

**Summary report on the  
AFP surveillance  
and polio laboratory  
coordinators  
intercountry meeting –  
Group (B)**

Muscat, Oman  
10–12 May 2022



**World Health  
Organization**

REGIONAL OFFICE FOR THE **Eastern Mediterranean**

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## **1. Introduction**

One of the strategic objectives of the global Polio Eradication Strategy (PES) 2022–2026 is to improve detection and response through sensitive surveillance. The Global Polio Surveillance Action Plan (GPSAP) 2022–2024 lays out significant changes to surveillance operational strategies, including for acute flaccid paralysis (AFP), environmental and laboratory surveillance. This requires an understanding of the changes and their adaptation to the regional context, in addition to the actions needed to implement the strategies.

To support the effective implementation of the new strategies and related action plans, an intercountry meeting was held by the WHO Regional Office for the Eastern Mediterranean on 10–12 May 2022 in Muscat, Oman. The meeting was attended by representatives from 11 countries/territories of the WHO Eastern Mediterranean Region, including Bahrain, Egypt, Kuwait, Lebanon, Morocco, the occupied Palestinian territory, Oman, Qatar, Saudi Arabia, Tunisia and the United Arab Emirates. In addition, representatives attended from the Regional Commission for the Certification of the Eradication of Poliomyelitis (RCC), Oman’s national certification committee (NCC) and the US Centers for Disease Control and Prevention (CDC), as well as WHO staff from headquarters, Regional Office and country office levels.

The objectives of the meeting were to:

- introduce the new surveillance strategies, tools and standards in view of the PES 2022–2026 and GPSAP 2022–2024;
- strategize action plans for enhanced surveillance for each of the Member States, with an immediate priority of training subnational surveillance-related personnel; and
- contribute to the process of integration.

Dr Hamid Jafari, Director of Polio Eradication, WHO Regional Office for the Eastern Mediterranean, thanked the Government of Oman and His Excellency Dr Ahmed Bin Mohamed Bin Obaid Al Saidi, Minister of Public Health, for hosting the meeting and supporting the polio eradication programme in the Region. He also thanked Dr Jean Jabbour, WHO Representative in Oman, for his support. Dr Jafari stressed that the meeting was critical for achieving a highly efficient and sensitive AFP surveillance system, particularly among high-risk and underserved population subgroups, coupled with a supplementary surveillance system that includes both environmental surveillance (ES) and immunodeficiency-associated vaccine-derived poliovirus (iVDPV) surveillance, which have become ever more important as we move closer to interruption of all poliovirus transmission.

Dr Alaa Hashish, Medical Officer at the Oman WHO country office, representing Dr Jean Jabbour, welcomed participants and acknowledged the support of Oman's Ministry of Health. Dr Mohammed Saif Sultan Al Hosni, Undersecretary for Health Affairs in Oman, also welcomed participants, noting the danger of the introduction and spread of poliovirus and the challenges for AFP surveillance in Oman and other countries. Dr Bader Al Rawahi, Director of the Infectious Diseases Control Department at the Ministry of Health of Oman was selected as Chairperson of the meeting.

## **2. Summary of discussions**

### *Update on the epidemiology of poliomyelitis and regional priorities and strategies*

Globally, all wild poliovirus type 1 (WPV1) isolates, except for a case in Malawi, are reported from a single epidemiological block comprising Afghanistan and Pakistan, while circulating vaccine-derived poliovirus (cVDPV) is being reported in areas with low subnational population

immunity. However, all countries remain at risk of importation of WPV1 and cVDPVs. The international spread of poliovirus (PV) is evidenced and experienced by many countries within and beyond the Eastern Mediterranean Region.

The Region faces many challenges including ensuring sustained and uninterrupted access to all children for polio vaccination in Afghanistan, Somalia and Yemen, the health, humanitarian and economic crises in Afghanistan, a political transition in Pakistan that may be associated with a loss of momentum for polio eradication activities, and funding constraints on sustaining essential polio functions in 2023. Based on the challenges, the regional strategic priorities include: eradicating WPV1 in Afghanistan and Pakistan and sustaining political commitment in Pakistan; continuing progress towards full house-to-house vaccination and preventing collapse of the health system in Afghanistan; stopping the ongoing outbreaks of cVDPV in the Region; ensuring a swift response to any new outbreak; implementation of the Somalia Emergency Action Plan launched at the Somalia Summit in March; continuing advocacy for vaccination campaigns in Yemen, particularly in the northern region; and sustaining surveillance for PV and outbreak response capacity for countries at risk of polio outbreaks and countries under polio transition, by successful operationalization of the integrated public health teams approach.

#### *Existing surveillance systems in countries of the Region*

The main surveillance systems in place in the Region include the Early Warning, Alert and Response Network (EWARN), measles and rubella surveillance, sentinel site surveillance and PV surveillance. Through these systems, 33 outbreaks were reported from 12 countries in the Region between 2020 and 2021, with 80% of these outbreaks reported in countries affected by fragility, conflict and violence.

The Region's surveillance systems face many challenges, which include: maintaining adequate performance under adverse situations; insufficient resources for maintenance of systems, including inadequate human resources; security situations that negatively affect the implementation of surveillance activities; inadequately established case-based surveillance systems; weak coordination between surveillance units, the expanded programme on immunization (EPI) and laboratories; and limited use of surveillance data for timely action-taking and effective interventions.

Despite the multiple surveillance systems in the Region, potential exists for overall integration or among some parts. Although the PV surveillance system is well-developed, the sustainability of the system requires integration to reduce expenditure and decrease the burden on health systems.

#### *Overview of the GPSAP*

The GPSAP had been developed taking into account epidemiology, the impact of the COVID-19 pandemic on surveillance, subnational surveillance gaps and the transition of polio-specific activities in countries. The plan addresses AFP, ES and iVDPV surveillance, laboratory, data and information management, and management and accountability. New indicators include: timeliness of detection (> 80% of polioviruses confirmed and sequenced within 35 days of onset of the case or ES sample collection); subnational surveillance quality, including the non-polio AFP (NPAFP) rate, stool adequacy and ES; gender-related aspects in each area of work; and integration of identified areas at every stage of the process. Countries are prioritized based on risk assessment into very high-risk, high-risk and medium-high risk. Priority countries should focus on the activities identified in each section of the GPSAP. These activities have measurable core and non-core indicators with targets that are expected to be achieved.



### *Data management*

Objective 5 of the GPSAP is to increase efficiency in collecting, managing and using data for action. The rapid collection and processing of quality surveillance data is critical for real-time data and can only be achieved by shifting to a web-based information system, as well as moving towards electronic and mobile data collection tools and systems. The main obstacles to this include the lack of standardization across different platforms, which does not support data comparison, and the absence of a well-developed system for specimen tracking from the field to the laboratory.

The indicators to be measured and monitored are categorized into core and non-core indicators. All indicators must be analysed on a quarterly basis, except the core indicators in priority countries, which must be analysed on a monthly basis. WHO analysis shows that multiple countries are missing the subnational surveillance performance indicators outlined in the GPSAP. The timely reception by WHO of the revised and complete databases from countries in the recommended format is critical to ensuring accurate and consistent information-sharing. Shifting to electronic systems will enable WHO regions to standardize analyses. WHO is expected to share a revised case investigation form to support data analysis for the required indicators as well as any other indicators that may require adjustment and/or addition to the database. Training for data managers on the calculation of new indicators is planned for October 2022.

### *Update on iVDPV surveillance*

WHO has been leading studies on iVDPV surveillance with the support of the regional laboratory network in Egypt, Islamic Republic of Iran and Tunisia, who are pioneers in this area. In Tunisia, while there is no

regular surveillance of PV or enterovirus excretion in immunodeficient patients, studies were conducted as a collaboration between immunology laboratories, WHO and CDC in 1997, 2009–2010 and 2014, that contributed to the establishment of global and regional guidelines for iVDPV surveillance among patients with primary immunodeficiency.

Objective 6 of the GPSAP is to establish iVDPV surveillance to sustain polio eradication, and iVDPV surveillance is becoming more prominent in the certification and post-certification stages. Significant activities were undertaken in 2021 to integrate iVDPV surveillance into PV surveillance. Pilot testing has discovered several implementation challenges, particularly for information management systems. However, iVDPV surveillance is ready to be implemented according to each country's willingness and risk categorization. Formal approval and communication from the ministry of health is needed to initiate the surveillance.

#### *Risk assessment and country categorization*

Risk assessment is performed at the first administrative level every 6 months for all countries, excluding polio endemic countries (Afghanistan and Pakistan). The aim is to provide programmatic prioritization of countries through assessing: susceptibility (risk of importation-associated outbreak/transmission of WPVs and/or emergence of cVDPVs); sensitivity (risk of missing or delayed detection of PV circulation); and other factors (security, accessibility, other vaccine-preventable disease outbreaks, etc).

A 2021 risk assessment analysis found eight countries in the Region to be low performing (Djibouti, Iraq, Lebanon, Morocco, Somalia, Sudan, the Syrian Arab Republic and Yemen), with Iraq, Somalia, Sudan and

Yemen good in surveillance but average for susceptibility and other factors. In Somalia, surveillance is very good, but susceptibility and other factors are average, and the proportion of zero and less than expected doses is high, especially in south Somalia. In Morocco, susceptibility and other factors are good, while surveillance is extremely poor. Insecurity was found to be persistently high in Iraq, Somalia, Sudan, Yemen and the Syrian Arab Republic (in nine provinces compared to 12 in 2020). The enterovirus isolation rate is below the benchmark in most countries, except Egypt, Somalia, Sudan and Yemen (despite delayed stool shipment in Yemen). Morocco and Tunisia did not achieve both key surveillance indicators (NPAFP rate and stool adequacy) in 2021, and the proportion of zero dose children (NPAFP aged 6–59 months) reported was high in Somalia (12%) and Yemen (12%).

Continuous monitoring of the main surveillance indicators is needed on a weekly basis and risk assessment twice per year. A surveillance enhancement plan will be developed for low performing countries and a surveillance review conducted for high priority countries (Lebanon, the Syrian Arab Republic and Yemen). ES will be initiated, expanded and rationalized in countries, and outbreak preparedness and response plans improved, and polio outbreak simulation exercises (POSE) implemented in all high priority countries. Risk assessments will be revised through the addition or removal of variables as necessary.

#### *Handling inadequate AFP cases*

Inadequate AFP cases should be given careful attention with regards to contact sampling, investigation, 60-day follow-up examination by a paediatrician and case presentation to the expert review committee (ERC).

The key steps to be taken for dealing with an inadequate AFP case are:

- obtain three contact samples from healthy children, preferably below five years or age-matched and ‘true contacts’;
- determine in consultation with a clinician whether polio can be ruled out from the AFP case on overall assessment at the time of initial investigation or not;
- if not, label case as urgent/hot and complete detailed epidemiological investigation, including 30 household surveys;
- determine the reasons for the case inadequacy and take actions accordingly;
- ensure a 60-day follow up examination is done by a clinician to rule out the presence or absence of residual paralysis or weakness and document in detailed clinical notes: if no residual paralysis/weakness, record the final diagnosis; if residual paralysis/weakness is present, complete the case file and present the case for review by the ERC; and
- review of the case by the ERC for classification and, if discarded, final diagnosis.

### *Novel oral polio vaccine surveillance criteria*

Novel oral polio vaccine (nOPV) is now the vaccine of choice for preventing cVDPV2 transmission. However, the quality of the campaign(s) conducted remains key. Countries should fulfil the preparation criteria as soon as possible. The criteria have been reduced as the novel vaccine has entered into wider use under emergency use listing (EUL) phase C. nOPV2 preparedness has been completed in eight countries of the Region, namely Afghanistan, Djibouti, Egypt, Iran (Islamic Republic of), Iraq, Pakistan, Somalia and Sudan, and is underway in three countries (Jordan, Lebanon and Libya). The vaccine was used in Egypt in December 2021, the first instance in the Region, followed by Djibouti in 2022. Analysis of the results of nOPV2 monitoring and performance assessment in the field throughout the

EUL period is in progress and no red flags regarding vaccine safety or genetic stability have been reported.

### *Surveillance strategies in hard-to-reach areas and populations*

There are challenges to surveillance in hard-to-reach areas and populations that have an impact on immunization. It is important to identify these areas/populations, assess challenges and opportunities, develop plans and activities, document actions taken, and monitor and evaluate activities and progress. Various strategies exist for dealing with these situations, including negotiation and coordination with stakeholders, ad-hoc active case searches and community-based surveillance, targeted healthy children surveys (limited to special cases), ES and others. Hard-to-reach populations and areas play a significant role in the epidemiology of polio and the risk of undetected PV transmission. It is essential to develop specific plans, operational tactics and data collection/analysis to ensure the programme's reach to these geographies and/or population groups.

### *Shipment of AFP/environmental samples*

Travel embargos impacting shipment of samples due to COVID-19 and geopolitical complexities have led to the delayed detection of polio outbreaks and response, including in Sudan and Yemen. Proactive planning for anticipated challenges, identifying alternate routes and facilities, and use of technology in certain situations have all been helpful in dealing with this. Effective communication between all parties involved (sender, carrier and receiver) is vital. Samples are expected to be adequate and should reach the laboratory in good condition, with maintained reverse cold chain, within three days of second specimen collection date. Many approaches can help to achieve this, as well as to track and monitor sample shipments, including end-

to-end coordination, alternative routes/means of transport and storage, using log tags and adjusting analyses based on the situation.

### *Experience of working with samples from Yemen*

The workload of the Oman laboratory has been increasing since confirmation of the Yemen outbreak in 2020 and has increased further in 2022, with 1443 samples processed to date compared to 1928 samples in 2021. The average number of samples processed in 2017–2019 was 365 samples per year. WHO has provided the laboratory with additional human resources support from the Pakistan laboratory, which has been instrumental in the timely processing and finalizing of samples. For a sample from Yemen to reach the Oman laboratory, which is approximately 3000 km away from Yemen by road, it takes almost 40 hours (29 hours within Yemen and another 11 hours within Oman). Additionally, it requires several clearance letters for the Yemeni/Omani borders. Challenges include: truck breakdown and fridge failure; the need for several border clearances; the unknown timing of arrival; increased laboratory workload and limited storage capacity within the laboratory; the support being given to other public health activities, including COVID-19 testing by the laboratory; maintaining laboratory quality; and handling PV2 and the need for destruction.

### *Integration of polio surveillance*

Currently, surveillance activities at the WHO Regional Office are performed within many departments, including polio. An opportunity exists to pool resources and systems for effective and efficient integrated disease surveillance. Integration is needed of both surveillance functions and health information systems. Implementation of the WHO global strategy for comprehensive vaccine-preventable disease (VPD) surveillance and the documentation of country and regional best

surveillance practices, with examples from other WHO regions (Western Pacific Region and African Region), will help support this integration.

The various challenges and potential solutions to them are outlined in the table below.

| <b>Challenges</b>                       | <b>Solutions</b>  |
|---|---|
| Insufficient political commitment       | Ensure political commitment                                     |
| Uncoordinated vertical programmes       | Coordination, efficiency analyses                               |
| Variable standards and systems          | Technical convergence and harmonization                         |
| Lack of resources, inefficiencies       | Pooling of resources, elimination of duplication                |
| Insufficient data analysis              | Capacity-building   |
| Weak laboratory links                   | Public health laboratory policy, linkage                        |
| Limited monitoring and evaluation       | Monitoring and evaluation framework, key performance indicators |
| Limited use of information technologies | Consolidated digital platform                                   |

### *Integration of laboratory surveillance*

An accredited regional laboratory network supports PV surveillance activities in the Region. Two direct-detection laboratories will soon be established in Afghanistan and Yemen. The polio laboratory network was leveraged during the COVID-19 pandemic. As a result, numerous surveillance and laboratory staff were infected with SARS-COV-2, including four colleagues who sadly died.

To coordinate laboratory integration, agreement at the programme-level and advocacy at the country-level is needed to ensure governmental ownership and commitment. An initial step should be the mapping of the assets and needs of the integrating programmes and then a plan should be agreed for the transition, including the upgrading of laboratories and staff training in polio laboratory methods.

### *Outbreak response SOPs*

There are new definitions for events and outbreaks within the new outbreak response standard operating procedures (SOPs). Field investigation is a critical step to classify an event or an outbreak. It is important to note that an event does not mean that there is no risk of outbreak. The field investigation must be coupled with a risk assessment and followed by an immunization response, actions to improve surveillance sensitivity and a communication plan.

### *Regional Incident Management Support Team*

The regional Incident Management Support Team (IMST) aims to guide, support and coordinate country-led efforts to prepare for, respond to and close polio event and outbreaks. The Team also serves as a point of contact between country focal points and the broader GPEI structure.

### *Polio surveillance enhancement plan template*

Participants were subdivided into three country groups to discuss and draft plans. The groups were: Egypt, Morocco, occupied Palestinian territory and Tunisia; Kuwait, Lebanon and Saudi Arabia; and Bahrain, Oman, Qatar and United Arab Emirates. The groups then presented their draft plans for further discussion.

## **3. Conclusions and next steps**

- Ensuring an efficient, sensitive, comprehensive and responsive field and laboratory surveillance system is the main priority and this can be achieved through working on the GPSAP priorities.
- WHO is requested to update the template of the PSEP and share the updated version with countries by the end of May 2022, and to ensure that a PSEP is developed by all countries.



- The highest priority should be given to the essential immunization programme, polio outbreak preparedness and response plan, and POSE.
- The required frequency of indicator monitoring for priority countries is monthly for core indicators and quarterly for non-core indicators; for non-priority countries, the reporting should be done quarterly for all indicators.

### *Integration of surveillance*

- Integration is vital for having an efficient and sustainable surveillance system and should be taken into consideration at all levels and by all stakeholders.
- It is essential to map field and laboratory surveillance systems in countries and identify convergences.
- Suggested entry points for integration include: coordination between focal persons for AFP and VPDs at the different levels to ensure integrated reporting forms, databases, indicators, reviews, meetings and action taking; a unified laboratory approach; the periodic sharing of regional/national updates on diseases of concern (e.g. polio and measles); and the development of a comprehensive and integrated disease outbreak preparedness and response plan.

### *GPSAP*

- Risk assessment and periodic analysis remain critical for evidence-based decision-making and strategizing priorities and programmatic action(s). WHO will continue to share the biannual risk analysis with countries, while updating the risk assessment to include risk of emergence of VDPVs. Member States are expected to continue current periodic risk analysis using information for

action (IFA) modules and provide timely and complete risk assessment data to WHO.

- iVDPV surveillance will be critical for certification and post-certification. Both Egypt and Tunisia are requested to provide historical data and facilitate visits to test the proposed information management systems. Member States interested in initiating iVDPV surveillance are advised to send an official communication (e.g. Bahrain, Oman and Saudi Arabia).
- Member States are expected to review GPSAP priorities, including timeliness of detection, assessment of subnational level performance and analysis of indicators according to timelines, and look for areas of potential integration.
- WHO is expected to: provide an electronic system for surveillance (WebIFA) during 2022–2023 and transfer at least 5 years of historic data from the legacy IFA system to the new electronic system; provide suggested revisions of the case investigation form to support data analysis for the required indicators; and coordinate with departments for vaccine-preventable diseases and health emergencies for potential areas of integration.
- Member States are expected to: brief the leadership and team members on the salient features of the GPSAP; map out the digitalization of data collection and analysis tools used in the country for surveillance systems; plan to update national surveillance guidelines once the global and regional surveillance guidelines are available; and plan to conduct external surveillance reviews and POSE during 2022–2023.

#### *Surveillance, outbreak response and nOPV*

- Inadequate AFP cases should be given careful attention and the guidelines strictly followed.

- Special plans should be developed for the programme to access hard-to-reach geographies and/or population groups if needed.
- The monitoring and tracking of specimen shipment should be continued and the lessons learnt and contingency plans used during the COVID-19 response applied, as necessary.
- All Member States are expected to conduct training at all levels on the new outbreak preparedness and response SOPs (released in March 2022) to allow for the updating of national preparedness and response plans, as well as high-level orientation on VDPVs.
- Countries in process for nOPV2 verification are requested to complete their documentation, while countries that have not started preparedness are requested to communicate with nOPV2/Country Support Team focal persons for guidance on the process.
- WHO will share the available research data for comparison of nOPV2 with other PV2-containing vaccines, including safety-related data.

### *Country-specific*

- Morocco, the occupied Palestinian territory and Tunisia should investigate persistent subnational surveillance performance gaps.
- Iraq, Qatar and Saudi Arabia should implement ES.
- Oman should consider the purchase of a modular laboratory (prefabricated laboratory) in collaboration with CDC.
- Lebanon and Tunisia should develop a surveillance contingency plan to ensure surveillance functions and performance are maintained during the economic crisis and political instability.
- Gulf Cooperation Council (GCC) countries should focus more on expatriates (representing 25–50% of population) who utilize private sector health care.

#### **4. Recommendations**

##### *To all Member States*

1. Update national surveillance guidelines according to the new GPSAP 2022–2024 and global surveillance guidelines before the end of 2022.
2. Start ES initiation, expansion and rationalization.
3. Develop plans for conducting a POSE and external surveillance reviews in 2022–2023.
4. Integrate health-seeking behaviour information in the case investigation form.
5. Develop a sample tracking mechanism and software for human and environmental samples.
6. Move to electronic data collection (Web-IFA) in 2022–2023.
7. Use log tags in difficult areas.
8. Share the process adopted at national level for approval of polio surveillance action plan.

##### *To specific Member States*


9. Oman, Lebanon, Saudi Arabia and other interested countries: Initiate a plan to implement and integrate iVDPV surveillance.
10. Lebanon: Explore exporting data from the Demographic Health Information System (DHIS-2) to WHO's WebIFA.
11. Lebanon: Explore the possibility of implementing direct detection.
12. Lebanon: Purchase and install a solar system for sample storage at the national laboratory before sending of samples to the laboratory in the Syrian Arab Republic.

*To WHO*

13. Compile all country feedback and plans and develop a regional plan, with responsibilities and timelines,
14. Call for a meeting in Q4 of 2022 or Q1 2023 for countries showing progress in their plans to discuss and identify any remaining gaps or support needed.
15. Develop a dashboard for analysing and generating core and non-core indicators at the Regional Office.
16. Develop a set of slides for briefing departments within the Regional Office on the polio programme that can be used, if needed, at the country-level.

## **5. Closing remarks**

Closing remarks were delivered by Dr Ahmed Al-Mandhari, WHO Regional Director for the Eastern Mediterranean, who virtually joined the closing session and expressed his appreciation to all the participants and partners and to the Government of Oman and His Excellency, Dr Ahmed Bin Mohamed Bin Obaid Al Saidi, Minister of Public Health, for hosting the event and their unwavering support for polio eradication in the Region. Dr Al-Mandhari highlighted the importance of the meeting for achieving the goals of the GPSAP and the overarching goal of polio eradication.



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