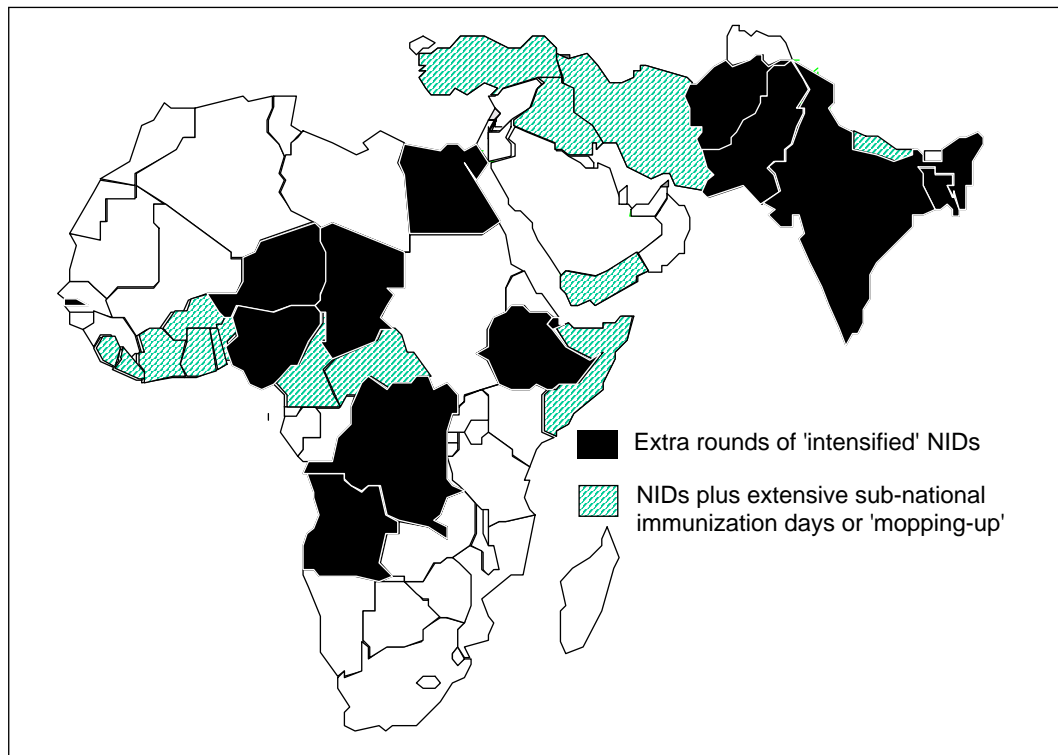
While substantial obstacles must still be overcome in some geographic areas to eradicate polio, the Global TCG was impressed with the tremendous progress made since its last meeting in July 1998. It is of particular note that, as of the end of 1998, wild poliovirus transmission was limited to several remaining foci of transmission in South Asia and Africa. Of 48 countries endemic or possibly endemic at this time, wild virus is still documented in 22 countries. Transmission is probable on epidemiological grounds in 13 countries where surveillance is still poor; it is less likely on epidemiological grounds, but still possible, in another 13 countries where surveillance quality is still insufficient (Figure 1).

Figure 1: Wild poliovirus, December 1998



Surveillance activities have improved in many endemic countries. All countries with known or suspected wild poliovirus transmission have conducted national immunization days (NIDs) and established surveillance for acute flaccid paralysis (AFP), with the exception of the Democratic Republic of Congo and Sierra Leone. All remaining countries considered as major global reservoirs are intensifying immunization efforts to interrupt transmission (Figure 2).

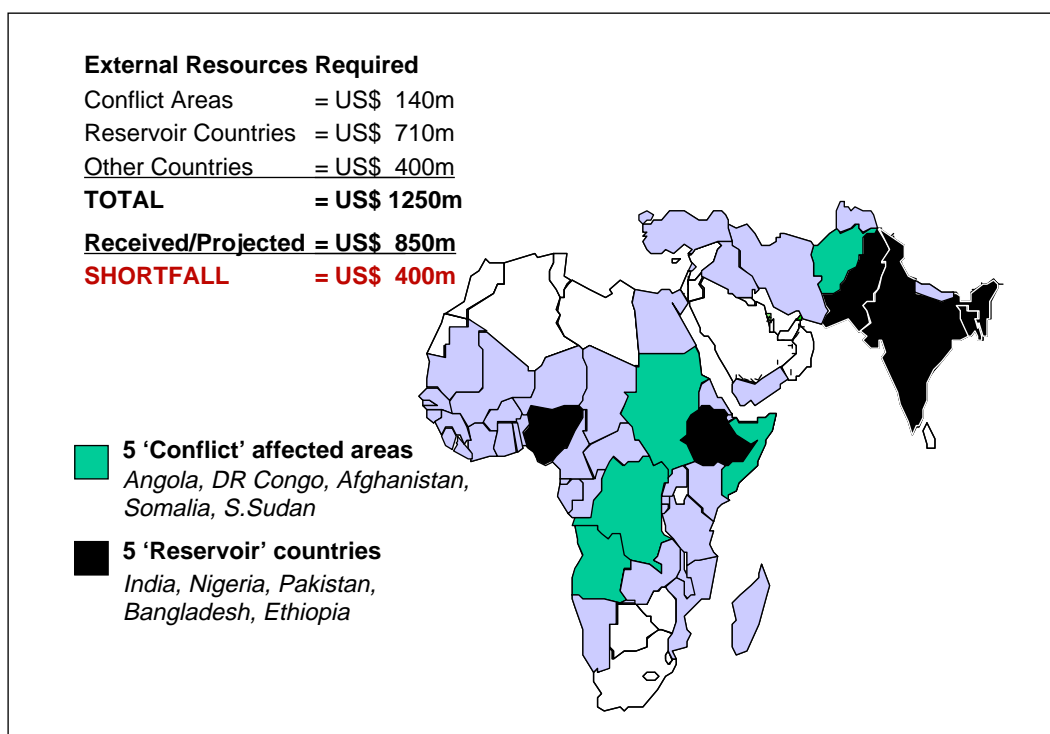
Figure 2 : Preliminary plan of action for acceleration of supplementary OPV immunization in priority countries (as of June 1999)



Considerable additional external funding has been provided by the international polio eradication partnership. Ninety-five per cent of the financial resource needs for the global eradication initiative for the next six months have been pledged. However, significant additional funding will be needed to support the global initiative from the year 2000 onwards, particularly in the countries that constitute major global poliovirus 'reservoirs' or polio-endemic countries affected by conflict (Figure 3).

The TCG was especially impressed with the leadership for the initiative at the highest level of WHO, evidenced most recently by the creation of a special task force to address administrative challenges within WHO. The TCG welcomed the new partners who have joined the polio eradication effort and applauded the ongoing commitments of longstanding polio eradication partners. The TCG appreciated the efforts of the Secretary General of the United Nations to support negotiations for 'days of tranquillity' for polio immunization in countries affected by conflict, particularly in the Democratic Republic of the Congo (DRC).

**Figure 3: Resource requirements for global polio eradication, 1999-2005
(as of June 1999)**



While there has been significant progress, major challenges remain, with only 18 months remaining to meet the year 2000 target. The eradication initiative needs urgent acceleration in all endemic countries. It is critical to achieve eradication as close as possible to the target date because of the potential for fatigue in maintaining eradication activities in those areas that have long been polio-free. In addition, after the year 2000 it will be more difficult to sustain the current high levels of external funding needed for supplementary immunization activities, surveillance and certification of polio eradication up to the year 2005 (Figure 3).

The TCG is convinced that the established strategies are the basis for success, provided the highest possible quality in their implementation is achieved. These strategies include achieving high levels of routine polio immunization, conducting NIDs, surveillance for AFP, and house-to-house mopping-up immunization activities in high-risk areas. The experience of the last 12 months has again demonstrated that highest priority must be given to maintaining and improving the quality of all polio eradication activities (i.e., to ensure success through sufficient planning, supervision, manpower and financial resources).

Recommendations:

- a) Polio eradication activities should be used to strengthen measles control and other disease control goals. This will require strategic planning, focusing on mortality reduction and the provision of guidelines for:
 - improving and sustaining routine immunization coverage,
 - incorporating vitamin A supplementation,
 - conducting outbreak investigations to generate more accurate data on age distribution, vaccination status and other risk factors important for refining immunization strategies.
- b) Countries still endemic for polio should exercise caution in embarking on measles elimination campaigns prior to completing polio eradication.

1.3 Commitment for acceleration of the global polio eradication initiative

The successful completion of the global eradication effort will require the highest possible commitment at all levels, not only within the United Nations agencies, but from individuals involved in polio eradication everywhere. This includes political and civic leaders, public health officials, health care providers, voluntary organizations, and other national and international partners. Facilitating this commitment requires the rapid dissemination of lessons learned to the appropriate levels in relevant countries where these can be applied to further improve and optimize the implementation of the eradication strategies.

Recommendations:

- a) WHO and UNICEF representatives at regional and country levels must give their full support to critical polio eradication activities. In a joint letter of commitment sent to regional and country representatives of both organizations earlier this year, the Executive Director of UNICEF and the Director-General of WHO express their hope that representatives will advocate, implement, monitor and report on critical polio eradication activities. Country representatives of both organizations should monitor and report on progress in their country of assignment at regular intervals. The secretariat should develop reporting formats and evaluation criteria for consideration by WHO and UNICEF.
- b) WHO and UNICEF staff should work with ministries of health to assure that commitments to polio eradication made at the 1999 World Health Assembly are translated into action.
- c) WHO and UNICEF staff should seek the commitment and support for all aspects of the polio eradication effort from relevant non-governmental organizations and other voluntary organizations, especially in countries affected by conflict.
- d) WHO and UNICEF should establish mechanisms at the respective headquarters, regional and country levels to ensure that all important information and data related to polio eradication, including lessons learned and updates on optimal strategy implementation, are rapidly shared and

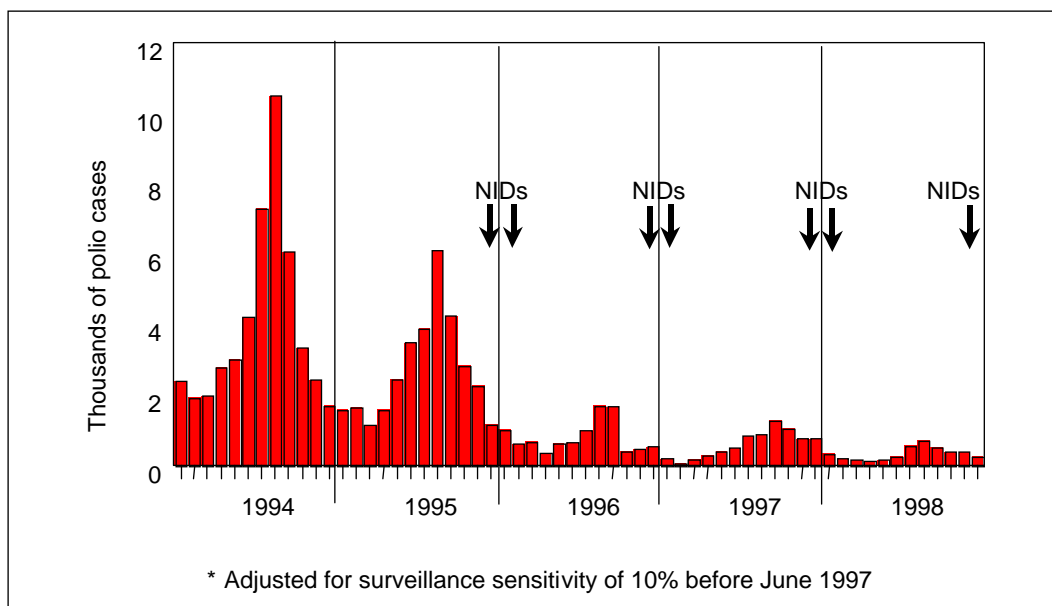
communicated to all relevant polio partners. A range of approaches should be used to share information, including intercountry and interregional workshops, exchange of visits and electronic data, including e-mail and presentation of data on worldwide web sites.

- e) WHO should ensure that all recommendations made by the WHO Administrative Task Force on staff recruitment, on strengthening the capacity to manage funds at country level, on the streamlining of administrative procedures, and on other issues are implemented as soon as possible.
- f) Given the dynamic nature of the global eradication initiative, and the emergence of urgent unforeseen needs for technical support, WHO and UNICEF should establish a pool of trained staff and expert teams who can be rapidly deployed at regional, national or subnational levels.

1.4 Acceleration of supplementary polio immunization

The TCG notes the enormous progress made in reducing wild poliovirus transmission in major poliovirus reservoir countries, such as India (Figure 4).

Figure 4: Reported polio incidence, India, 1994-1998



The TCG is convinced, however, that the interruption of wild poliovirus transmission by the end of the year 2000 will only be possible with additional nationwide immunization rounds, in addition to two yearly rounds of NIDs. This is particularly obvious in countries, or sections of countries, where routine immunization coverage is low and birth cohorts are large, leading to the rapid accumulation of large numbers of susceptible children in the intervals between NIDs. The presence of a sufficient number of susceptible children, combined with high population density and poor sanitation, establishes an ideal environment for the sustained transmission of wild poliovirus.

It is critical to achieve the very highest levels of coverage in both routine and supplementary immunization activities. Immunizing house-to-house, or family-to-family in areas where families are not likely to come to a fixed immunization post (i.e. urban slum areas, border and other inaccessible areas, or areas with migrant and displaced populations), is more likely to achieve optimal coverage, particularly among hard-to-reach populations, compared to NIDs utilizing solely or predominantly fixed-post immunization. As a result, NIDs in remaining polio-endemic countries will need to be 'intensified' to include a large house-to-house oral polio vaccine (OPV) delivery component.

There is neither a set formula nor a single approach for implementing polio eradication strategies in all countries. Acceleration must be tailored to individual countries and regions, depending on their epidemiologic situation and operational realities.

Intensified and additional rounds of NIDs/sub national immunization days (SNIDs) will be associated with substantially increased resource requirements. However, the net benefits justify the additional costs by accelerating the eradication of polio.

Recommendations:

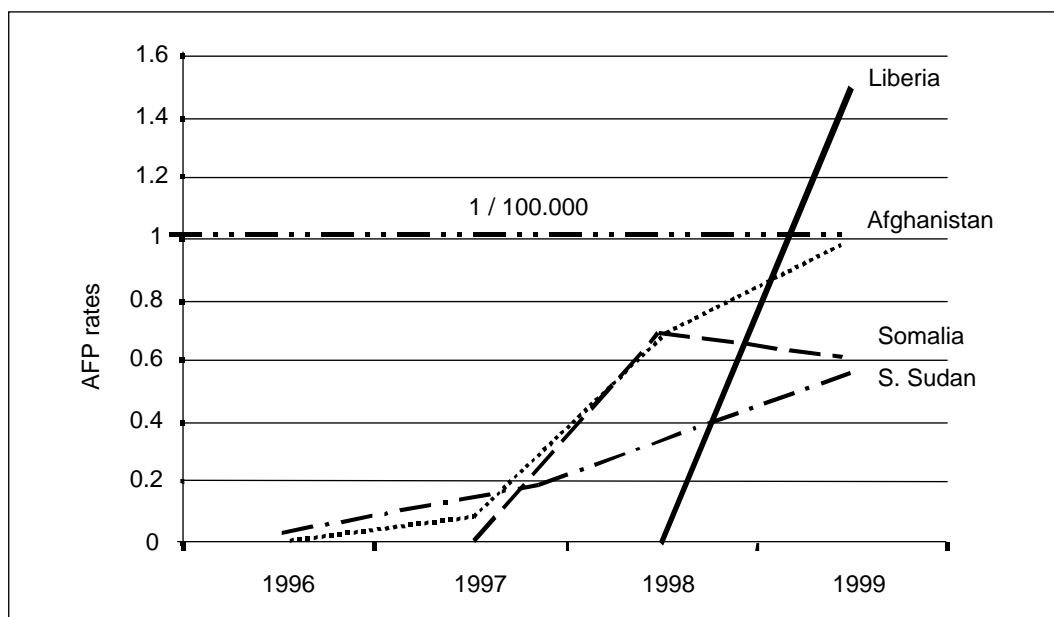
- a) Additional NID or SNID rounds must be conducted in the global reservoir countries (Bangladesh, Ethiopia, India, Nigeria, Pakistan) and most conflict-affected areas (Afghanistan, Angola, DR Congo, Somalia, southern Sudan).
- b) Noting that India contributes the majority of polio cases reported globally (60 to 70%), and based on the unique epidemiological picture in this country, the TCG endorses the plan for India to conduct four consecutive nationwide NID rounds from October 1999 to January 2000, followed by two SNID rounds in the spring of 2000 in eight high-risk states. All efforts should be made to ensure that the quality of vaccine used during supplementary rounds is maintained.
- c) The TCG also supports the current plans to conduct three nationwide rounds in Angola, DR Congo and Nigeria in 1999, and the combination of two NIDs followed by extensive mopping-up covering more than 80% of Pakistan.
- d) All other remaining polio endemic countries should be closely scrutinized to establish, by end-August 1999, whether additional nationwide rounds are required or whether subnational rounds would stop transmission.
- e) All NIDs and SNIDS should be intensified by incorporating a significant component of house-to-house, or family-to-family immunization, targeted at a minimum to high risk populations. These house-to-house efforts should cover large populations, particularly in countries representing major reservoirs or those affected by conflict. In some polio-endemic countries house-to-house immunisation may need to cover the entire target population nationally.
- f) Improving the quality of NIDs/SNIDs must be a priority and incorporate the following elements:

-
- preliminary walk-through to ensure the feasibility and logistic capacity to cover all populations,
 - mapping to ensure that all geographic areas are assigned to an immunization team,
 - schedules and maps for supervisory visits,
 - increasing the number of immunization teams and ensuring adequate numbers of trained supervisors,
 - systematic training in vaccine transportation and storage, as well as the use of vaccine vial monitors (VVMs) to ensure the availability of potent vaccine,
 - measuring the number of children never previously vaccinated ('zero-dose' children), and
 - systematic monitoring and review of NIDs/SNIDs in order to improve their quality.
- g) Identification of pockets of unimmunized children, through site visits during NIDs /SNIDs or the analysis of AFP case data, should lead to immediate supplementary OPV immunization in that locality.
- h) In countries affected by conflict, extensive mopping-up immunization activities should be conducted whenever the opportunity arises through a break in hostilities. Current United Nations efforts to facilitate "days of tranquillity" and ceasefires to allow the conduct of supplementary immunization activities should continue. The TCG welcomes the draft statement by the United Nations Interagency Standing Committee (IASC) to facilitate "Days of Tranquillity" and truces.
- i) Community and religious leaders should be fully involved in planning and implementing NIDs.
- j) Health workers should be reimbursed for their additional expenses involved in house-to-house immunization.
- k) Consideration should be given to the use of cash or non-cash incentives for high-quality performance in surveillance and during intensified NIDs /SNIDs. The implications of these incentives on other health programmes should be considered. Partner agencies in each country should agree on the type and level of incentives offered.
- l) Given that high-level OPV immunization coverage will need to be sustained at least through certification of eradication, ministries of health, WHO, UNICEF, and other partners must continue the systematic strengthening of routine immunization services.
- m) Successful polio eradication will require intensive social mobilization/communication efforts to assure that:
- all persons involved are aware of the eradication effort and its importance,
 - all target children receive OPV during supplementary immunization rounds, particularly those who were not previously immunized, and
 - polio eradication activities are used to promote routine immunization and use of health services.

1.5 Acceleration of AFP surveillance

The ultimate test for evaluating the success of the eradication effort is high-quality surveillance. Such surveillance data are critical to determining high-risk populations, the need for extra NIDs, SNIDs and mop-ups (targeted house-to-house immunization efforts in addition to NIDs and SNIDs), and determination of whether continuing polio transmission is the result of lack of immunization or vaccine failure.

Figure 5: AFP surveillance in countries affected by conflict



The TCG noted with satisfaction the visible progress in AFP surveillance in almost all remaining polio-endemic countries, particularly in India and Nigeria. The excellent progress in establishing sentinel surveillance systems in several countries affected by conflict (Figure 5) should be a model for efforts in other such countries and areas. Progress in surveillance was slow, however, in a number of other priority countries.

The gold standard for the final classification of AFP cases remains the collection of two adequate stool specimens with timely processing in a WHO accredited laboratory. The role and significance of the 60-day follow-up examination in case classification and for identification of areas at high risk of continued poliovirus transmission was discussed at the meeting. The TCG agrees that the role of the follow-up exam in AFP surveillance (i.e. for AFP case classification or the detection of infected areas) is limited. The best way to reduce the need for 60-day follow-up examinations is to collect stool specimens from a higher proportion of cases.

Recommendations:

- a) The effective, proven strategy of active, facility-based AFP surveillance must either be adopted or the quality must be improved, as rapidly as possible in those areas where certification standard surveillance has not yet been achieved. At this point in the eradication initiative this will require the recruitment and thorough training of a number of designated AFP surveillance officers.
- b) Polio eradication staff at all levels must assure that complete AFP/polio data and laboratory results are made available on a weekly basis to regional and global levels. At the national level, WHO representatives should work to facilitate the timely transmission of these data.
- c) Surveillance for AFP in countries affected by conflict should employ the following approaches:
 - regular active surveillance by designated staff,
 - close supervision with strong central coordination,
 - start by including large, accessible health facilities as surveillance sites,
 - appropriate remuneration linked to performance, and
 - collaboration with NGOs working in the country.

There is a special need for external resources to support these surveillance systems. As soon as feasible, the number of active surveillance sites should be expanded to cover the entire population.

- d) Regardless of where an AFP case is detected or reported, the AFP case investigation must include an early visit (i.e. within 48 hrs) to the locality where the patient developed paralysis to determine whether
 - there are additional cases in the community,
 - there is poor routine immunization coverage and
 - the community was reached by the last NIDs.

Corrective action must be taken if necessary.

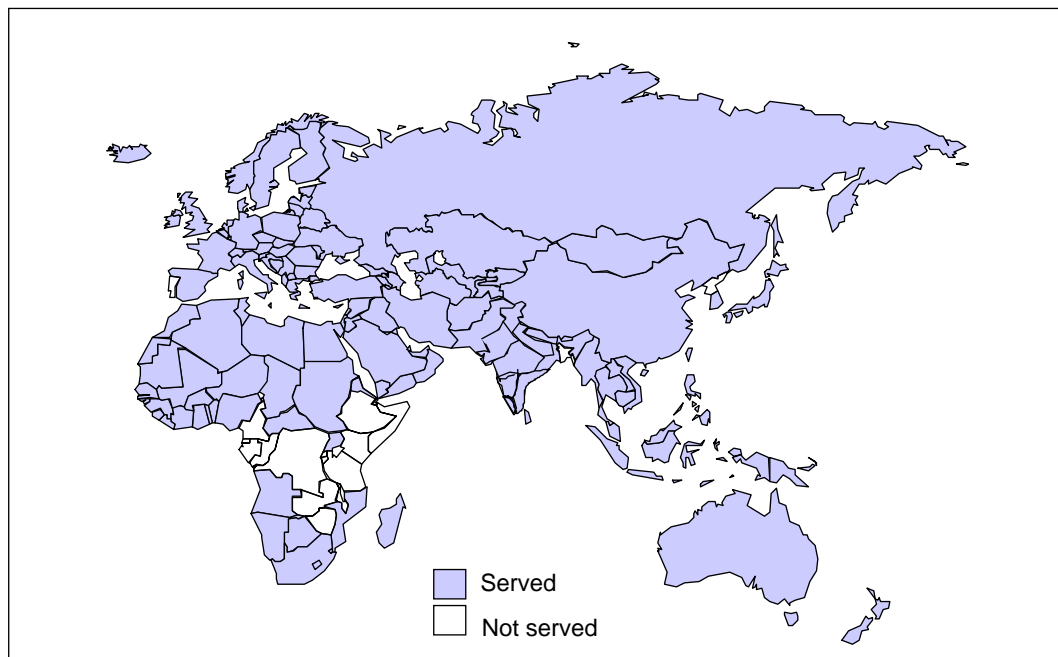
- e) The completeness of investigation of the locality of onset (i.e. village/district) for all AFP cases should be monitored, and appropriate action taken.
- f) Major efforts need to be made to increase the proportion of AFP cases from whom two adequate stool samples are taken within 14 days of paralysis onset.
- g) The 60-day follow-up examination for an individual AFP case should be retained. However, it does not need to be conducted if the AFP case had a proper investigation at site of onset, two adequate stool specimens collected within 14 days of onset and timely analysis of the specimens at a WHO-accredited laboratory.
- h) International AFP surveillance reviews should be reintroduced as a routine element of the process of rapidly improving the quality of AFP surveillance in countries where AFP performance, as measured by standard performance indicators, is chronically lagging.
- i) In those countries where surveillance continues to be poor, WHO regional offices should critically evaluate whether the available human and financial resources are being used in the most efficient and productive manner, and seek to resolve any remaining problems.

-
- j) AFP data must be systematically analysed to define the characteristics of confirmed and discarded cases and to take appropriate action to improve surveillance if defects are identified. Cases of AFP in unvaccinated children should lead to targeted supplementary immunization activities. Cases occurring in vaccinated individuals should trigger careful evaluation of the cold chain and vaccine quality.
 - k) All polio cases in whom the infection occurred in another country, should be considered “imported cases”. All cases in which infection occurred within the country should be considered “indigenous” to that country, even if closely linked epidemiologically to an imported case.
 - l) In areas with suboptimal surveillance, consideration should be given to actively search for recent AFP/polio cases during NIDs/SNIDs and other supplementary immunization activities, in order to identify previously undetected chains of transmission of poliomyelitis. This approach would be particularly valuable in areas with limited access to health care facilities, as in countries affected by conflict.

1.6 The Global Polio Laboratory Network

The Global Polio Laboratory Network has made substantial progress between 1997 and 1998. However, in a number of critical geographic areas there has been a chronic failure to reach accreditation standard performance (Figure 6). While some Regions have been able to offset this problem by shipping specimens to another accredited laboratory, this has not been a viable solution for ensuring proper specimen processing in all areas of the WHO African Region.

Figure 6: Countries served by a WHO-accredited poliovirus laboratory, as of June 1999 (data for WHO regions that have not been certified polio-free)



Recommendations:

- a) Each WHO region should establish by mid-June 1999, a plan of action to ensure that polio laboratory performance meets accreditation standards by September 1999. These plans of action should identify the financial, human or other resources that are required, the partner agency responsible for resolving each issue and the timeframe in which it must be completed. If laboratories do not comply with accreditation standards, routine splitting of specimens from AFP cases with parallel processing in accredited laboratories, should be instituted by September 1999.
- b) Given that the most viable option for AFRO is the urgent upgrading of existing facilities, priority must be given by partner agencies to support the implementation of the Plan of Action of the Polio Laboratory Coordinator in that region. For this reason, the AFRO laboratory coordinator should prioritize the order of attention to each laboratory, based on the existing status of the lab, its strategic importance to the initiative and the projected rate of increase in workload based on the AFP surveillance system.
- c) To facilitate the integration of laboratory personnel into the AFP surveillance system of each country, the WHO/ EPI polio medical or technical officer in that country should begin biweekly visits to the facility to assist with the resolution of logistic problems (i.e. communications, equipment, supplies).
- d) Given the critical importance of virological data to the eradication initiative, and recognizing the intractability of some issues affecting the unaccredited laboratories, WHO should direct its country representatives to assume responsibility for resolving these problems. The necessary solutions may include ensuring
 - appropriate financial remuneration to retain trained staff,
 - adequate laboratory space,
 - communications, and
 - clearing equipment through customs.
- e) In those laboratories which are still not accredited, WHO should immediately identify and orient consultant virologists to work for periods of at least two months on site, to upgrade laboratory staff skills and resolve other technical impediments.

1.7 Containment of wild poliovirus and stopping immunization against polio

The TCG notes that the World Health Assembly Resolution of 21 May 1999 on polio eradication was unanimously passed by WHO Member States and endorsed the safe handling and laboratory containment of polioviruses.

The TCG supports the revision of the Proposed Global Action Plan for Laboratory Containment of Wild Polioviruses based on the suggestions received during the public comment period of the latter half of 1998. The major revisions include a change in the containment level from maximum (BSL-4) to high (BSL-3) during Phase II, beginning one year after detection of the last wild poliovirus. This change is justified by the high level of inactivated polio vaccine/oral polio vaccine (IPV/OPV) immunization anticipated during this Phase. The TCG further supports the exclusion

of blood (or serum) and cerebral spinal fluid as potentially infectious materials when collected routinely or for non-polio epidemiological surveys and studies. Such materials rarely contain poliovirus and represent an extremely low risk.

The TCG welcomes the progress made in both the ongoing and newly initiated research studies to finalize the strategy for stopping immunization against polio. The TCG looks forward to the results of the studies so that a rational strategy for stopping immunization can be developed.

Recommendations:

- a) By the end of 1999, the WHO Regions of the Western Pacific, the Americas and Europe should pilot the revised global action plan and guidelines for implementing Phase I and provide feedback by the end of 1999 to WHO headquarters to guide further revision.
- b) WHO headquarters should prepare a detailed plan of action for implementing the containment plan and guidelines during the year 2000.
- c) WHO headquarters should communicate the revised Phase II containment requirements to the IPV producers and explore with them plans to increase containment for vaccine production when OPV immunization stops.

Annex 1 to Report of Global Technical Consultative Group: Agenda

Tuesday, 1 June 1999

- 08:00-08:30 Registration
- 08:30-08:45 Opening Dr M. Scholtz
- Introductions and Election of Officers
Administrative Remarks
- Session 1: Global status and Acceleration
Plans for the Eradication Initiative**
- 08:45-09:15 Report on the Polio Eradication Initiative Dr B. Aylward
- Implementation of the 1998 TCG recommendations
 - Status of the laboratory network
- Session 2: Rationale for Acceleration of
Polio Immunization Strategies**
- 09:15-9:25 Introduction and Rationale Dr C. de Quadros
- 09:25-09:35 Shifting from fixed-site to house-to-house immunization during NIDs: rationale and operational implications. Dr J. Bilous
- 09:35-10:00 Discussion - clarification
- 10:00-10:30 Coffee**
- 10:30-10:50 Situation analysis & plan in countries with persistent circulation
- Pakistan (10 min.) Dr S. Hadler
 - Turkey (10 min.) Dr G. Oblapenko
- 10:50-11:00 Discussion - clarification
- 11:00-11:30 'Intensified NIDs' & Increasing the Number of Immunization Rounds
- AFR priority countries: Nigeria, Ethiopia, DR Congo, Angola (15 min.) Dr J.M. Okwo-Bele
 - SEAR priority countries: India, Bangladesh (15 min.) Dr J. Andrus/
Dr K. Banerjee

11:30-12:30	Discussion and summary	Chair
12:30-12:40	Lessons in prioritization: polio eradication and accelerated measles control	Dr A.M. Henao-Restrepo
12:40-13:00	Discussion	
<i>13:00-14:00</i>	<i>LUNCH</i>	
	Session 3: AFP Surveillance and Laboratory Network	
14:00-14:15	Surveillance for wild poliovirus under difficult circumstances • Afghanistan, Somalia, S. Sudan	Dr H. Jafari
14:15-14:45	Discussion	
14:45-15:00	Role of 60-day follow-up examination	Dr M. Otten
15:00-15:15	Discussion	
15:15- 15:30	Rapid expansion of AFP surveillance: implications for the lab network	Dr R. Sanders
<i>15:30-16:00</i>	<i>Coffee</i>	
	Session 4: Stopping immunization and Poliovirus Containment	
16:00-16:10	Report of 1999 CDC/WHO meeting on 'stopping immunization'	Dr R. Sutter
16:10-16:20	Update: plan for biocontainment of wild polioviruses	Dr W. Dowdle
16:20-17:00	Discussion and summary	Chair
17:00	Adjourn	
17:30-18:30	Special evening session: "Challenges to stopping transmission and certifying eradication - case study: Egypt"	Dr M. Wahdan

Wednesday, 2 June 1998

08:30-09:45	Discussion of TCG recommendations
<i>09:45-10:00</i>	<i>Close of TCG meeting</i>

Annex 2 to Report of Global Technical Consultative Group: List of participants

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2.

Report of the Global Commission for the Certification of the Eradication of Poliomyelitis, Geneva, 2 June 1999

Present:

Co-Deputy Chairs, presiding: Dr C. de Macedo, Sir J. Smith

Rapporteurs:

Dr A. Adams, Dr R. Leke

Members:

Dr F. Nkrumah, Dr A. Deria, Dr M. Sulieman Ali Jaffar, Dr S. Drozdov, Dr H.M. Abednego, Professor Natth Bhamarapavati, Dr Wang Ke An

Members absent with apologies:

Professor J. Kostrzewki, Chairman; Dr F.C. Robbins

Introduction

A meeting of the Global Certification Commission (GCC) was held from 10:30 to 13:00 on 2 June 1999 in Geneva, following the meeting of the Global Technical Consultative Group (TCG) on Polio Eradication which had been attended by most members of the Commission.

2.1 Agenda item 1 – Reports on activities of the regional commissions

Brief reports were received from each of the regions on the activities of their commissions. It is notable that commissions are now constituted and active in all of the regions and plans of action have been developed for stimulating countries to produce the information necessary for certification. The AMR Commission has not met since 1994. The WPR Commission is meeting in August 1999 in anticipation that the region may be certified during the year 2000. The European Commission is considering the scientific basis for alternate data for certification in the industrialized countries that will not be presenting acute flaccid paralysis (AFP) surveillance data for certification. Detailed reports on activities are provided in the reports of each of the regional commission meetings.

2.2 Agenda item 2 – Implications of cross-membership between the Global Certification Commission and the Technical Consultative Group

Informal questions were recently raised about overlapping membership between the Global Certification Commission and the Global Technical Consultative Group (TCG). The Global Certification Commission discussed the issue thoroughly. It concluded that the essential issue was whether members of the TCG could be considered as being actively involved in the management of the global eradication initiative. They concluded that the TCG was, in fact, a consultative group only. Since its recommendations need not be accepted by WHO staff and programme managers, the TCG – and, by extension, regional technical advisory groups – could not be considered as actively involved in managing the initiative. Accordingly, the GCC did not feel that a limited cross-membership between the TCG and the GCC or the regional certification commissions and the regional advisory groups would present a conflict of interest.

Decision: The GCC agreed that, insofar as possible, new members of both Regional and global commissions should not be selected from the technical consultative groups.

The issue of employment of members of the regional and global commissions as consultants for WHO was also discussed.

Decision: The GCC agreed that, under WHO rules, members of the commissions could be termed as consultants for official business related to the commissions (i.e. attending commission meetings, country visits on official business of the commission, including site visits for consultation with national certification committees and technical visits to provide members with a field orientation to programme activities).

Decision: The GCC agreed that, in order to maintain the impartiality of the commissions, WHO should not employ members of the regional and global certification commissions for assignments related to the technical implementation of the programme.

2.3 Agenda item 3 - Issues arising from the Technical Consultative Group Meeting

a) Response of the WHO Director-General to the request of the GCC for her personal support to ensure the success of the polio eradication initiative

Members of the GCC noted with satisfaction the Director-General's increasingly visible support for the polio eradication initiative. Of particular importance were her participation in a national immunization day (NID) in Côte d'Ivoire, her letter, sent jointly with Ms Bellamy, to UNICEF and WHO country representatives, her convening a meeting of ministers of health of priority countries, the World Health Assembly resolution, her introduction of procedures to facilitate the administration of the initiative, WHO's allocation of excess casual income for polio and her personal involvement in fund-raising.

Decision: The GCC agreed to write a letter of appreciation to the Director-General.

b) *Egypt*

In response to the presentation during the TCG meeting on progress towards polio eradication in Egypt, the GCC noted the difficulties encountered in Egypt's national programme, particularly the persistence of low-level transmission despite repeated NIDs.

Decision: The GCC recommended that a letter be sent to the Minister of Health of Egypt encouraging him and his staff to seek the final reservoir of wild poliovirus in the country and to ensure that all children were immunized during upcoming house-to-house NIDs.

2.4 Agenda item 4 - Formal reviews of regional certification

Dr de Macedo expressed concerns about flagging enthusiasm for polio surveillance in the Americas. If surveillance performance declined, the American Regional Certification Commission might not be able to provide all the data necessary for the eventual global certification of polio eradication. It was necessary to reinforce the importance of maintaining surveillance for polio in the region and to ensure that all countries of the Americas would be fully prepared for global certification.

Decision: After discussion, the GCC agreed that a formal review should be made of current surveillance data for the region, the region's strategy for containment of wild polioviruses and its plans for preparing documentation for final certification. Accordingly, the Region of the Americas should be requested to make a formal presentation on the findings of this review at the next meeting of the GCC. It was also considered that the presentation should prove a valuable exercise for the GCC in considering the data it will require from all regions for eventual global certification.

Decision: The GCC agreed that one of its members would meet with staff of the Region of the Americas to discuss the preparation of the documentation on regional certification.

2.5 Agenda item 5 - Other business

a) *Destruction of variola virus*

Members of the GCC expressed their dismay at the decision by the World Health Assembly, taken two weeks prior to the GCC meeting, to delay the destruction of the known remaining stocks of smallpox virus. Several GCC members noted that this would have negative implications for the containment of wild poliovirus stocks since countries might now consider poliovirus stocks as national, rather than WHO, property. They felt that the decision could make the eventual destruction of wild poliovirus stocks more difficult to achieve.

Decision: The GCC recommended that a letter be sent from the commission to the Director-General to express these concerns.

b) Distribution of reports from the 1998 TCG and GCC meetings

The GCC was concerned that they had received their reports of the 1998 TCG and GCC only after great delay. This led to a general discussion of the need for members to be fully informed on progress of the initiative.

Decision: The GCC felt that they should receive all the reports routinely distributed by the polio initiative, including programme updates from the Weekly Epidemiological Record (WER), regular issues of Polio News, progress reports, technical reports and reports from the regional commissions. The WHO secretariat regretted the delay in the production and distribution of the reports of prior year's meetings and will endeavour to produce the reports earlier and to include GCC members on mailing lists for publications related to the initiative.

c) Next scheduled meeting of the GCC

The members of the GCC understood that the coordination of multiple meetings during the week of the TCG did not permit sufficient time for a full and formal meeting of the Global Certification Commission.

Decision: The GCC recommended that a formal meeting of the commission be organized in the next six to nine months to consider, inter alia, issues related to certification of countries not producing AFP surveillance data, the formal presentation of the Region of the Americas, and the information that will be required from regional commissions for the purposes of global certification.