WHO-EM/POL/258/E

Report on the

Twelfth meeting of the Eastern Mediterranean Regional Commission for Certification of Poliomyelitis Eradication

Cairo, Egypt
13–14 October 2004

World Health Organization
Regional Office for the Eastern Mediterranean

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1. INTRODUCTION

The Twelfth Meeting of the Eastern Mediterranean Regional Commission for Certification of Poliomyelitis Eradication (RCC) was held in Cairo, Egypt, from 13 to 14 October 2004. The meeting was attended by: members of the RCC; Chairmen of the National Certification Committees (NCCs) or their representatives and national programme managers from Djibouti, Egypt, Lebanon, Pakistan, Palestine, Sudan and Yemen. Other participants included: representatives of Rotary International and of the European and African Regional Commissions for Certification; staff from WHO headquarters and WHO Regional Offices for Africa and Eastern Mediterranean.

The meeting was opened by Dr Ali Jaffer Mohammad Sulaiman, Chairman, RCC, who welcomed all participants and thanked Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean, for his unstinting support and encouragement for polio eradication activities. Dr Jaffer expressed his satisfaction at the progress of the polio eradication initiative in the Region. He felt that the challenge is now to stop transmission in the remaining endemic countries and to create a barrier against importation of wild poliovirus by improving surveillance as a whole but especially in the border areas. Dr Jaffer also stressed the need to improve routine immunization in countries where the coverage rate is low.

Dr Abdullah Assa'edi, Assistant Regional Director, WHO/EMRO, welcomed the participants and delivered a message on behalf of Dr Gezairy. In his message Dr Gezairy thanked the members of the RCC for their work and dedication to polio eradication in the Region. He referred to the substantial decline in the total number of wild poliovirus cases in the Region. The political commitment for polio eradication from the highest national authorities remained strong and augured well for the final stage of polio eradication. The recent cases reported in Sudan had shown the serious threat posed by importation. Dr Gezairy welcomed the submission of national documentation from Palestine and Somalia and expressed appreciation for the efforts made by the NCCs in Egypt and Pakistan in compiling provisional reports for review by the RCC.

The programme and the list of participants are given in Annexes 1 and 2, respectively. The model format for national documentation for regional certification is given in Annex 3.

2. PRESENT SITUATION OF POLIO ERADICATION

2.1 Eastern Mediterranean Region

Overview

A summary report on the current status of the polio eradication initiative was presented by Dr Faten Kamel, Medical Officer, Polio Eradication, WHO/EMRO. During the current year (2004) up to 3 October, a total of 48 cases of wild poliovirus were reported as compared to 93 cases reported for the same period in 2003. Of the 48 cases reported in 2004, 3 were from Afghanistan, 1 from Egypt, 31 from Pakistan and 13 from Sudan (all of which were imported cases). The surveillance indicators on a regional basis have continued to meet certification standard. The non-polio AFP rate per 100 000 children under the age of 15 years was 2.41 in 2003 and the annualized rate for 2004 is 2.53. Up to 3 October 2004, adequate specimens were obtained from 80% or more of AFP cases in all countries except for Djibouti. Since the last meeting of the RCC in April 2004, AFP surveillance reviews have been carried out in Egypt, Lebanon, Libyan Arab Jamahiriya and Tunisia. Dr Kamel summarized the main weaknesses detected during the reviews and the steps recommended to overcome them. The second meeting of the Regional Technical Advisory Group (TAG) was held on 23–24 June 2004, and TAG meetings were held for Egypt (end May 2004 and mid October 2004) and for Pakistan (September 2004).

In her presentation, Dr Kamel also described the challenges facing the eradication initiative in Afghanistan, Egypt and Pakistan and the special problem of imported cases in Sudan. In Afghanistan, efforts are underway to stop transmission in the few remaining districts.

In Egypt, transmission of poliovirus appears to be geographically restricted to a few areas such as Upper Egypt, (Assiut/Minya border), from which Egypt's single case was reported in May this year. Of the 8 lineages of type 1 poliovirus found in 2002 and 3 found in 2003, only one has been detected to date in 2004. Due to a decline in the sensitivity of environmental sampling, it has been difficult to interpret the 2004 data and it is possible that ongoing transmission may have been missed. Despite this setback, there has been a marked improvement in the quality of AF surveillance. The annualized AFP rate for 2004 is 2.98 compared to 2.45 in 2003. The data from AFP cases indicate that the proportion of children between 6 months and 5 years receiving five or more doses of OPV has remained high reaching 98% in 2004. Attempts are under way to further improve the quality of supplementary immunization activities in Upper Egypt and in the greater Cairo area.

In Pakistan, of the 31 cases reported so far (the lowest ever for this period), 16 were from Sindh, 7 from NWFP and 8 from Punjab. No case has been reported from Baluchistan since October 2003. Transmission is most intense in Sindh. The quality of AFP surveillance remains very high and the system is constantly under review. There is evidence from the OPV status of non-polio AFP cases of continuing improvement in the immunization status of children under five years. However, in areas with ongoing transmission the proportion of under-immunized children, especially those under 2 years of age, remains higher than the national average. While political commitment for polio eradication remains strong and sustained, management issues at the district levels in high-risk areas persist.

Sudan had been polio free since April 2001, when in May 2004 a case was detected in Baheela, West Darfur State. The WPV 1 isolated from the case was closely related to the P1 virus of Nigeria that passed through Chad to Sudan. More cases with the same imported virus were reported from Kass locality in South Darfur State. The spread from the imported case was facilitated by the low immunity in Darfur states due to low coverage with both routine immunization and in SIAs caused by security problems. Following this, a P3 case was reported from Babanoosa in West Kordofan State in mid July 2004. Genomic sequencing data showed that the closest link to this virus was the P3 virus isolated from Sudan in 1999. This finding indicates the likelihood that circulation of P3 virus has been ongoing. The surveillance system in the northern parts of the country is well established but some gaps do exist, especially in underserved and hard to reach areas. As a response to these developments second rounds of SNIDs were carried out in Darfur and multiple rounds of high quality NIDs are planned and a surveillance review will take place in January 2005.

Dr Humayun Asghar, Virologist, Polio Eradication, WHO/EMRO summarized the activities of the poliovirus laboratory network in the WHO Eastern Mediterranean Region. The network is performing at high quality standard and all laboratory performance indicators are well above the set targets, except transportation of samples within 3 days, which is below 70%. The molecular data are routinely used to identify endemic reservoirs and importation. So far the identified genotypes are specific to the endemic countries of the Region.

In Egypt, environmental surveillance is used to increase sensitivity of the AFP surveillance. The percentage of environmental sites positive for polioviruses decreased from 57% in 2001 to 16% in 2002, 4% in 2003, and less than 1% to date in 2004. Numerous separate chains of transmission of a single genotype of WPV type 1 were detected through environmental monitoring. The percentage of positive samples in 2004 should be taken with great caution, since it was noted that there was gradual decline in isolation of polioviruses and non-poliovirus enterovirus (NPEV) starting from late 2003

and became evident since early 2004. The problem was addressed and resolved since July 2004.

The regional polio laboratory network is faced with the challenges of sustaining performance and retaining trained manpower and the availability of specific budget allocation for polio laboratories. WHO/EMRO is working closely with countries, and advocating the sustainment of certification standard quality laboratory performance and utilization of expertise of the polio laboratory network for the development of other disease surveillance programmes.

Nine of 22 countries of the Region have completed phase 1 of laboratory containment of wild polioviruses and have been requested to submit their quality assurance report on containment activities by end November 2004. Another 9 countries are near completion of phase 1 containment activities. Egypt, Palestine, Pakistan and Somalia will initiate laboratory surveys by end of the year. The Fourth Intercountry Meeting of Containment Coordinators will be held in Oman from 7 to 8 December 2004. The agenda includes issues related to OPV cessation and change in containment focus leading to the development of third edition of the Action Plan for Poliovirus Containment.

2.2 African Region

An overview of the polio eradication initiative in the African Region was provided by Dr Mbaye Salla, Medical Officer, Polio, WHO Regional Office for Africa (WHO/AFRO). The progress in the polio eradication initiative in the region, as evidenced by the number of endemic countries dropping from 32 in 1999 to only 2 in 2002, has suffered a setback by the resurgence of wild poliovirus cases in Nigeria and Niger (largely due to the controversy over OPV, and poor quality supplementary immunization activities), the importation of cases in nine polio free countries and the re-establishment of transmission (persistence of imported wild poliovirus for more than six month) in Chad, Cote d'Ivoire and Burkina Faso that has been facilitated by the low routine coverage with OPV 3, poor quality supplementary immunization activities, gaps in AFP surveillance and lack of funds for eradication activities. The resurgence of cases is being addressed through implementation of 2–3 rounds of synchronized NIDs in 23 West and Central African countries during 2004 and at least 5 supplementary immunization rounds in Nigeria and Niger during 2005 combined with 2–3 NIDs in all the 23 countries during the first six months of 2005.

Surveillance for AFP of certification standard is present in 33 countries of the region and is sub-optimal in seven. However, in several of the countries with well-established surveillance, there are gaps at the subnational level. Sixteen accredited laboratories, three of which serve as regional reference laboratories, provide laboratory

support to the eradication initiative. Thirty-two countries have established national task forces for laboratory containment and 4 countries have completed the laboratory survey and inventory. Regarding certification activities, 8 countries have so far submitted their national documents and the AFR RCC has accepted 3 of these reports.

2.3 European Region

An overview of the post certification situation of the polio eradication initiative in the European Region was provided by Professor Sergey Drozdov, Member of the RCC for the European Region. Professor Drozdov referred to the shift in the immunization policy in the countries of the region. Whereas in the year 2000, only 7 countries were using IPV, by 2004 it was being used in 16 countries. SIAs are planned for Russia, Tajikistan, Turkey, Turkmenistan and Uzbekistan during the coming years and up to 2008. Annual updates continue to be submitted by the Member States. Following regional certification, Member States of the European Region were asked to prepare national plans for sustaining 'polio free status'. So far, 48 out of 52 Member States had prepared these plans and of the 48 plans; the WHO Regional Office for Europe (WHO/EURO) had classified 32 as 'adequate', 8 as being borderline and the remaining 8 as inadequate. The main challenges facing the region were: the continued risk of importation; the persistence of susceptible population sub-groups and no global support for supplementary immunization activities; maintaining high quality AFP surveillance; and sustaining supplemental virological surveillance. Regarding laboratory containment, the laboratory survey has been completed in 49 Member States and 159 laboratories have identified as storing wild poliovirus and/or potentially infectious material. Forty-two countries out of 52 have submitted reports on quality assessment of Phase1. Thirty-seven of these reports were considered very good or good.

2.4 South-East Asia Region

Dr N. K. Shah, Chairman, SEA Regional Commission for Certification of Poliomyelitis Eradication, provided a summary update on the situation of the polio eradication initiative in countries of the South-East Asia Region. Of the 11 countries in the region, 6 (Bhutan, Democratic People's Republic of Korea, Indonesia, Maldives, Thailand, Timor Leste and Sri Lanka) have been polio free for more than 5 years; 3 (Bangladesh, Myanmar and Nepal) have been polio free for between 3 and 5 years; and only one country (India) remains polio endemic. As compared to 88 cases of wild poliovirus reported in 2003, in 2004, a total of 63 cases of wild poliovirus (P1=59, P3=4) had been reported from 27 districts in India by 27 September. Most of the infected districts are in Western Uttar Pradesh, accounting for 42 out of 62 cases. Bihar is the other province with continued transmission. However, the geographic spread has been limited and out of 14 families of virus that were circulating in 2002, 11 have been eliminated. The proportion of non-polio AFP cases receiving 4 or more doses of OPV has

increased from 90% in 2003 to 98% so far in 2004. AFP surveillance continues to be well above the certification standard. The annualized rate for 2004 is 2.84 as compared to 2.12 for 2003, with 83% of specimens being collected with in 14 days. Efforts are now being directed to improving the quality of supplementary immunization activities in high-risk areas.

2.5 Global overview

Dr Rudi Tangermann, Medical Officer, Polio Eradication Initiative, WHO headquarters, summarized the progress of the eradication initiative since the launch of the 2004–2005 'Intensified Plan' in WHO regions. In the Western Pacific Region, countries continue to maintain good AFP surveillance and high routine coverage. China and Japan have still not finalized phase 1 of laboratory containment and investigations are ongoing of the VDPV isolated from 2 AFP cases in south-central China. In the Region of the Americas, the first meeting of the newly established Regional Commission for Laboratory Containment and Maintenance of Polio-free Status was held in March 2004. The quality of AFP surveillance is good throughout the region, with the exception of a few countries such as Haiti.

The strategic priorities for 2004–2005 were to: stop transmission in Asia with targeted mop-ups plus six weekly NIDs with district specific focus and accountability; implement synchronized NIDs in West and Central Africa; revise the strategy in Egypt to conduct 6-weekly full NIDs through to mid 2005 and accelerate access to monovalent OPV1; and enhance surveillance in west, central and Horn of Africa. At the moment a funding gap of US$ 100 million exists. The emergency response in West and Central Africa will require an additional US$ 100 million.

Dr Tangermann also summarized for the participants the main recommendations of the Ad Hoc Advisory Committee on Poliomyelitis Eradication (AACPE) that had met in WHO headquarters on 21–22 September 2004. The full text of the recommendation will be shortly appearing in the WHO Weekly Epidemiological Record.

2.6 Discussion on the presentations on the present situation of the polio eradication initiative

The members of the RCC appreciated the up-to-date information provided during the presentations and raised several issues that dealt with:

- the seriousness of the funding gap and the likelihood of its growing in the coming years;

- the need to stop transmission in the still endemic countries as fatigue with conducting repeated NIDs is growing;

- the increase in the number of compatible cases being detected in India;

- who will be responsible for the last word on the destruction of wild poliovirus isolates;

- the need to avoid giving undue prominence to the issue of stopping OPV cessation at this point when all attention should be diverted to stopping transmission;

- the persistence of low level transmission in Egypt;

- previous experience with monovalent OPV;

- the threat of spread of wild poliovirus eastwards from Sudan;

- the need to improve the sub-optimal coordination between AFRO and EMRO to deal with the situation in Sudan and the Horn of Africa.

3. REVIEW OF NATIONAL DOCUMENTS

3.1 Palestine

While considering the report from Palestine, the RCC was fully cognizant of the special problems facing the country and was appreciative of the efforts involved in producing the report under unusual and taxing circumstances. The RCC made several comments on the report that will be communicated to the Chairman, NCC in a letter from the Chairman RCC. The RCC was especially concerned about the decreasing sensitivity of the AFP surveillance and noted that WHO will respond to requests from the authorities for provision of necessary support to improve the quality of AFP surveillance. It was agreed that a revised report, including data up to the end of 2004, should be submitted to the RCC at its next meeting in April 2005.

3.2 Somalia

The RCC expressed its appreciation for the efforts involved in preparing the very well documented report from Somalia. The situation in the country was still fragile especially in view of the minimal routine coverage with OPV 3. While appreciating the development and implementation of several activities as part of the eradication initiative, the RCC recommended that they should in no way replace the supplementary immunization activities. A major challenge is to keep the country free of polio from

importations, especially from Ethiopia. The WHO team was advised to establish a National Expert Group for Somalia, separate from that of South Sudan, and to explore the possibility of establishing a NCC for the country. Detailed comments on the report will be sent to the Coordinator of the programme. The RCC agreed that an updated and revised report should be submitted at its next meeting.

3.3 Egypt (provisional report)

The RCC welcomed the provisional report submitted by the Chairman, NCC, Egypt, and commended the marked improvement in programme activities during the past three years. An explanation was not easily forthcoming for the persistence of low-grade transmission, as evidenced by the results of environmental sampling and the finding of a wild poliovirus case in May this year, in the presence of a high coverage with routine OPV 3 and in multiple supplementary immunization campaigns conducted during the past three years. The RCC noted that the TAG for Egypt was meeting immediately after the meeting of the RCC and would be discussing this issue in detail, including the possible introduction of innovative strategies for ending transmission. The members requested that the report of the TAG meeting for Egypt be sent to them for information as soon as it is finalized. The RCC requested the Chairman of the NCC to submit the next status report in one year’s time.

3.4 Pakistan (provisional report)

The RCC welcomed the provisional report submitted by the Chairman, NCC, Pakistan, and considered it to be a status or a programmatic report. The compilation of a provisional report at this stage would facilitate the eventual preparation of the final document when transmission had ceased in the country. The RCC was pleased to note the high quality of surveillance and that the coverage in supplementary immunization activities has increased with the exception of a few districts with accessibility and management problems that are being tackled actively. Concern was expressed about the continued low routine coverage with OPV 3. The RCC recommended that the polio staff in the country should give necessary attention to promoting routine immunization, which is one of their responsibilities. The RCC made some suggestions about improving the report that would be communicated to the Chairman, NCC and agreed that the next status reports should be submitted in one year’s time. The RCC also advised the national authorities to be on the lookout for cases of VAPP and consider the possibility of carrying out a retrospective review of the records of AFP cases to detect possible VAPP cases. The RCC requested the Chairman, NCC, to submit the next status report in one year’s time.

4. REVIEW OF ANNUAL UPDATES FOR 2003

The RCC considered the annual update for 2003 from Lebanon and the revised annual updates for the same year from Djibouti, Sudan and Yemen.

In the case of Djibouti and Yemen, the RCC was concerned about the low routine coverage with OPV 3 and the capacity to respond to an importation in the absence of high quality surveillance for AFP. It was pointed out that a surveillance review is planned for both these countries early next year. While reviewing the report from Sudan, the RCC was briefed both by the representative of the NCC and by the secretariat on the recent importations and the finding of a case of wild poliovirus (P3) in Kordofan and about the actions taken to address the importations.

In addition to the above observations, the RCC made several minor comments on the reports from Lebanon, Djibouti, Sudan and Yemen and decided to accept them provisionally subject to submission of satisfactorily revised reports. The RCC's comments will be communicated to the respective Chairs of NCCs in these countries in letters from the Chairman, RCC.

5. OTHER MATTERS

5.1 Status of national plan of action for an effective response to importation of wild poliovirus into polio-free areas

The RCC was presented with a summary review of the national plans of action for an effective response to importation of wild poliovirus into polio free areas that have been submitted by the NCCs so far. It was agreed that all countries submitting reports at the next meeting of the RCC would be asked to critically review their plans and re-submit them with their reports for RCC 13, when the RCC itself will review them.

5.2 Draft format for Final National Document for Regional Certification

The RCC welcomed the detailed draft format and, apart from a few minor changes, decided to accept it. The format is given in Annex 3. It was agreed that all those countries whose national documents had been accepted and who had completed the phase 1 of the laboratory containment (Bahrain, Islamic Republic of Iran, Jordan, Lebanon, Oman, Qatar, Saudi Arabia and United Arab Emirates) would be requested to submit final reports for certification using the approved format for review by the RCC at its next meeting.

5.3 Outcomes of the recent surveillance reviews and their implications

The RCC was briefed on some of the weaknesses identified during the AFP surveillance reviews conducted since its last meeting in Egypt, Lebanon, Libyan Arab Jamahiriya, Syrian Arab Republic and Tunisia. Reviews are planned for several of the polio-free countries (Bahrain, Djibouti, Jordan, Morocco, Oman, Qatar and Saudi Arabia) during the remaining period of 2004 and in early 2005. Members of the RCC will be informed of the dates for these reviews for their possible participation.

5.4 Suggestions for drawing up a plan of work for the RCC for the next 4–5 years

It was agreed that the secretariat should draw up a tentative work plan for the RCC based on the assumption that regional certification could possibly take place in late 2008.

5.5 Meeting of Coordinators of Laboratory Containment, 7–8 December 2004, Oman

It was agreed that Drs Khan and Salisbury would attend the meeting of the coordinators of laboratory containment scheduled for early December 2004.

5.6 Development of a ‘proactive’ strategy

The RCC was very concerned about the fragility of the epidemiological situation in several of the countries whose national documents have been accepted, such as Djibouti, Sudan and Yemen, or have been discussed (Somalia). In these countries, and in others like Lebanon, the coverage with routine immunization is low or slipping and the quality of surveillance was sub-optimal and they were greatly vulnerable to importation, especially from cross-border movements including nomads and displaced persons. The imported cases in Sudan have shown the real threat of the poliovirus moving eastwards from Nigeria. It was felt that there was a need to be ‘proactive’ in order to pre-empt the emergence of wild poliovirus in countries at risk. In order to avoid dealing with the situation on a piecemeal basis, the RCC recommended that the secretariat develop a forward-looking regional coordinated strategy for response in close collaboration with AFRO, as several of the countries at risk have borders with those in the African Region. The proposed strategy should include suggestions for rapidly adjusting existing resources and/or mobilizing additional resources to meet the needs of the rapidly changing epidemiological situation in the countries.

5.7 Dates for the next meeting of the RCC

The members agreed that next (13th) meeting of the RCC would be held from Tuesday, 19 April to Thursday 21 April 2005. Provisionally, the 14th meeting of the RCC would be held around mid November 2005.

Annex 1

PROGRAMME

Wednesday, 13 October 2004

09:00–09:30 Opening session
- Introductory remarks by Dr Ali J. Sulaiman, Chairman of RCC
- Message from Dr Hussein A. Gezairy, Regional Director, WHO/EMRO
- Adoption of agenda

09:30–10:45 Present situation of polio eradication initiative
- EM regional overview, Dr Faten Kamel, Dr Humayun Asghar, WHO/EMRO
- AFR, Dr Mbaye Salla, WHO/AFRO
- EUR, Dr Sergey Drozdov, Member, EUR RCC
- SEAR, Dr N.K. Shah, Chairman, SEA RCC

10:45–11:45 Present situation of polio eradication initiative (Cont.)
- Global overview, Dr Rudi Tangermann, WHO/HQ
- Discussion

11:45–12:45 Presentation and discussion of national document of Palestine

12:45–14:30 Presentation and discussion of national document of Somalia

14:30–15:30 Presentation and discussion of (provisional) national document of Pakistan

15:30–17:30 Private meeting of the RCC members

Thursday, 14 October 2004

08:30–11:00 Review of annual update 2003 of Lebanon
Review of revised annual updates 2003 of Djibouti, Sudan and Yemen

11:00–12:00 Presentation and discussion of (provisional) national document of Egypt

12:00–14:30 Private meeting of the RCC members

Annex 2

LIST OF PARTICIPANTS

Members of the Regional Certification Commission for the Eastern Mediterranean

Dr Ali Jaffer Mohamed Sulaiman
EMR RCC Chairman
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RUSSIA

Representatives of the African Regional Certification Committee

Professor Kusum Jackison Nathoo
Member, African Regional Certification Commission
Harare
ZIMBABWE

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Mr Kenneth Collins
Past Rotary International Director
Mt Claremont
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Dr M.H. Wahdan, Special Adviser to the Regional Director for Poliomyelitis Eradication, WHO/EMRO
Dr Faten Kamel, Medical Officer, Poliomyelitis Eradication, WHO/EMRO
Dr Mary Agocs, Medical Officer, Poliomyelitis Eradication, WHO/EMRO
Dr Humayun Asghar, Virologist, Poliomyelitis Eradication, WHO/EMRO
Dr Hala Safwat, Technical Officer, Poliomyelitis Eradication, WHO/EMRO
Dr Abdalla Alkassabany, Short-term Professional, Poliomyelitis Eradication, WHO/EMRO
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Ms Fatma Moussa, Senior Secretary, Poliomyelitis Eradication, WHO/EMRO
Ms Rasha Naguib, Secretary, Poliomyelitis Eradication, WHO/EMRO

Annex 3

FORMAT FOR FINAL NATIONAL DOCUMENTATION FOR REGIONAL CERTIFICATION

Name of Country: _____

Submitted to WHO/EMRO on: _____

Introduction

The EM Regional Commission for Certification of Poliomyelitis Eradication (RCC) at it Twelfth Meeting held from 13-14 October 2004, approved the following format for use by the National Certification Committees (NCCs) in the EM Region for submitting their Final Country Reports to the RCC as a prelude to Regional Certification.

This Final Report to be submitted by the NCCs, unlike the National Document and the Annual Updates submitted by the NCC in the previous years, will be largely descriptive (around 25-30 pages long) and supported by a number of tables, graphs and maps which are listed at the end of this section. In some ways it is a synthesis of reports submitted earlier by the NCCs and should be written from a point of view of also providing a summarized historical record of polio eradication in the country.

The report consists of the following sections:

1. Executive summary (3-5 pages long)

2. Country background information

3. Description of the certification process

4. History of poliomyelitis in the country

5. Performance of AFP surveillance

6. Laboratory activities, including laboratory containment of wild poliovirus and potentially infectious material.

7. Immunization activities.

8. Updated national plan of action for responding to an importation with wild polio-virus.

9. Lessons learnt from the polio eradication initiative related activities and their implications for control of other vaccine preventable and communicable diseases.

10. Feasibility of sustaining the polio free status.

Information required under each of the above sections is mentioned in the succeeding pages. Where tables and maps are needed, reference is made to relevant tables included in the format for National Document and the Annual Update and they are also

reproduced with some minor modifications, at the end of these guidelines. *Data up to the end of year previous to submitting the final reports should be included in this report*.

It should be noted that NCCs that have submitted Final Reports will be still required to continue to submit Annual Updates, albeit in an abbreviated form, until Global Certification has occurred.

1. Executive summary

This should be a carefully written self-contained section that could be attached to RCC's own report to the Global Commission for Certification. It should include a short description of the certification process in the country, relevant country background (demographic and socio economic) as it impinged on the polio eradication activities and an assessment of: the performance of AFP surveillance and case investigation activities; laboratory activities including containment of wild poliovirus and infectious material; routine and supplementary immunization activities for polio eradication and of the ability to detect and respond to an importation of wild poliovirus. Finally the NCC should comments on the sustainability of post-polio free activities and on any other area (s) of special concern.

2. Country background information

This section should include:

2.1 information on the demographic situation, the latest total population figures and the % of population less than 15 years, 5 years and 1year (An updated version of the table under item (1) of National Update), (Annex – Item 1);

2.2 a map showing major population centers and indicating geographically remote and relatively inaccessible areas should be attached, (Annex – Item 2);

2.3 latest socio economic and health indicators, (check and modify if necessary the list of indicators available in EMRO that are enclosed);

2.4 brief description of the organization of the health system and of the immunization services and the role of private sector in the various polio eradication activities.

3. Description of the certification process

This section should include information about:

3.1 when were the National Certification Committee (NCC) and National Expert Group (NEG): constituted and mention expertise represented in the two committees. A list of members of the NCC and NEG, indicating their titles and the duration for which they served (Annex – Item 3);

3.2 their methods of working including frequency of meetings;

3.3 modalities for interaction with the national program;

3.4 mechanisms employed to validate the findings presented by the national program for inclusion in the National Document and Annual Update reports to the RCC;

3.5 any other pertinent information such as constraints in NCC's functioning;

3.6 Names of the person(s) and their designation, who were responsible for national polio immunization policies and activities and for polio surveillance activities since the time polio eradication activities were started in the country, (Annex – Item 4).

4. History of poliomyelitis in the country

This section should describe the epidemiology of polio in the country and show the progressive decline and elimination of wild poliovirus. It should include:

4.1 a line chart showing polio incidence for as many years as possible, as given in the National Document under item 18, (Annex – Item 5);

4.2 details of the last confirmed case of wild poliovirus (as mentioned in item 19 of the National Document);

4.3 the year when the national program shifted to virological classification;

4.4 a table, as given in item 21 of the National Document, showing the numbers of vaccine-associated polio cases (VAPP) and of polio-compatible cases (Annex – Item 6). Briefly describe the activities carried out following the detection of the last 5 polio-compatible cases;

4.5 map showing the location of cases of wild poliovirus for five years preceding the establishment of a polio free status, as given in Item 22 of the National Document, (Annex – Item 7).

5. Performance of AFP surveillance

This section should describe when and how the AFP surveillance activities were initiated and developed over the years mentioning the important milestones and should include the following:

5.1 how were the staff involved in these activities selected and trained;

5.2 what were the criteria used for selecting sites for active surveillance;

5.3 what were the problems involved in establishing active surveillance and how they were resolved;

5.4 summarize efforts that were made to ensure certification quality surveillance for AFP was carried in areas considered at high risk for undetected virus transmission;

5.5 completeness of reporting over the preceding 5 years from health facilities and active surveillance sites, as in table under items 40 and 43 respectively in the National Document (Annex – Item 8 a and b);

5.6 list AFP surveillance indicators in a tabular form for the preceding 10 years, as given in table under item 46 in the National Document, (Annex – Item 9);

5.7 criteria employed for referring cases to the NEG;

5.8 diagnosis of AFP cases discarded as non polio by the NEG over the last 10 years, as given in table under item 52 of the National Document, (Annex – Item 10);

5.9 if any supplementary surveillance activities had been carried out during the last ten years then provide a summary description of these activities and of results obtained;

5.10 in case any WHO/EMRO sponsored AFP surveillance review(s) had been carried out during the last five years, then provide a summary of the conclusions and recommendations.

6. Laboratory activities including laboratory containment of wild poliovirus and potentially infectious material

In case the stool specimens from AFP cases were being sent to another country for processing, then under this section just mention the address of the laboratory where the specimens were sent.

If the specimens were being processed in a specialized polio laboratory with in the country that is part of the regional network polio laboratories, please give its full address, the name of the current and the past Directors, clarify its status i.e. whether it is national or a regional reference laboratory and provide the following details under this section:

6.1 summarize the results of national laboratory accreditation since 1997, as in table under item 63 of the National Document, (Annex – Item 11);

6.2 summarize in a table form the origin and number of specimens processed by the laboratory during the previous ten year and the polio viruses isolated, as given in tables under item 65 and 68 of the National Document, (Annex – Item 12 a and b);

6.3 summarize the genomic sequencing data, if available, on most recent wild polioviruses in the country;

6.4 describe how coordination was effected with surveillance staff including communication of results;

6.5 a summary of final report on completion of activities listed under Phase 1 of the Global Action Plan (Second Edition) for laboratory containment of wild poliovirus and potentially infectious material and attach a copy of the latest inventory, (Annex – Item 13).

7. Immunization activities carried out for polio eradication

The section should cover the history of polio immunization, current immunization schedule, the polio vaccines used and trace the coverage by routine polio immunization for as far back as records permit. Indicate population subgroups at high risk of poliomyelitis due to low immunization coverage and describe steps taken to raise coverage in these groups and the outcome of these efforts. This section should also list the various supplementary immunization activities (NIDs/ SNIDs /iSNIDs/ mopping up) over the last ten years with percentage of population covered at each round. The following tables should be included in this section:

7.1 Annual routine immunization coverage with OPV3 by the first administration level for the last 10 years, as in table under item 82 of the National Document, (Annex – Item 14);

7.2 Summary of supplementary national and/or sub-national immunization days and of mopping activities during the last ten years, modified from the tables given under items 90 and 92 of the National Document, (Annex – Item 15 a and b).

8. Updated national plan of action for responding to an importation with wild poliovirus

Attach to the report the latest version of the national plan for an effective response to an importation with wild poliovirus. In case there had been importations during the last ten years, provide a summary report on the detection and response to each importation.

9. Lessons learnt from the polio eradication initiative related activities

This section should also highlight the contributions of national polio eradication efforts to the control and prevention of other communicable diseases and to the development of health services especially for the under privileged and those living in underserved and remote areas.

10. Feasibility of sustaining the polio free status

Describe any areas of special concern affecting the sustainability of polio free status that needs attention both before and after global certification.

Supporting documents

1. Demographic data.

2. Map of the country showing major urban centres, population density and geographically remote and relatively inaccessible areas.

3. List of members of the National Certification Committee and the National Expert Group with their designations and the period during which they served as members.

4. Names of staff responsible for polio eradication activities, for surveillance of AFP and for the national polio laboratory.

5. Line chart showing polio incidence for as many years as possible.

6. Table showing the numbers of vaccine-associated polio cases (VAPP) and of polio-compatible cases during the last ten years.

7. Map showing the location of cases of wild poliovirus for five years preceding the establishment of a polio free status.

8. Table showing completeness of reporting over the preceding 5 years from health facilities and active surveillance sites (as in table under items 40 (7.a) and 43 (7.b) respectively in the National Document).

9. AFP surveillance indicators in a tabular form for the preceding 10 years (as in table under item 46 in the National Document).

10. Summary of AFP cases discarded as non-polio by the NEG over the last 10 years (as given in table under item 52 of the National Document).

11. Summary of results of laboratory accreditation for the last ten years (as in table under item 63).

12. The origin and number of specimens processed by the national polio laboratory during the previous ten year and the polio viruses isolated (as in tables under item 65 (11.a) and 68 (11.b) of the National Document).

13. National Inventory of laboratories with wild poliovirus infectious or potential infectious materials.

14. Annual immunization coverage with OPV3 by the first administration level for the last 10 years (as in table under item 82 of the National Document).

15. Coverage rate of supplementary national and/or sub-national immunization days and of mopping activities during the last ten years (modified from the tables given under items 90 (14.a) and 92 (14.b) of the National Document).

ANNEX / Item

1. Demographic data

	Total Population	Population aged less than 15 years	Population aged less than 5 years	Population aged less than 1 year
Number of persons				
Percentage of total population	100 %	_____%	_____%	_____%

ANNEX / Item

2. Map of the country showing major urban centres, population density and geographically remote and relatively inaccessible areas.

ANNEX / Item

3. List of members of the National Certification Committee and the National Expert Group with their designations and the period during which they served as members.

ANNEX / Item

4. Names of staff responsible for polio eradication activities, for surveillance of AFP and for the national polio laboratory.

ANNEX / Item

5. Line chart showing polio incidence for as many years as possible.

6. Number of vaccine-associated polio cases (VAPP) and polio compatible cases during the last 10 years

Year	Vaccine-Associated polio cases	Polio-compatible cases

ANNEX / Item

7. Map of polio cases:

Please provide a map by year showing the location of all polio cases which were either virologically confirmed or clinically diagnosed for five years preceding the establishment of a polio free status.

Differentiate the cases by year, using different symbols or colours for each year.

ANNEX / Item

Year	Number of reporting sites	# reports expected*	# reports received	% reports received	(i.e. areas with poor reporting)

8.(a) Completeness of routine reporting from health facilities in the last 5 years

* number of routine reporting sites x number of reporting periods in 1 year (i.e. if monthly reporting, periods = 12; if weekly reporting, periods = 52)

ANNEX / Item

8.(b) Summary of the completeness of *active surveillance* visits for AFP in the last 5 years

* Number of active surveillance sites x number of visits in 1 year (i.e. if weekly, periods =52)

Year	No of active surveillance sites	No of visits expected*	No of visits conducted	% of visits conducted	Comment (i.e. areas with pooractive surveillance)

ANNEX / Item

9. Performance of AFP Surveillance over the last 10 years (in population under 15 years of age)

Year	Total AFP cases	Total 'non-polio' AFP cases	Population	Non-polio AFP rate*	Total AFP cases with 2 adequate stool samples	% AFP cases with adequate stool samples
						%
						%
						%
						%

ANNEX / Item

population aged less than 15 years

10. Summary of final diagnosis of AFP cases discarded as non-polio by National Expert Group since the National Expert Group was established

Year	GBS** (No. and %)	Transverse Myelitis	Trauma	Other (please specify)	Unknown	Total AFP cases discarded as non-polio

** Guillain-Barre Sydrome

ANNEX / Item

11. Summary of National Laboratory Accreditation Results since 1997

*Countries with national laboratories.

Year	Score of onsite review	Proficiency test score (%)	NPEV** isolation ratio	Annual # of specimens processed	Correct polio typing result (%)	Results reported on time (%)	Fully accredited (yes / no)

** NPEV = non-polio enterovirus (in specimens of all sources).

ANNEX / Item

12. (a) Summary of specimens submitted for poliovirus studies since 1997

Year	specimens from AFP case	Specimens from AFP contacts	Other stool specimens*	Other clinical specimens**	Environment specimens	Total

*other stool specimens such as stool from surveys or from cases other than AFP cases and their contacts (e.g. aseptic meningitis)

**other specimens: samples and clinical specimens other than stools.

ANNEX / Item

12.(b) Summary of polioviruses isolated from specimens and processed for intratypic differentiation during the previous 10 years

(Please include data for the country only)

Year	Total polioviruses isolated from Specimens	Source of poliovirus isolates		No. of isolates sent for Intratypic Differentiation	Intratypic differentiation (I.D.) results		
		AFP cases specimens	Other specimens		Sabin like	Wild	Mixed W+SL

Please attach specimen line list including Province, District, Source, P1, P2 and P3 results

ANNEX / Item

13. National inventory of laboratories with wild poliovirus infectious or potential infectious materials

Government Department	Name of Institution	Address	Only WPV infectious materials	Only WPV potential infectious materials	Both WPV infectious and potential infectious materials	Total number of laboratories	Biosafety level of laboratories with polio materials

ANNEX / Item

14. Annual routine immunization coverage by first administrative level: i.e. state, province, or governorate for the last 10 years

Immunization coverage (%)											
Name	**Year:**	**Year:**	**Year:**	**Year:**	**Year:**	**Year:**	**Year:**	**Year:**	**Year:**	**Year:**	**Remarks**

ANNEX / Item

15.(a) SIAs coverage for the last 10 years

Please attach a table with the SIAs coverage by first administrative level (i.e. province, state, etc.) *for each SIA*

Year	Type of campaign NID / SNID	Area	Age group	Date	% coverage

ANNEX / Item

15.(b) Summary of 'Mopping-up' activities in the last 5 years

Year	Reason for 'Mopping-up'	Geographic area included	Age group	Date	% coverage