Summary report on the

Review meeting for Phase III of the Middle East polio outbreak response

WHO-EM/POL/420/E

Beirut, Lebanon
22–23 October 2015

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Regional Office for the Eastern Mediterranean

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1. Introduction

The Middle East polio outbreak began with the reporting of type 1 wild poliovirus (WPV) cases from the Syrian Arab Republic in October 2013. This followed earlier isolation of wild polioviruses from sewage specimens in Egypt, Israel and Palestine. Genetic analysis of the outbreak virus strain indicated that it was likely imported from Pakistan. Following the identification of the first WPV cases, a coordinated response effort was made to control the outbreak, the most significant feature of which was the extraordinary commitment demonstrated by the governments of affected countries and their implementing partners. Consequently, about 70 vaccination campaigns were implemented in three phases of the outbreak response in spite of a very complex and volatile security situation in the sub-region. Millions of children were vaccinated and thousands were saved from permanent disability due to poliomyelitis.

A meeting was convened on 22 and 23 October 2015 in Beirut, Lebanon to review Phase III of the response, with the primary aim of ascertaining whether the Middle East polio outbreak is over, based on available evidence. The meeting also aimed to determine the nature and scope of the strategic priorities for the next phase of the response. The timing of the meeting was crucial given that more than 18 months had elapsed since the last wild poliovirus was isolated in the region. Prior to the meeting, multi-country desk reviews and field assessments of polio eradication activities were conducted by WHO and UNICEF regional offices, with support from the headquarters of both organizations.

Participants at the review meeting included delegates from seven countries of the Eastern Mediterranean Region involved in the response, namely Egypt, Islamic Republic of Iran, Iraq, Jordan, Lebanon, Palestine and the Syrian Arab Republic. Delegates consisted

of leaders of the various national polio programmes and representatives of partner agencies, including Rotary International, UNICEF and WHO representatives from headquarters and regional and field offices. The meeting was co-chaired by Dr Nima Saeed Abid, Team Leader, Cross Cutting Functions, Polio Eradication, WHO Regional Office for the Eastern Mediterranean and Mr Jalaa Abdel Wahab, Deputy Team Leader Polio, UNICEF headquarters.

2. Summary of discussions

Country presentations, field and desk outbreak assessments and group discussions showed that Phase III of the outbreak response plan was successfully implemented. All countries show evidence of improved polio vaccination status, surveillance quality, and consistency. More than 18 months have elapsed since the last polio case was reported in the Eastern Mediterranean Region (Iraq) in April 2014. Key surveillance indicators confirm the sensitivity of surveillance systems in countries of the Region. Five WHO accredited laboratories tested more than 10 000 stool specimens for wild poliovirus from AFP cases and 700 stool specimens from contacts and declared all specimens were polio free. Additionally, wild poliovirus has not been isolated from monthly environmental stool samples collected from Egypt, Gaza and West Bank since March 2014. These indicators and facts imply the cessation of poliovirus transmission in the Region. However the risk of poliovirus importation remains significant due to the inaccessibility of certain areas for immunization activities and the continued presence of the poliovirus in Afghanistan and Pakistan with uncontrolled population movement from both countries to other countries in the Region.

Several key lessons were learned from the response. Unprecedented multicounty coordinated response helped to achieve the goal of interruption in shorter duration. National government leadership and

coordination among all key partners was cornerstone to success. Synchronized regional communication campaigns paid off well. Use of the phase approach and strong monitoring and evaluation in the response ensured that plans were based on evidence and paved the way for all the achievements. The role of paediatricians was crucial in sending clear and convincing messages for vaccination. Access mapping was instrumental in covering the unreached communities. Nothing could have been possible without the dedication and hard work of the front line workers.

The review recognized a few best practices shared by country teams, notably: a) mapping high risk populations; b) subnational analysis of missed children to guide interventions; c) engagement of private sector physicians through different means including social media; d) mobilizing community influencers' support for tailored activities suiting local context; and e) use of mobile and GPS technology to monitor supplementary immunization activities and collect timely data for immediate action.

The work group agreed on describing the coming, post-outbreak period as a Risk Reduction Phase. The most important priority is to maintain the momentum as governments and partners work to address all existing gaps in immunity and surveillance in order to mitigate the risk of poliovirus importation. Preparedness and contingency plan should be put in place. They should be realistic and simulated exercises should be conducted to ensure the achievement of polio-free status is maintained and new virus importation is prevented in the region. All countries are expected to follow the new standard operating procedures in when preparing these plans.

Key conclusions of the meeting were as follows.

- Phase III plans were successfully implemented and most of the targets fully or partially achieved despite a rapidly evolving and complex security situation in the Region.
- There is evidence of improvement in immunization status and surveillance quality in the affected countries.
- Based on field assessments, surveillance data and the time lapse since the last reported case (>18 months), there is reason to infer that wild poliovirus transmission associated with the 2013 importation has been interrupted.
- However, there are outstanding risks and gaps warranting immediate risk reduction plans. Key risks and gaps include pockets of children persistently missed due to insecurity (adjacent governorates of the Syrian Arab Republic and Iraq, in particular) and operational issues (Baghdad and Damascus, for example).
- Additionally, there is continued endemic transmission in Pakistan and Afghanistan, which means there remains a risk of new WPV importations given the frequency of population movements between these countries and those affected by the outbreak.
- The risk of emergence of vaccine-derived poliovirus (VDPV) is also high in the Region, particularly in conflict-affected countries, due to deteriorating routine immunization coverage.

3. Recommendations and the way forward

1. Overarching policy should aim at maintaining vigilance and commitment of governments and partners, and ensuring that subnational gaps are addressed.
2. Geographical prioritization of the affected countries based on perceived vulnerability should remain as in the past. These include Zone 1: most vulnerable countries, i.e. the Syrian Arab

Republic and Iraq, and Zone 2: at-risk countries, i.e. all other countries in the Region.

3. Strategic priorities for all countries should include the following.

- Coordination among the different implementing partners to keep the programme in the right direction.
- Communications and advocacy to keep polio at the top of the national public health agenda and continued engagement of the top political and technical leadership.
- Achieving high population immunity uniformly at sub-national levels through strengthening of routine immunization services.
- Ensuring sensitive AFP surveillance systems meeting global certification standards.
- Continued focus on high-risk areas for all components of the polio programme, including surveillance, immunization activities and advocacy and communications.
- Adequate levels of preparedness for any possible new poliovirus importation and field testing of the readiness plan, including ensuring adequate vaccine supply and logistical support.
- In the Syrian Arab Republic and Iraq, in addition to the above mentioned activities, supplementary immunization activities should be conducted with focus on low performing areas and/or epidemiologically high risk areas. Special strategies for reaching children in inaccessible areas should be a core component of country plans.

4. Updated plans for each country countries will be shared with WHO by 15 November 2015 based on the broad guidelines provided to them for the above-mentioned strategic priorities.

5. Immediate priorities for the regional level leadership are as follows.

- WHO and UNICEF: conduct advocacy with high-level government officials to maintain vigilance and canvass for budget allocations; and facilitate intercountry coordination on cross-border issues.
- WHO and UNICEF Regional Offices: work closely with countries to encourage them to license or grant temporary import waivers for WHO prequalified OPV vaccines to increase the supply flexibility; and document the best practices for emulating in other programmes.
- WHO: continue the surge support in 2016; and institute environmental surveillance in Iraq and the Syrian Arab Republic.

World Health Organization
Regional Office for the Eastern Mediterranean
P.O. Box 7608, Nasr City 11371
Cairo, Egypt
www.emro.who.int