Ad-hoc meeting of Chairpersons of Regional Commissions for the Certification of Poliomyelitis Eradication

(11th meeting of the Global Certification Commission)

Geneva, November 17, 2009

Note for the record - December 15, 2009

Findings, conclusions and recommendations

A side meeting of Chairpersons of Regional Commissions for the Certification of Polio Eradication (RCCs) was convened at WHO Geneva on November 17, 2009, in advance of the meeting of the global Advisory Committee on Polio Eradication (ACPE, Nov. 18-19). The meeting was attended by Dr Anthony Adams, Chair, Global Certification Commission (GCC) and also Chair, RCC/WPR, Dr Francis Nkrumah, member of the RCC/AFR, representing Dr Rose Leke, Chair, RCC/AFR, who was unable to attend, and Dr Ali Jaffar, Chair, RCC/EMR.

Also unable to attend were Dr David Salisbury, Chair, RCC/EUR, Dr Carlyle de Macedo, Chair, Regional Commission for Poliovirus Laboratory Containment and Verification of polio-free status in the American Region, and Dr Nazrul Islam, Chair, RCC/SEAR. WHO secretariat 'certification focal points' from all WHO Regional Offices (except EURO) attended the meeting also.

RCC chairperson's deliberations and findings:

1) Overall status of Polio Eradication

The Global Polio Eradication Initiative is facing significant challenges in 2009. As of 11 November 2009, 1337 cases due to wild poliovirus (WPV) were reported from 23 countries, compared to 1473 cases from 16 countries for the same period in 2008. The decline in cases (10% overall) is primarily due to a significant drop in the number of cases reported from Nigeria. Nearly 20% of global cases have been reported from 19 re-infected countries. Angola and Chad have sustained WPV transmission following importation for over 12 months

and must now be considered to have re-established transmission. The same is probably true also for Southern Sudan and DRC, where the genetic and epidemiological evidence as not as strong as in Angola and Chad.

The current global PE challenges should not be allowed to overshadow significant achievements in 2009. In Nigeria, considerable progress has been made in engaging political and traditional leaders, with resulting improvements in reaching children during campaigns and a rapid decline in transmission of all poliovirus types. In India, Afghanistan, and Nigeria, the geographical scope of infected areas has been further reduced. All four endemic countries have made significant efforts to reach vulnerable populations during SIAs. The speed of response to importations has improved markedly in 2009, and 70% of all importation events in the last 12 months have been resolved. Programme research has led to the development of bivalent Oral Ppolio Vaccine in record time and this vaccine will likely be introduced for programme use before the end of 2009.

However, there are clearly major barriers to polio eradication, including to sustain programme momentum and the tremendous intensity of activity in endemic countries, limitations on access to communities due to problems of security in key endemic and re-infected areas, the difficulties of rapidly engaging political and health leaders in re-infected countries to respond quickly and effectively to WPV importations, and the persistence of transmission in a handful of re-infected countries that now pose a major threat for continued international spread.

The recent 'Independent Evaluation of Major Barriers to Interrupting Wild Poliovirus Transmission' concluded that if these barriers are addressed, polio eradication can be achieved (a view shared by the global Advisory Committee on Polio Eradication at their meeting subsequent to the RCC chair's meeting) . The Independent Evaluation Team concluded that recent progress, especially in the endemic countries, must be maintained and built on to sustain current momentum and to ensure that polio eradication is completed.

2) Reports on the status of certification activities in WHO Regions

a) African Region

The group appreciated the update report from the African Region, which initially highlighted that three documents constitute a country's 'complete documentation' in the Region: 1) the status report on PE consisting of detailed chapters on WPV transmission status, quality of AFP surveillance, the levels of immunity, focusing on routine immunization and SIAs, and laboratory activities; 2) a report on containment activities, and 3) a plan of preparedness for importation of PV, including a budget for a response SIA.

All AFR countries prepare either an annual progress report (from countries for which complete country documentation has not yet been accepted), or 'post presentation' annual progress reports for countries which have successfully presented complete country documentation (i.e. showing the absence of circulating wild PV at the time of submission of the documentation).

The last 'regular' meeting (also called 'annual general meeting') of the ARCC (African Regional Certification Committee) was conducted in October 2008 in Brazzaville. A shorter ad-hoc meeting of the ARCC was conducted in May 2009 in order to review a backlog of 18 unreviewed annual reports. ARCC members, during 2009, also participated in country-level activities, including advocacy visits and AFP surveillance reviews in critical countries.

As of November 2009, 29 of 46 WHO AFR member states have prepared and presented to the ARCC their complete country documentation; of these, 25 country documentations have been accepted as indicating that the country is free of circulating wild poliovirus at the time of submitting their documentation. Acceptance of documentation from Tanzania and Madagascar was deferred due to significant gaps in the quality of AFP surveillance. The planned acceptance of reports prepared by Cameroon and Burkina Faso were deferred due to WPV importations into both countries, which occurred just before the ARCC meeting.

The renewed wave of outbreaks following importation, mainly in West Africa, was the main reason why the ARCC meeting planned for mid-2009 was postponed to January 2009. As of now, two countries (Gabon and Tanzania) were selected to present their complete country documentation at the meeting in January 2010.

National task forces for laboratory containment have been formed in 42 of 46 AFR member states; in 12 of these 42 countries, national surveys and inventories of laboratories with PV

infectious or potentially infectious materials have been prepared. A validation exercise is being planned for three AFR countries which each have an estimated more than 500 bio-medical laboratories (South Africa, Kenya, and Uganda).

Main current concerns of the ARCC are to assure that the PE certification and containment agenda is continued while

- indigenous WPV transmission continues in Nigeria, and
- outbreaks in 18 previously polio-free countries continue (up from 4 countries in 2007), with prolonged circulation (> 12 months) in Chad and Angola.

The ARCC is also concerned about the fact that nine of the 18 previously polio-free, now re-infected countries, are countries for which the ARCC had already 'accepted' complete country documentation.

Main priorities for the ARCC for 2009 will be to:

a review the performance (AFP, immunization activities) in all 25 countries which successfully submitted complete country documentation;

b accelerate containment activities in the remaining countries;

c ensure re-orientation of selected national certification committees;

d support selected countries to prepare and submit country documentation;

e assure that ARCC memebers continue to support advocacy and surveillance-strengthening efforts in countries of the Region.

b) Region of the Americas

The update from the Americas showed that, during 2008 and 2009 overall, AFP reporting had been maintained at a rate of > 1/100.000 population < 15, with collection of 1 adequate stool specimen from 79% of all AFP cases during 2008. A review of AFP surveillance quality by country showed that, in 2008, the collection of adequate stool specimens was below 80% in the following countries: Bolivia, CAREC (a group of small Carribbean island nations), Cuba, Dominican Republic, Nicaragua, Urugay and Venezuela. All AMR member states report

coverage with 3 doses of polio vaccine (tOPV, except for USA and Canada, which use IPV) of 80% or higher.

In terms of progress towards laboratory containment, the 4th meeting of the AMR Regional Commission for lab containment and verification of polio-free status was held in Urugay earlier in 2009. The Commission determined that all AMR member states, except Brazil, had completed Phase 1 of lab containment. Brazil is expected to present their final report on completing Phase 1 on November 30, 2009.

The Commission was established several years ago to oversee laboratory containment activities and 'the verification of polio-free status in the American Region', but has focused almost exclusively on laboratory containment to date. The Commission will meet again in the first quarter of 2010 to determine whether the phase 1 lab containment goal has been achieved; it is expected that the Commission will then turn its attention to working with national committees to review in more detail the current status of maintenance of polio-free status, and possible additional necessary activities at the country level.

c) Eastern Mediterranean Region

The RCC EMR has accepted basic national documentation (i.e., complete national documentation following 3 years without isolation of WPV, under 'certification quality surveillance') from 20 of the 23 countries of the Region. Of these 20 countries, 15 (BAH, DJI, IRN, IRQ, JOR, KUW, LEB, LIB, MOR, OMA, QAT, UAE, SAA, SYR, & TUN) have been polio-free for 5 or more years and have complete phase I of laboratory containment. The RCC distinguishes these 15 countries as having successfully submitted final national documentation.

EMR countries which submitted basic national documentation, but have not yet submitted final documentation (such as Egypt or Palestine) submit a regular annual update report on

maintaining polio-free status. Countries which have submitted final documentation submit a shorter 'abridged' Annual Update to the Commission.

The RCC EMR will continue to review the regional situation, especially in countries which are currently endemic and polio-free countries at risk of an importation with subsequent spread. The RCC will also provide support to NCCs and national programmes to ensure that the current momentum for PEI does not wane, and ensure the completion and full documentation of phase I of laboratory containment and submission of reports assessing the quality of containment activities.

d) European Region

Representatives from EURO were unfortunately unable to attend the ACPE or certification side meeting, and Dr R. Tangermann summarized the current situation in EUR, based on the most RCC/EUR report.

At their most recent meeting in June 2009, the RCC/EUR noted that the Region had remained polio-free since the last case due to circulating indigenous WPV had been reported from Turkey in 1998. The RCC was confident that the main reason responsible for this achievement were the strong health systems in the great majority of member states, assuring > 90% coverage with polio vaccines (except Georgia + Tajikistan) for all infants born in the Region. While both AFP surveillance (43 of 53 member states) and enterovirus surveillance (38 countries) and environmental surveillance (21 countries) for polioviruses continue, main concerns of the RCC EUR at their June 2009 meeting were:

- the slowly declining quality / sensitivity of AFP surveillance in several countries,
- and the declining quality of work of many National Certification Committees to assist in maintaining polio-free status in their countries.

The RCC EUR continued to rely on a thorough country-by-country assessment of the risk of spread of imported wild poliovirus (or of emerging cVDPV) conducted by the WHO EURO secretariat for each EUR member state. Main indicators used for this assessment were:

a the number of NCC meetings held from 2004 to 2008,

b the reported coverage with 3 doses of OPV or IPV by 1 year of age (from joint UNICEF/WHO reporting forms),

c the quality of AFP surveillance as expressed through the AFP index (non-polio AFP rate X % AFP with 1 adequate specimen) for 2000 to 2008,

d the % AFP cases with follow-up within 60 to 90 days, and

e the availability of finalized Plans of Action to sustain polio-free status and of plans for preparedness to control importations.

As for previous assessments, four countries (Bosnia-Herzegovina, parts of Eastern Turkey, Georgia and and Tajikistan) were considered to be at high risk of transmission following WPV importation. Fourteen other countries, including (amongst others) Austria, Greece, the Netherlands and Portugal, were considered to be at intermediate risk, mainly because of lower than expected reported coverage, or because of the presence of high-risk groups (for example, the presence of a large population group refusing any vaccines for religious reasons in the Netherlands).

Despite the shortcomings of evidence submitted from some countries, the RCC / EUR concluded that circulating WPV continued to absent from the Region. However, there was a persisting risk of spread and subsequent ourbreaks, following WPV importation, in some countries. The RCC was also concerned that many NCC reports were incomplete and 'not convincing', or indeed would not be adequate for final global Certification; also, national plans for importation preparedness were missing in many countries.

The RCC notes that the current status of the GPEI calls for continued strong political and financial support to maintain the Region polio-free; the RCC appreciated the piloting in France of a framework for the implementation of the third edition of the Global poliovirus containment Action Plan (GAP III, i.e. containment of SABIN straing PVs, and containment agenda following OPV cessation).

The RCC's main recommendations were for WHO to revitalize functional NCCs where these are inactive, using the new NCC TORs, and to provide stronger guidance / standards to NCCs to improve the quality of annual reports on maintenance of polio-free status. The RCC

also requested ETAGE (Regional Technical Advisory Group on VPDs) to provide technical advice on the issue of which vaccines (OPV, or also IPV) can/should be used to respond to the introduction and spread of WPV into a member state.

e) South-East Asian Region

Even though the Region is dominated by India, the largest remaining polio-endemic country in the world, and efforts to interrupt transmission in India have high priority, certifcation activities do continue in the Region. Complete national documentation has been accepted from all countries in the Region except India and East Timor. Following the acceptance of national documentation, countries are regularly submitting annual update reports including information on laboratory containment activities, udated plans for WPV importation or cVDPV outbreaks, and information related to IHR implementation.

Nine countries of the Region have submitted their report on finalizing Phase 1 lab containment; phase 1 activities are in progress in India, and East Timor is the only country where formal containment activities have not yet been initiated.

In 2010, the RCC plans to facilitate a review of Phase 1 containment activities in the 're-infected' countries of Bangladesh, Indonesia, Myanmar and Nepal, in order to resurvey high risk laboratories. The RCC also hopes that the both certification and lab containment activities can be initiated in Timor L'Este, the newest SEAR member state.

f) Western Pacific Region

The RCC WPR, at its last meeting (December 2008), had concluded that the Region had remained free of circulating WPV. Apart from reviewing annual update reports from all member states, the RCC also reviewed a draft strategic plan for maintaining polio-free status 2008-2012, and endorsed the plan. Main components of the new strategic plan include to ensure continuous political commitment and support for PE activities in the Region, to maintain high levels of immunity against polio through routine and supplementary immunization, to sustain high-quality surveillance for polio through AFP surveillance and the

continued functioning of the regional polio laboratory network, the preparedness for controlling wild poliovirus importations and cVDPV emergence, as well as meeting the requirements for poliovirus laboratory containment.

As in previous meetings, the RCC WPR noted that it will be essential to assure the allocation of sufficient financial and human resources to allow all necessary activities, particularly laboratory work, to be conducted at the necessary level of quality.

Noting that all countries in the Region had now completed phase 1 of lab containment activities (national survey, leading to inventory of facilities with wild PV infectious materials), the RCC specifically commented on the need to prepare for Phase 2 containment. This would include for all countries to create and maintain a permanent focal point or office within the MOH to maintain communications with institutions listed on the inventory, to keep both the national database and national inventory current, in order to prepare for phase 2 and implementation of containment requirements one year after detection of wild poliovirus anywhere in the world.

3) Inter-regional coordination of activities to maintain polio-free status

The WHO American, European and Western Pacific Regions (AMR, EUR, and WPR) - have already been certified as free of indigenous wild poliovirus transmission for 10 or more years. Regional Certification Commissions and National Certification Committees continued to function in two Regions - EUR and WPR - in order to facilitate the maintenance of polio-free status in all member states of the Region.

Aware of the continued risk of wild poliovirus importations and the possiblility of outbreaks following the emergence of circulating, paralyzing vaccine-derived poliovirus (cVDPV), RCCs in EUR and WPR, assisted by regional WHO secretariats, have annually reviewed each country in the Region to assess if the quality of AFP and other surveillance activities and of immunization activities were sufficient to detect importations of wild poliovirus and prevent its spread and prevent the emergence of cVDPVs.

The continued activity of RCCs and NCCs has been helpful to assist countries of EUR and WPR in maintaining their polio-free status. Of note, countries in the Americas (AMR) have maintained their polio-free status, through continued good quality AFP surveillance and high immunization coverage, even without 'reminders' from RCC or NCCs, which were dissolved in the Region immediately after certification. The Regional Commission established in the Americas 5 years ago has worked exclusively on laboratory containment of wild polioviruses, which had not been part of the polio effort yet when regional certification occurred in 1991.

The WHO Western Pacific Regional office secretariat noted specific challenges for maintaining polio-free status in certified WHO Regions, mainly related to the relatively higher priority given by the global polio initiative to all polio-related activities in 'endemic' Regions.

Some of the specific interests and concerns related to maintaining certified Regions polio-free, such as optimizing the annual country risk assessments, or the addition of OPV vaccination to other immunization activities (immunization weeks, other EPI/CHD activities), are seldom reflected on the agendas of regional or global polio eradication technical advisory groups. Both staff time and financial resources for 'polio-free maintenance' are relatively minimal in certified Regions; for example, the EUR and WPR secretariat find it difficult every year to finance even basic activities of their regional polio laboratory networks.

Another area of work of great interest to polio-free Regions is the programme of work to prepare for the post-eradication / post-OPV-cessation era are, particularly issues like the definition, classification and management of polio cases caused by VDPVs, or technical guidance for countries considering to switch routine polio immunization from OPV to IPV (i.e. VAPP surveillance issues, communication strategy).

Suggestions made by the WPR secretariat in order to improve the support for and coordination between polio-free Regions include the following:

a forums / meetings of WHO regional and HQ certification focal points once or twice a year, for example in conjunction with other meetings,

b to increase the fime spent by the certification focal point at WHO/HQ on technical support for polio-free Regions ,

c establishment of a specific online repository of technical materials,

d cross-participation of WHO regional focal points in meetings of RCCs, possibly TAG meetings, of certified Regions.

4) Other issues

a) Reporting requirements from Regional Commissions to the Global Commission

Dr. A. Adams, chairman of the Global Certification Commission (GCC) and of the RCC WPR, discussed the need for more regular and standardized reporting from each RCC to the global level (GCC, through WHO/HQ), both to inform the GCC about progress in more detail, and to build the information base on which eventual global certification would occur.

He noted that each RCC was currently meeeting once or even twice a year, and that a detailed written report was produced for each meeting. While the actual format of the report varied considerably between the Regions (polio-free vs. endemic Regions, other differences), the meeting reports generally do contain all relevant details on progress towards regional certification (endemic Regions), on maintenance of polio-free status, or on progress towards laboratory containment.

While the GCC currently receives update information on the status of global polio eradication from WHO/HQ every 4 to 6 months, the detailed meeitng reports are not forwarded to the GCC. Dr Adams noted the usefulness of the meeting reports and re-iterated a request previously issued as a GCC decision (GCC 8, 2003) - for the GCC (Chair and all interested GCC members) to receive all RCC meeting reports as soon as possible after the respective RCC meeting.

Dr Tangermann, WHO/HQ, agreed that this would be useful and feasible, provided the RCC reports reach WHO/HQ. Unfortunately, this is currently not the case; there are considerable delays (up to one year) between RCC meetings and the finalization of the report in all Regions; also, not all RCC reports, even once finalized, are 'automatically' shared with WHO/HQ.

Dr Adams also reminded the group of another request and decision made by the GCC (8th meeting report, section 9), namely for RCCs to provide a brief annual summary report to the GCC / WHO/HQ, following their annual meeting. Objective for these summary reports, for which RCCs / regional WHO secretariats should all use the same standarized format, would be to assure that the core data with relevance for certification and maintenance of polio-free status (i.e. quality of surveillance and immunization activities, lab containment) would become acessible and comparable in one central database, also as a kind of 'historical record', to prepare for eventual global certification.

Dr Tangermann presented a suggested format for the annual summary report, including sections on:

a the certification process (functioning of RCCs and NCCs);

b quality of AFP surveillance or other surveillance activities,

c maintance of sufficient immunity levels (reported / assessed immunization coverage, possible SIAs)

d plans of preparedness for importation, and

e progress towards laboratory containment.

The group agreed with the concept of annual summary reports from all RCCs to the GCC, and requested the secretariat to finalize an appropriate template for review by the GCC at their next meeting.

b) Procedure for RCC review of re-infected, previously 'polio-free' countries

As noted in section 1 of this report, RCCs in both the African and Eastern Mediterranean Regions had already 'accepted' final national documentation for polio-free certification from several countries (i.e., agreed that the documentation submitted was sufficient to assume the country was free of circulating wild PV at the time of submission), which then experienced a renewed wild PV importation with subsequent epidemic spread and polio outbreaks.

This issue was brought up at the side meeting, and it was noted that there was currently insufficient guidance from GCC or other PE technical bodies on a standardized approach to

take by RCCs to deal with this problem - i.e. under which conditions countries would have to undergo a renewed comprehensive review by the RCC.

The GCC has indeed not yet addressed this issue directly; however, it was noted that both affected Regions - AFR and EMR - had handled this scenario in similar ways. Key to how the situation is handled in both Regions is to assure a sufficient surveillance response, i.e. to be able to reliably detect or exclude secondary spread following the importation. In both Regions, polio-free countries with 'accepted documentation' detecting an importation which does not result in secondary spread, continue their scheduled annual update reports to the RCC; a detailed report on the importation is required as part of their next scheduled report.

However, polio-free countries with accepted documentation where a wild PV importation results in epidemic spread are requested by the RCC to re-submit their basic documentation after one year from the date of onset of the last case of this epidemic, provided that continued circulation could reliably be excluded through maintaining certification-quality surveillance.

The approach taken by both RCCs is consistent with, or even goes beyond, the WHO/HQ policy towards re-infected countries: epidemic spread following an importation into a previously polio-free country is considered as terminated if no wild PV genetically linked to the initial wild PV importation has been found, with certification -quality surveillance, for more than 6 months from the date of the onset of the first importation-related case.

The group noted that the approach taken by the RCCs in EMR and AFR towards re-infected countries for which full country country documentation had been previously accepted was reasonable. It was suggested that the issue should be reviewed and officially decided on by the GCC at their next meeting.