WHO-EM/POL/401/E

Report on the

# Twenty-sixth meeting of the Eastern Mediterranean Regional Commission for Certification of Poliomyelitis Eradication

Dubai, United Arab Emirates
3–5 April 2012

World Health Organization

Regional Office for the Eastern Mediterranean

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## 1. INTRODUCTION

The Eastern Mediterranean Regional Commission for Certification of Poliomyelitis Eradication (RCC) held its 26th meeting in Dubai, United Arab Emirates during the period 3–5 April 2012. The meeting was attended by members of the RCC, chairpersons of the National Certification Committees (NCCs) and national polio eradication officers of 20 countries of the Region (Bahrain, Djibouti, Egypt, Islamic Republic of Iran, Iraq, Kuwait, Lebanon, Libya, Morocco, Oman, Palestine, Qatar, Saudi Arabia, Somalia, South Sudan, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates and Yemen). It was also attended by a representative of Rotary International and by WHO staff from the Regional Offices for Africa, Eastern Mediterranean, Europe, South-East Asia and Western Pacific and from Somalia and South Sudan country offices. The programme and list of participants are attached as Annexes 1 and 2, respectively.

The meeting was opened by Dr Ali Jaffer Mohamed, Chairman of the RCC, who welcomed the participants and thanked the Ministry of Health of the United Arab Emirates for hosting the meeting. He acknowledged the strong commitment of the Regional Director and all polio staff. The Chairman welcomed Dr Mohamed Helmy Wahdan as a new RCC member.

Dr Mahmoud Fikri, Under-Secretary, Ministry of Health, United Arab Emirates, delivered a message on behalf of H.E. Mr Abdel Rahman Mohamed Al Owais, Minister of Health. He said that the Government of the United Arab Emirates would continue to extend support to eradication efforts in the remaining endemic countries in close collaboration with WHO, UNICEF and the Red Crescent Society of the United Arab Emirates.

Dr Ezzeddine Mohsni, Coordinator, Polio Eradication, Regional Office for the Eastern Mediterranean, delivered a message from Dr Ala Alwan, WHO Regional Director for the Eastern Mediterranean. In his message, Dr Alwan expressed concern about the continued circulation of poliomyelitis in Pakistan and Afghanistan and the potential negative impact of the prevailing situation in some countries of the Region with respect to polio eradication efforts. He expressed the hope that through the dedication of national and international staff and continued support of the polio partners, the Region would soon become polio free.

## 2. UPDATE ON POLIOMYELITIS ERADICATION IN THE REGION

*Dr Tahir Mir, WHO Regional Office for the Eastern Mediterranean*

With regard to the recommendations of the RCC during its twenty-fifth meeting, the two remaining endemic countries (Pakistan and Afghanistan) continue to treat polio eradication as an emergency. The emergency standard operating procedures with respect to polio eradication have been further strengthened. Information on detected vaccine-derived polioviruses (VDPVs) in the Region has now been added to the weekly PolioFax.

In the two endemic countries (Pakistan and Afghanistan) additional human resources support has been provided and the management and accountability framework in the programme is being introduced. Advocacy visits to Pakistan by the Regional Director and

Special Adviser to the Director-General on Polio Eradication were helpful for sustaining political commitment at the highest levels. Monitoring mechanisms for supplementary immunization activities were strengthened through the expansion of lot quality assurance sampling (LQAS) and improving independent monitoring. The Regional Office is holding weekly technical consultations with Afghanistan and Pakistan polio eradication teams. As well the IACSG and Partners Conference is a regular weekly feature of consultation with headquarters and partners.

In Pakistan, the Federally Administered Tribal Areas (FATA) and the Quetta block in Balochistan are the areas which continue reporting cases. In November 2011, the national task force endorsed the augmented national eradication action plan which makes district officers accountable for campaign quality at union council level. The plan also focuses on involving public representatives to help polio eradication efforts in their constituencies, particularly with respect to proper campaign planning (micro-planning, team composition and deferment of campaigns in case of inadequate preparations). LQAS in Pakistan is showing recent positive development.

The Technical Advisory Group (TAG) for Pakistan in its March 2012 meeting concluded that the augmented national eradication action plan provides a platform to take Pakistan to polio eradication provided it is fully and consistently implemented. The overarching recommendations include enhancing political commitment through financial engagement, immediate scaling up special strategies for high-risk groups, use of innovative strategies like short interval additional dose rounds, expanded age groups, polio-plus delivery, partnerships for service delivery and improved monitoring. The TAG endorsed the outline of the media action plan, the planned supplementary immunization activities for 2012 (4 NIDs, 4 sub-NIDs) and the type of vaccine to be used: trivalent oral poliovaccine (tOPV) in 2 national immunization day campaigns (NIDs) and bivalent OPV (bOPV) in all other rounds. It recommended flexibility in timing of supplementary immunization activities as per epidemiologic developments. Province-specific recommendations were also made highlighting the geographical and population priorities.

In Afghanistan, the number of polio cases increased by more than 200% in 2011 compared to 2010. More than 80% of the cases are reported from the known endemic provinces of the south including Farah. Sporadic cases were detected from other regions of the country denoting 13 new infected provinces in 2011. No wild poliovirus type 3 was detected for more than a year. Afghanistan has developed a polio emergency action plan for 2012, entitled “Moving from Priority to Emergency”. In the plan, the Office of the President will oversee progress by establishing and updating the dashboard through a focal person. The first update is planned at end of May 2012. The programme will develop a reporting system to engage district and provincial governors.

The polio-free status of 21 countries is maintained. However some countries are at high risk of spread following importation. These include Djibouti, Libya, Somalia, Sudan, South Sudan, Syrian Arab Republic and Yemen.

Yemen is facing multiple challenges of insecurity, low routine immunization and cVDPVs. Two NIDs have been conducted, one in November 2011 using bOPV and the second in January 2012 using tOPV. As well, tOPV was added to measles campaigns conducted in March and April 2012. The next NID is planned in May 2012.

In Somalia, inaccessibility in central and southern regions is a big challenge and around 1 million target children are inaccessible. Due to low routine immunization coverage, cVDPVs in Somalia are another issue. NIDs and child health days were conducted in February, March and April, but only in accessible areas.

The Horn of Africa TAG emphasized the need for 6-month emergency action plans and the use of every opportunity to provide OPV doses, particularly in high-risk areas and groups. It endorsed the use of risk assessment models. It also emphasized the implementation of recent acute flaccid paralysis (AFP) surveillance review findings and continued contact sampling in high-risk countries and groups.

In the Syrian Arab Republic, if the current situation continues, population immunity may be affected due to disturbance in the immunization services. Supplementary immunization activities are planned for high risk populations in March/April 2012. The challenge will be the continuity of routine immunization services.

Maintaining the status of polio-free countries is continuously monitored through the regional risk assessment methodology. The key surveillance indicators namely non-polio AFP rate and percent adequate stools, are satisfactory at national level but subnational levels indicate gaps in some countries.

## 3. INTERREGIONAL COORDINATION

### 3.1 African Region

*Dr M. Salla, WHO/AFRO*

In 2011, a total of 350 cases (285 type 1 and 65 type 3) were reported from 12 countries in the African Region, with Chad and Democratic Republic of Congo accounting for 64% of the cases. Nigeria, after a 96% decrease in cases in 2010 as compared to 2009, experienced a 4-fold increase in 2011 over 2010. The last reported case due to wild poliovirus type 3 (WPV3) in 2011 in Africa was reported from Angola on 7 July 2011.

High level advocacy visits to priority countries were conducted during 2011 by the WHO Director-General and Regional Director for Africa, UNICEF Executive Director and Mr Bill Gates. As well, the engagement of all polio partners (WHO, UNICEF, CDC, Rotary International and Bill and Melinda Gates Foundation) was reaffirmed. In September 2011, Member States of the WHO African Region adopted a resolution declaring polio as a national public health emergency. This was translated into surge capacity in the 4 priority countries (Angola, Chad, Democratic Republic of Congo and Nigeria). The Regional Director for Africa convenes a quarterly consultation with the 4 countries and follows up implementation

of the emergency action plan through a monthly progress report submitted by WHO Representatives.

The remaining challenges in some countries of the African Region include low population immunity, inadequate translation of the high level political commitment into action at lower, particularly the delivery levels, security concerns and inadequate cross-border collaboration.

### 3.2 European Region

*Dr E. Gavrilin, WHO Regional Office for Europe*

In 2010 the WHO European Region faced an outbreak of poliomyelitis after 13 years since the last indigenous case in 1998. The outbreak was first reported by Tajikistan and was found to be due to a WPV1 closely linked to circulating viruses in India and resulted in 457 cases with 29 deaths. It spread to Kazakhstan (1 case), Russian Federation (14 cases) and Turkmenistan (3 cases). The last case of this outbreak was reported from Russian Federation on 25 September 2010. In response supplemental immunization campaigns were conducted in the affected countries and also in Kyrgyzstan and Uzbekistan, where more than 45 million doses of OPV were used.

Routine immunization services are well established with high coverage of 3 doses of polio-vaccine in the vast majority of Member States. Countries are also conducting outreach immunization services for socially isolated, internally displaced and refugee populations, particularly in association with the European immunization week.

Surveillance for poliomyelitis is strong with most countries (42) relying on AFP surveillance, 38 relying on enterovirus surveillance and 21 conducting environmental surveillance. A large laboratory network is supporting surveillance with all polio laboratories having passed the accreditation levels of virus isolation and intratypic differentiation and in 2011, 98.5% were fully accredited.

The main concerns in the Region include the presence of some underperforming districts with regard to vaccination in several countries and a declining trend in the quality of AFP surveillance and in the work of National Certification Committees.

The risk of transmission of polioviruses following importation remains low for the region as a whole. However, ten countries and one subnational region are assessed to be at high risk and another seven countries at medium risk.

### 3.3 South-East Asia Region
*Dr P. O'Connor, WHO Regional Office for South-East Asia*

Tremendous progress occurred in the region with the last case of endemic transmission reported on 13 January 2011. As a result, India was removed from the list of endemic countries on 25 February 2012 and now the region is on track to be certified polio free in January 2014.

This success has not come easily and there has not been one single national approach. Several lessons can be learned from the success in India:

- Strong government ownership from local to national. The Government of India has taken leadership in providing personnel and financial support;
- Close partnership between government agencies, WHO, UNICEF, nongovernmental organizations and local populations;
- Focusing on quality and accountability; and
- Creating high public demand for polio immunization.

The main challenge in the region is to maintain the present achievements.

### 3.4 Western Pacific Region
*Dr R. Sigrun, WHO Regional Office for the Western Pacific*

The WHO Western Pacific Region was declared polio free in October 2000. The recorded importations that occurred in 2006 from Nigeria to Singapore and in 2007 from Pakistan to Australia did not result in any secondary cases. Also the cVDPV outbreaks that occurred in Philippines (2001), China (2004) and Cambodia (2005–2006) were brought quickly under control. Countries of the region maintain a strong awareness of the need for continued effort to maintain the polio free status guided by the regional strategic plan 2008–2012.

The majority of countries report national polio coverage over 90% but subnational coverage gaps exist. Of the 36 countries, 16 are using inactivated poliovaccine (IPV). The quality of surveillance is waining since declaration of the polio free status; however most countries are maintaining the minimum AFP rate. Four countries (Cambodia, Laos, Papua New Guinea and Philippines) are graded at high risk of spread following importation.

An outbreak was reported by China in August 2011 with date of onset of paralysis from early July 2011, resulting in a total of 21 cases. Eleven of these cases were among adults (19−53 years). The outbreak was the result of an importation from Pakistan. National response was quick and over 4 million children were vaccinated and a second round was conducted after 4 weeks. These rounds targeted mainly children under 5; in some areas the target age was under 15. Additional rounds targeting over 4.8 million aged 15−39 were carried out. A third immunization round for all these age groups was carried out after one month and a fourth round after 4 months and another round is planned.

The main challenges relate to the delay in global eradication which has resulted in loss of institutional memory. As well other challenges including SARS, H5N1 and H1N1 have led to shifting priorities and significant reduction in external financial resources.

## 4. VACCINE-DERIVED POLIOVIRUSES AND THEIR STATUS IN THE REGION

Vaccine-derived polio viruses (VDPVs) are rare, but have serious implications for the polio eradication initiative. With the decrease in wild poliovirus circulation, there is more focus on VDPVs which are in fact adverse events associated with the use of OPV. Historically Sabin virus type 1 and type 3 with ≥ 1% nucleotide divergence (≥ 10) nucleotides in VP1 sequence are classifies as VDPV of the same serotype. Since 2010, Sabin virus type 2 with ≥ 0.66% nucleotide divergence (≥ 6 nucleotides) in VP1 sequence are classified as VDPV. The following are types of VDPVs.

- iVDPV: detected among cases of immunodeficiency and usually associated with long-term excretion of the virus from the same patient.
- cVDPV: >1 paralytic case (evidence of circulation) with isolation of related but non-identical viruses.
- "Other" VDPV (aVDPV – ambiguous VDPV): single isolate with no immunodeficiency in patient; environmental source without cases.

The iVDPVs detected in the Region have been isolated from immunodeficient children in Egypt, Islamic Republic of Iran, Iraq, Kuwait, Morocco, Saudi Arabia, Tunisia and Yemen. Most of iVDPVs are type 2, only Egypt and Tunisia have reported one case each type 1 and type 3. The cVDPVs outbreaks have been reported in Afghanistan (2009–2011), Somalia (2008–2011) and Yemen (2011).

In Afghanistan, data might suggest that there was circulation in 2009 but no obvious epidemiological evidence was found at that time. In 2010 there was clear evidence of circulation in Hilmand province. The last case of cVDPV2 was reported from Nad Ali in January 2011 which was related with 2010 circulation.

In Somalia, a total of 19 cases of cVDPV2 have been reported from 2008 to 2011 in the central and south zones, which have had no NIDs or child health day campaigns since 2010 due to local authority refusal to allow vaccination campaigns. This has led to low population immunity which in turn resulted in continued circulation of cVDPVs in these areas. The last cVDPV2 was isolated in July 2011.

In Yemen, since April 2011, nine cVDPV2 have been isolated from cases/contacts from Sa'dah, Ibb, Sana'a City and Amran governorates. They represent three independent emergences of cVDPV2: Sa'dah group is one emergence and clearly represents circulation; Amran group consists of two contacts and is from a separate emergence; Aljawf virus is another emergence without evidence of circulation at this point (only one virus isolated). The potential turmoil and inaccessibility and discontinuation of immunization activities have led to low population immunity.

The aVDPVs isolated from the Region were detected in sewage wastewater samples in Egypt (aVDPV1 and aVDPV2) and from one AFP case each in the Syrian Arab Republic (aVDPV2) and South Sudan (aVDPV2).

The most important risk factor associated with emergence of cVDPVs is low levels of immunity against polio viruses which may result from low routine immunization or stopping of polio supplementary immunization activities, but continued use of OPV. Emergence of VDPVs will only stop after cessation of OPV immunization as soon as wild polio viruses are eradicated.

Upon discovery of a VDPV, an exhaustive epidemiological and clinical investigation should be carried out to determine the cause and type of VDPV. This should include clinical and immunologic assessment of the case; immunization coverage in the area and review of the quality of surveillance including retrospective record review; active search for missed cases and contact and follow up sampling to assess circulation. Laboratory investigation should be carried out to determine the genetic characteristics to track the possible source or relatedness of viruses. These investigation's results will guide further intervention. In case of cVDPV, mop-up campaigns are needed but in case of iVDPV or aVDPV action will depend on immunization coverage data. Immunization response to cVDPV should be initiated immediately and all national and international partners informed. Immunization response depends on extent of the outbreak, but in principle it should be large.

## 5. DISCUSSION OF REPORTS

### 5.1 Abridged annual updates

#### *5.1.1 Bahrain, Egypt, Islamic Republic of Iran, Iraq, Kuwait, Lebanon, Libya, Morocco, Oman, Palestine, Qatar, Saudi Arabia, Syrian Arab Republic and Tunisia*

The RCC acknowledged the comprehensiveness, accuracy and completeness of the reports. A few comments made on each of them will be relayed to the chairpersons of the NCCs. The RCC decided to provisionally accept the reports. Formal acceptance will be made upon receipt of the amended reports taking into consideration the comments of the RCC.

#### *5.1.2 United Arab Emirates*

The RCC shared the conclusions of the NCC with respect to the population figures. However this meant that some of the basic rates required for certification such as AFP and routine immunization at subnational levels were either not calculated or did not reflect the realities on the ground.

The RCC noted that parts of the report needed to be re-written to be in line with the requirements of certification, such as the executive summary, and also noted the need for recalculation of some of the rates.

In order to receive RCC acceptance, the NCC is requested to re-submit the report taking into account the comments of the RCC which will be relayed to the Chairman of the NCC in a letter from the chairman of the RCC.

*5.1.3 Djibouti*

The RCC acknowledged the frankness of the report and the details of shortcomings and weaknesses in surveillance, including low stool adequacy and the inability to reach to the final diagnosis of any of the AFP cases. The NCC is not confident that Djibouti is polio free.

The RCC therefore did not accept the report and endorsed the recommendations of the NCC to continue efforts which have already started to improve surveillance. The comments made by the RCC will be relayed to the Chairman of the NCC to take into account in preparing future reports. The RCC requested WHO to continue to support the efforts being made to strengthen technical capabilities of the programme especially with respect to surveillance. It also called on all polio partners to continue their support to ensure implementation of at least two rounds of NIDs annually as recommended by the Horn of Africa TAG to boost the population immunity levels and hence prevent any spread following importation, particularly as Djibouti is at high risk of importation. The RCC expects to receive a report during its meeting next year.

### 5.2 Final national documentation for regional certification of Yemen

Recognizing the significant value of the data that should appear in the final national document, the RCC did not accept the document submitted as it did not comprehensively and accurately cover all items expected to be included in the final national document. It requested the NCC Chairman to review the document using available data at the national level and if needed seek WHO assistance in obtaining more data. The RCC will review the final national document during its meeting next year.

### 5.3 Annual updates of Sudan, South Sudan and Somalia

The RCC acknowledged the efforts made by the programmes in maintaining polio free status. There were few comments made on each of the reports which will be relayed to the chair of the NCC of Sudan and the responsible officers from WHO in Somalia and South Sudan. The RCC decided to provisionally accept the reports. Formal acceptance will be made upon receipt of the amended reports taking into consideration the comments of the RCC.

## 6. OTHER MATTERS

### 6.1 NCC meetings

The RCC noted that the NCCs differed in the number of meetings held and the dates of these meetings and recommended that the NCC should hold at least two meetings. One should be held upon return from the RCC meeting and receipt of the comments of the RCC on the national report. This meeting would essentially reflect to the NCC members the

comments and observations of the RCC on the report and other matters discussed during the RCC meeting. It can also review the amended report before sending it to the RCC. The second meeting should be held before submitting the next report to the RCC. This meeting would review the report to ensure that it satisfies all the requirements as per guidelines.

The RCC encourages holding additional meetings in between the above mentioned two meetings as and when required in response to the responsibilities of the NCC.

### 6.2 Formats of the reports

It was noted that some of the reports submitted by the NCCs were changed from the standard format, mostly by deleting some of the text or modifying some of the tables.

The RCC strongly advised that no change should be made in the format and that the preambles of each section should be maintained and carefully read before preparing the relevant section and taken into consideration in the answers.

The RCC specifically emphasized that the executive summary should include all the items spelled out in the preamble. It expressed surprise that most of the countries which had experienced significant political and security situations during 2011 did not refer to the impact of these developments on national polio eradication activities.

The RCC reiterated its previous recommendations that all the text and replies provided by the NCCs should be written in a different format to facilitate review (e.g. bold or in italic).

The RCC recommended some modifications in the formats of the annual and abridged annual reports and final national documentation and requested the secretariat to update them accordingly. These changes are meant to cover important additions such as for example cVDPVs and some amendments in the text of some items to overcome ambiguity. It also agreed that these formats would be translated to French and Arabic but required that the reports continue to be submitted in English.

### 6.3 National expert groups

The RCC noted that in some countries the national expert groups have not been adequately involved in the classification of cases. The guidelines specify that the AFP cases to be referred to national expert groups must at minimum be those cases that have inadequate stools and residual paralysis, are lost for follow-up or die.

The RCC recommended in its 24th meeting that the national expert group should review at least all cases with inadequate stools. It further recommended that the national programme refers to the national expert group 5%–10% of AFP cases diagnosed by the programme and discarded as a check to the quality of the diagnosis.

### 6.4 AFP cases diagnosed as traumatic neuritis

The RCC noted with great concern that, in some countries, traumatic neuritis mainly caused by improper injection practice is the cause of a large proportion of cases of acute flaccid paralysis mostly ending in residual paralysis. It calls on the NCC chairpersons and national EPI managers to give this matter their utmost attention and draw attention of national authorities efforts to minimize this problem.

### 6.5 Definitions

The RCC noted from some of the reports that some basic definitions of items used in the reports do not appear to be followed. The RCC therefore requested the secretariat to redistribute to all NCC chairpersons the glossary section in the basic document after updating it with additional items and called on the NCCs to strictly follow them in preparing their reports.

Upon the request of the chairpersons of the NCC, the WHO secretariat is requested to also provide them with the methodology of risk assessment.

### 6.6 Date and venue of next meeting

The RCC recommends that its next meeting be held on 2–4 April 2013. The Secretariat is requested to make arrangements for a 2-hour session between members of the RCC and NCC chairs at the beginning of the meeting. The RCC recommends that the venue of this meeting be either Egypt or Lebanon.

**Annex 1**

## PROGRAMME

**Tuesday, 3 April 2012**

| | |
|---|---|
| 08:30–09:00 | Registration |
| 09:00–09:30 | Opening session |
| 09:30–09:45 | Introductory Remarks, Dr A. Jaffer, Chairman of RCC<br>Welcoming remarks by H.E. Minister of Health<br>Message from Dr Ala Alwan, Regional Director, WHO/EMRO<br>Adoption of Agenda<br>Implementation of the recommendations of the 25th RCC meeting |
| 09:45–10:30 | Regional overview |
| 10:30–11:15 | Discussion on regional situation |
| 11:15–12:15 | Inter-regional coordination<br>WPR (China outbreak)<br>SEAR (India success story)<br>EUR (Tajikistan outbreak)<br>AFR |
| 12:15–12:30 | Discussion |
| 12:30–14:30 | Presentation and discussion of abridged annual update reports of the United Arab Emirates, Bahrain and Djibouti |
| 14:30–16:00 | Presentation and discussion of abridged annual update reports of the Egypt, Iran and Iraq |
| 16:00–17:00 | Private meeting of the RCC |

**Wednesday, 4 April 2012**

| | |
|---|---|
| 08:30–09:30 | Status of VDPVs in EMRO |
| 09:00–10:00 | Presentation and discussion of the final national document for regional certification of Yemen |
| 10:00–11:30 | Presentation and discussion of abridged annual update reports of the Kuwait, Lebanon and Libya |
| 11:30–14:05 | Presentation and discussion of abridged annual update reports of Morocco, Palestine and Qatar |
| 14:05–15:35 | Presentation and discussion of abridged annual update reports of Saudi Arabia, Syrian Arab Republic and Tunisia |
| 15:35–16:35 | Private meeting of the RCC |

**Thursday, 5 April 2012**

| | |
|---|---|
| 09:00–09:30 | Private meeting of the RCC |
| 09:30–09:40 | Presentation and discussion of abridged annual update report of Oman |
| 09:40–11:40 | Presentation and discussion of annual update reports of Somalia, Sudan and South Sudan |
| 11:40–12:10 | Private meeting of the RCC |
| 12:10–13:10 | Closing session and concluding remarks |

## Annex 2

## LIST OF PARTICIPANTS

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