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Report on the

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

Cairo, Egypt
19–21 April 2005

World Health Organization
Regional Office for the Eastern Mediterranean
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CONTENTS

1. INTRODUCTION

The Thirteenth Meeting of the Eastern Mediterranean Regional Commission for Certification of Poliomyelitis Eradication (RCC) was held in Cairo, Egypt, on 19–21 April 2005. The meeting was attended by members of the RCC, Chairmen of the national certification committees (NCCs) and national programme managers from Afghanistan, Bahrain, Djibouti, Islamic Republic of Iran, Iraq, Jordan, Kuwait, Libyan Arab Jamahiriya, Morocco, Oman, Qatar, Saudi Arabia, Sudan, Syrian Arab Republic, Tunisia and United Arab Emirates. Other participants included representatives of Rotary International and the African Regional Commission for Certification and staff from WHO headquarters and the Regional Offices for Africa, South-East Asia, Europe and the Eastern Mediterranean.

Dr Ali Jaffer Mohammad Sulaiman, Chairman, RCC, opened the meeting by welcoming all the participants. He thanked Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean for his continued support and guidance of polio eradiation activities and the polio eradication staff for their continued and excellent efforts. Dr Ali Jaffer referred to significant progress in the Eastern Mediterranean Region, especially in Afghanistan, Egypt and Pakistan, where there was evidence for reduced virus transmission and diversity. The outbreak in Sudan was winding down and it was gratifying to note the rapid and effective response to the two importations in Saudi Arabia.

Dr M.H. Wahdan, Special Adviser (Polio) to the Regional Director, welcomed the participants and delivered a message on behalf of Dr Gezairy. In his message, Dr Gezairy welcomed all the participants and expressed his appreciation for their efforts and sustained commitment to eradicating polio from the Region. He referred to the considerable setback to the programme in Sudan and that this underscored the need to be on guard for importation by maintaining certification quality surveillance for AFP and ensuring a high level of immunity through routine immunization and well-implemented supplementary immunization activities. Dr Gezairy commended the close collaboration between countries of the African and the Eastern Mediterranean regions as was evident at the recent meeting between countries neighbouring Sudan. Although it was recognized that communities and programme staff both in polio-free and polio-endemic countries might be experiencing a certain amount of fatigue in the face of the repeated rounds of immunization campaigns and in fulfilling the reporting requirement of AFP surveillance, he emphasized the need to ensure that there was no diminution in attention being paid to eradication related activities. He also emphasized the importance of complete and timely submission of annual updates by the national certification committees to the Regional Commission, and urged the national committees to closely follow up the completion of the first phase of laboratory containment of wild poliovirus.

The programme of the meeting and the list of participants are given in Annexes 1 and 2, respectively. The format for final national documentation for regional certification of poliomyelitis eradication is attached as Annex 3.

2. CURRENT SITUATION OF POLIOMYELITIS ERADICATION

2.1 Eastern Mediterranean Region

Overview

Dr Faten Kamel, Medical Officer, Polio Eradication, WHO/EMRO presented a summary overview of the current situation of polio eradication initiative in the Region. In 2005, up to17 April, a total of 23 cases of wild poliovirus have been reported as compared to 13 for the same period in 2004. Of the 23 cases reported so far in 2005, 4 were from Pakistan and 19 from Sudan. No cases have been reported from Afghanistan and Egypt, respectively, since mid November 2004 and early May 2004. Seventeen countries have been polio-free for more than three years and the last case from Somalia was reported in October 2002. Genomic sequencing results show diminished genetic diversity of viruses isolated from Afghanistan and Pakistan as well as from Egypt, indicating progress towards eradication in these countries.

In the year 2004 the non-polio AFP rate for the entire Region was 2.70 cases per 100 000 population with adequate specimens collected from 88.9% of cases. In all countries except of Bahrain, Djibouti and Palestine, the indicators for surveillance were of certification standard. Bahrain and Djibouti have small populations and only a small number of cases were expected, and the difficult security situation in Palestine makes effective surveillance difficult. As at 17 April, the annualized regional non-polio AFP rate for 2005 was 2.62 with adequate specimens being collected from 90.8% of cases. In order to validate the quality of surveillance and to identify any weaknesses, the programme has continued to carry out surveillance reviews in endemic and polio-free countries. Since the last meeting of the RCC in October 2004, surveillance reviews have taken place in Saudi Arabia (26 February–3 March 2005) and in Yemen (29 January–2 February 2005), Reviews for Bahrain, Djibouti, Islamic Republic of Iran, Jordan, Kuwait and Qatar are scheduled to take place during the remainder of this year.

Regarding supplementary immunization activities (SIAs), most of the countries that have become polio-free have recently stopped implementing SIAs or have conducted sub national campaigns in at - risk areas. The immunization status of non-polio AFP cases has continued to show improvement in the endemic countries. However, according to the figures for 2004, coverage with OPV 3 through routine immunization continues to be low in several of the countries. It was less than 80% in 6 countries (Afghanistan, Djibouti, Pakistan, Somalia, Sudan and Yemen). In Pakistan during 2004, seven rounds of NIDs

and SNIDs in high-risk areas were conducted. Afghanistan and Egypt conducted four rounds of NIDs and SNIDs in high risk-areas. So far in 2005, several rounds of NIDs have been conducted in Afghanistan, Egypt and in Pakistan. The quality of SIAs in some of the districts of mega-cities in Egypt needs to be further improved. In Sudan, as mentioned below, several rounds of NIDs have been conducted since the outbreak began in June 2004. All the campaigns were carried out using detailed micro-planning and on a house-to-house basis and were intensively supervised as well as being monitored by independent international and national monitors.

The Technical Advisory Groups (TAGs) for the endemic countries have and will continue to provide oversight and guidance to the programme. Meetings for the TAGs for Egypt, Pakistan and Sudan will be held respectively in June, May and July 2005. The third meeting of the Regional TAG will be held end June 2005.

The outbreak in Sudan represented a considerable setback to the steady progress of polio eradication in the region. Prior to May 2004, the last case of wild poliovirus in Sudan was reported on 24 April 2001. Following the prompt detection of a case on 24 May 2004 in West Darfur state, which was found to be genetically related to wild poliovirus type 1 imported from Chad, a number of other cases caused by the same virus were reported in early July from South Darfur state where many internally displaced populations are residing. After this, cases started to be reported from various places in the country. To date 145 cases have been reported, all wild poliovirus 1 type except for three cases of P3 detected in Babanosa, West Kordufan state and in south Sudan.

The rapid spread of the epidemic could be ascribed to: the importation occurring at the beginning of the high transmission season; low population immunity due to low routine coverage and no NIDs since late 2002 due to limited funds and global tactical shift with concentration on endemic countries; large population movements due to insecurity in Darfur and the movement of large population of pilgrims from West African countries through Sudan.

In response to the appearance of several cases in Darfur, a mop-up immunization covering the three states of Darfur was carried out in July and August 2004 with a coverage rate of 98% and 102% respectively. Following this, two rounds of NIDs were implemented during October and November 2004, again with a high coverage rate. During 2005, additional rounds were conducted during January and February. Another round took place in during the first half of April.

With these supplementary immunization activities, the cases being reported have progressively decreased. The number of cases with onset from the beginning of 2005 until mid April amounted to 19 cases. The last case in 2005 was reported from Gedarif

state with date of onset on 21 February 2005. The number of states that were affected by the epidemic was 18.

Dr Kamel also referred to the two importations detected in Saudi Arabia and described the immediate surveillance and immunization response to these importation. One of the cases was a two-year-old girl from Port Sudan, Sudan, who was detected in Jeddah and the other was a five-year-old Nigerian boy illegally residing in Mecca since his birth.

The participants were also briefed about the outbreak in Yemen that was reported during the RCC meeting and about the investigations under way.

The main challenge facing the programme is the continued circulation of the wild poliovirus in Afghanistan, Egypt (where transmission of wild poliovirus appears to be very efficient), and Pakistan and since June 2004 in Sudan and most recently in Yemen. Steps are being taken to improve the quality of SIAs in all these countries. The OPV status of non-polio AFP cases shows a continuing improvement in the immunization status of children under the age of five years. In order to interrupt the remaining chains of transmission of type 1 poliovirus in Egypt, and as per the recommendation of the Ad Hoc Advisory Committee on Polio Eradication, steps were taken to license the new monovalent oral poliovaccine in the NIDs starting from the May 2005 round. In Sudan and Yemen, the main challenge is to stop the ongoing circulation of wild poliovirus as soon as possible through boosting population immunity, particularly in the south of the country, by repeated rounds of high quality NIDs/SNIDs and maintaining certification-standard surveillance.

In view of the above challenges, the regional priorities are to: stop circulation in the endemic and re-infected countries; ensure preparedness for importation through sustaining high quality surveillance and high population immunity through SIAs and improved routine coverage; complete phase 1 of laboratory containment; and prepare for certification.

Polio laboratory network

A summary report on the work of the polio laboratory network and the progress in laboratory containment was presented by Dr Humayun Asghar, Virologist, Polio Eradication, WHO/EMRO. During 2004, all the twelve polio laboratories in the Region were fully accredited except for the one in Iraq that could not be visited due to security concerns. Meanwhile samples from Iraq are being tested in the Regional Reference Laboratory (VACSERA) in Egypt. The laboratory performance indicators continued to meet the required criteria. In 2004, the mean time from onset of paralysis to ITD results was 37 days and to date in 2005 it is 36 days. Inadequacy of stool samples and delays in

transport of specimens are still a problem in some countries and are being addressed by the respective national programmes. On a regional basis, 18% of specimens were positive for non-polio enterovirus.

Regarding laboratory containment of wild poliovirus, Dr Asghar briefed the RCC on the main outcomes and recommendations of the fourth intercountry meeting of national containment coordinators held in December 2004. Of the 18 polio-free countries, nine have reported completion of laboratory survey and establishment of an inventory (Bahrain, Djibouti, Islamic Republic of Iran, Jordan, Lebanon, Libyan Arab Jamahiriya, Oman, Qatar and Saudi Arabia), and another six are in the final stages of completion (Iraq, Kuwait, Morocco, Syrian Arab Republic, Tunisia and United Arab Emirates). Yemen has revised the national plan of action and has started to implement its activities. The remaining three (Pakistan, Palestine and Somalia) have not yet started containment activities. In Sudan, due to the recent outbreak, a reassessment of the results of the original laboratory survey will be conducted once poliovirus transmission has been interrupted again and a fresh survey of the high-risk laboratories should be conducted. Of the 19 060 laboratories surveyed so far in the Region, only six laboratories were identified having infectious or potentially infectious material.

The RCC requested the Chairmen of NCCs in countries that have completed the survey to ensure the submission of the report on Phase 1 and in countries where the survey is in the final stages, to facilitate its completion and submission of report.

2.2 African Region

A summary update on the polio eradication initiative in the WHO African Region was provided by Dr Sam Okiror, Medical Officer, Polio, WHO/AFRO. In 2004, 11 countries in the region reported 930 cases of wild poliovirus as compared to 10 countries that reported 446 cases of wild poliovirus in 2003. Up to 13 April 2005, a total of 39 cases had been reported, including 37 from Nigeria and one each from Cameroon and Ethiopia. Local transmission was re-established in Cote d' Ivoire, Burkina Faso, Chad and in Central African Republic. Most of the cases were in the very young (70% less than two years) and under-vaccinated (64% of cases had less than three doses of OPV). SIAs were resumed in Kano, Nigeria, in July 2004 and during that year all polio-infected countries had 3–6 rounds.

Surveillance for AFP has not reached certification standard in 8 countries of the region and in several of the others there are surveillance gaps at the subnational level. Regarding progress in the certification process 8 countries have presented their national documents to the AFR RCC. Reports of three countries (Gambia, Senegal and Rwanda) have been accepted. Acceptance has been deferred in case of Burundi and the United Republic of Tanzania because of declining surveillance and of reports from Cameroon and Guinea due to continuing importation. Another set of 5 countries has been selected to

present their reports in 2005. Regarding laboratory containment, 32 countries have established task forces and five have completed the survey and inventory report.

Priority actions for achieving wild poliovirus interruption involve: addressing the existing gaps in AFP surveillance; improving the quality of SIAs; synchronization of cross-border activities; instituting appropriate and timely communication; and strengthening training and supervision of vaccinators and supervisors. Certification-related actions include: supporting the work of NCCs; orientation for laboratory containment; and preparation of national documents of polio-free countries for submission to the next meeting of AFR RCC in October 2005.

2.3 European Region

An overview of the post certification situation of the polio eradication initiative in the WHO European Region was provided by Dr James Zingeser, Medical Officer, Vaccine Preventable Diseases and Immunization, WHO/EURO. The main emphasis of the Initiative in the region, consisting of 52 countries with a total population of 876 million, was sustaining the polio-free status following regional certification in June 2002. Coverage with routine immunization remains above 80% in the vast majority of the countries. The non-polio AFP rate was below certification level in 25 countries. The risk of transmission following an importation exists in all the countries but was high in and south-eastern Turkey and in the northern Caucasus. Regarding the containment of wild poliovirus, of the 44 340 laboratories that had been surveyed (with a response rate of 99%), 159 laboratories in 24 countries were found to store wild poliovirus or infectious material.

Dr Zingeser traced the history of the use of different poliovaccines used in the countries of the region since the 1980s. Some of the challenges facing the region include: maintaining high quality surveillance and a high level of coverage with routine immunization, especially in high-risk areas, through routine vaccination plus SIAs; containment of wild poliovirus; and preparing for the post-polio eradication period by using the lessons learnt and the available resources to maintain the momentum for the elimination of other vaccine-preventable diseases.

2.4 South-East Asia Region

Of the 11 countries in the region, India continues to be the only endemic country. The number of wild poliovirus cases has declined considerably since the year 2002, when 1600 cases were reported, to 225 cases in 2003, 136 in 2004 and, as of 14 April, only 14 cases in 2005, all of which have occurred in the same areas or near areas with ongoing transmission in late 2004. The sensitivity of surveillance in the endemic provinces of Bihar and Uttar Pradesh has improved with a 3-fold to 4-fold increase in the number of AFP cases detected as compared to previous years. As well, the genetic biodiversity of

virus isolates has reduced to one active genetic cluster in 2005 versus 3 different genetic clusters of P1 virus in 2004. A good effect is anticipated from the administration of mOPV 1 in high-risk areas involving 31.6 million children under 5 years of age in 13 districts of west Uttar Pradesh, all of Bihar and 3 districts of Maharashtra. Following the detection of an imported case in Nepal along the border with Bihar in late 2004, a number of SIAs were carried out during 2004 and in early 2005.

The main priorities for 2005 are to interrupt transmission in India with 2 NIDs and 6 SNIDs and to strengthen AFP surveillance and improve coverage with routine immunization in all countries.

2.5 Global overview

Dr Ronald Sutter, Medical Officer Polio, IVB/VAM, WHO headquarters, presented a summary overview of the polio eradication initiative from a global perspective. The impact of intensification of polio eradication activities following the launch of 'Intensified Plan 2004–2005' was evident in the declining number of cases of wild poliovirus in Afghanistan, Egypt, India and Pakistan and the limitation of transmission to a few foci. The challenge in Asia is reaching every child in key districts. In the African Region, due to cessation of polio eradication activities in northern Nigeria, wild poliovirus has spread widely across the continent. Fourteen polio-free countries, including Saudi Arabia and Sudan in the Eastern Mediterranean Region, had importations from Nigeria and polio was 're-established' in six of these countries, including Sudan. In response to this wide spread of polio across western and central Africa, synchronized polio campaigns were carried out in 23 countries involving nearly 80 million children in October/November 2004 and again in February, April and May 2005.

Dr Sutter described the rationale behind the addition of monovalent OPV type 1 vaccine in Egypt and India. He emphasized that polio continues because campaigns are still missing too many children in limited geographic areas. Gaps in AFP detection rates continue to exist as evidenced by discovery of an eliminated P3 strain in Sudan in 2004. He also highlighted the risks associated with continued use of OPV, i.e. vaccine-associated paralytic poliomyelitis occurring in vaccine recipients or in contacts of OPV recipients and outbreaks due to circulating vaccine-derived polioviruses. The prerequisites for OPV cessation included: confirmation of interruption of wild poliovirus; appropriate containment of all polioviruses; global surveillance and notification capacity; mOPV stockpile and response mechanism and the development of 'Post-OPV' immunization policy at the national level. The cessation of OPV for routine immunization should take place as soon as possible after the interruption of wild poliovirus transmission while immunity and surveillance are high. In conclusion, he mentioned the existence of a funding gap of US$ 75 million for 2005 and US$ 200 million for 2006.

2.6 Discussion on the current situation

During the discussion on various presentations it was stressed that all national programmes should remain on constant look-out for importations and try to better define areas and population groups with immunity gaps and where surveillance for AFP has slipped or is below certification levels. Well-conducted and comprehensive AFP surveillance reviews should be carried out in all countries.

It was pointed out that there is continuing close coordination with the polio eradication programme in the African Region, with sharing of information and synchronization of SIAs in countries in the two regions that share borders. It is not clear that whether the P3 wild poliovirus detected in south-west Sudan last year was imported or represented a focus of transmission that was missed.

Funding continues to be a major constraint in implementing the required number of NIDs/SNIDs in endemic countries and in those where the polio-free situation continued to be fragile as was the case in Sudan and Yemen where due to lack of funds and a tactical shift in priorities no funds could be allocated for SIAs during 2003.

In response to the interest expressed by several of the participants who wanted to know about the pros and cons of introduction of IPV in their immunization programmes, it was clarified that this is a complex issue and it was up to individual countries to decide on this issue. However, WHO is working to develop clear guidelines during 2005. It was also clarified that the introduction of mOPV 1 in Egypt and India is not intended to replace the trivalent OPV in routine immunization but is an addition in order to reinforce immunity against type 1 wild poliovirus.

3. REVIEW OF FINAL NATIONAL DOCUMENTATIONS FOR REGIONAL CERTIFICATION

At its previous meeting, the RCC had requested countries whose national documents had been accepted and who had completed Phase 1 of laboratory containment (Bahrain, Islamic Republic of Iran, Jordan, Oman, Qatar, Saudi Arabia and United Arab Emirates) to submit final reports, according to an agreed upon format, as a prelude to eventual regional certification.

During the current meeting, the seven final national documents for regional certification were reviewed by the RCC. Apart from specific comments on individual reports (which will be communicated to the respective Chairmen in a letter from the Chairman, RCC), it was felt the preparation of these by the seven NCCs and their review by the RCC had been a useful exercise. There was, understandably, variation between the reports in the degree of detail provided and this was particularly marked in the content

and format of the 'Executive Summary'. There was some divergence of opinion about what the executive summary should contain, i.e. whether this should be a summary of the contents of the main report or it should be a commentary or critique by the NCC on the report which is assembled by the national programme. It was proposed that the Secretariat try to develop a 'model' based upon material taken from the seven executive summaries. The model could be used as a guide to the NCCs in the preparation of their reports. The RCC reviewed a slightly modified format for submission of the final report document and decided to adopt it for future use (Annex 3).

The seven countries (Bahrain, Islamic Republic or Iran, Jordan, Oman, Qatar, Saudi Arabia and United Arab Emirates) that had submitted final national documents for regional certification will be asked to resubmit these reports in the revised format including data up to the year 2005 and incorporating the comments of the RCC.

4. REVIEW OF NATIONAL DOCUMENTATION: AFGHANISTAN

The RCC welcomed the provisional national documentation report submitted by the NCC of Afghanistan and expressed its appreciation for the efforts made by the national authorities with support from WHO, UNICEF and other partners in interrupting transmission of wild poliovirus under very difficult circumstances and in compiling the provisional report. The last case was reported in November 2004. The challenge was to keep the country free of polio in the coming years by maintaining certification standard AFP surveillance and implementing high quality SIAs. Efforts to increase coverage with routine immunization should continue unabated. The comments made by the members of the RCC on the report will be communicated in a letter from the Chairman, RCC, to the Chairman, NCC.

5. REVIEW OF ANNUAL UPDATES

The RCC considered the annual updates for 2004 from Djibouti, Iraq, Kuwait, Libyan Arab Jamahiriya, Morocco, Sudan, Syrian Arab Republic and Tunisia. The RCC was most concerned about poor routine immunization coverage in Djibouti and the decision of responsible officials in Djibouti to postpone implementation of an NID to September 2005. The Commission advised the Chair, NCC, Djibouti to communicate these concerns to the Ministry of Health and advise the concerned officials of the Regional Office's preparedness to underwrite the expenses involved in implementing a campaign at an earlier date.

The RCC once again expressed its concern about the functioning of the poliovirus laboratory in Kuwait, which also serves as a Regional Reference Laboratory and has not

been able to respond in a timely manner to the needs of Member States referring samples to it for intratypic differentiation of polioviruses.

In addition to the above observations, the RCC made some minor comments on some of the reports that will be communicated to the respective Chairmen of NCCs in a letter from Chairman, RCC. It was decided to provisionally accept the annual update reports for 2004 from Djibouti, Iraq, Kuwait, Libyan Arab Jamahiriya, Morocco, Syrian Arab Republic and Tunisia. Final approval will be conveyed after amended reports incorporating the RCC's comments have been received. Regarding Sudan, it was agreed that a detailed letter should be sent to the Chairman, NCC, Sudan, conveying RCC's concerns about gaps in surveillance and the low coverage with routine immunization. The NCC should also be informed that they will be required to re-submit a national document at least a year after the last case was reported and that a fresh laboratory survey will need to be carried out.

6. OTHER MATTERS

6.1 Timely submission of report by the NCCs

The RCC was concerned about the delays in receiving reports for its meetings by the due dates. Some of this could be ascribed to the poor communication and lack of effective working relationship between the NCCs and the national programme staff in several of the countries. It was agreed that this issue would be broached during the EPI managers meeting in June this year.

6.2 Format for annual update reports to be submitted by countries that have submitted final national documentation for regional certification

The RCC agreed that countries that had submitted the final national documentation for regional certification should be requested to submit a short annual update. The secretariat will prepare a draft format for consideration of the RCC at its next meeting.

6.3 Draft work plan for RCC for the period 2005–2008

As some of the assumptions which underline the basis of the draft workplan prepared by the secretariat for the RCC's review might be modified following the 9th meeting of Global Certification Commission, to be held immediately following the RCC's meeting, it was decided to defer this item to the next meeting of the RCC.

6.4 Dates and venue for the 14th meeting of the RCC

The RCC decided that its next meeting would be held on 7–8 December 2005 in Cairo, Egypt.

Annex 1

PROGRAMME

Tuesday, 19 April 2005

08:30–09:00	Registration
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
09:30–10:30	Overview of the present situation of polio eradication EM regional overview, Dr F. Kamel, WHO/EMRO, Dr H. Asghar, WHO/EMRO
10:30–12:30	Regional overviews SEAR, Dr A. Thapa, WHO/SEARO EUR, Dr J. Zingeser, WHO/EURO Global Overview, Dr R. Sutter, WHO/HQ Discussion
12:30–15:30	Review of final national documentation for regional certification of Qatar, Islamic Republic of Iran and Jordan
15:30–17:30	Private meeting of the RCC

Wednesday, 20 April 2005

08:30–10:30	Review of final national documentation for regional certification of Oman, Bahrain, Saudi Arabia and United Arab Emirates
10:30–13:30	Review of the (provisional) national documentation for certification of Afghanistan AFR Region Overview, Dr S. Okiror, WHO/AFRO
13:30–15:30	Review of 2004 annual updates of Djibouti, Iraq and Kuwait
15:30–17:00	Private meeting of the RCC

Thursday, 21 April 2005

08:30–10:30	Review of 2004 annual updates of Libyan Arab Jamahiriya, Morocco and Sudan
10:30–12:30	Review of 2004 annual updates of Syrian Arab Republic and Tunisia
12:30–15:00	Private meeting of the RCC

Annex 2

LIST OF PARTICIPANTS

Dr Ali Jaffer Mohamed Sulaiman (Chairman)
Director General of Health Affairs
Ministry of Health
Muscat

Dr Magda Rakha
First Under-Secretary
Ministry of Health and Population
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African Regional Certification Commission
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Dr Hossein Malek Afzali
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South-East Asia Regional Certification Commission
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Dr Salah Al-Awaidy
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Dr Khalifa Al-Jaber
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Dr Sayed Fazal Shah
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Professor Ghazi Jamjoum
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UNITED ARAB EMIRATES
Professor Yousef Abdulrazzaq
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Dr Ali Al-Marzouki
Director of Preventive Medicine
Ministry of Health
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Representatives of the African Regional Certification Committee

Professor Joseph Andoh
Member, AFR Regional Certification Commission
Abidjan

Other organizations

Rotary International
Dr Diaa Seif El Din
Chairman, National PolioPlus Committee of Egypt
Cairo

Mr Mounir Ezz-Eldin
Member, National PolioPlus Committee of Egypt
Cairo

Other WHO offices

Headquarters
Dr Roland Sutter
Medical Officer, Polio
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Dr Sam Okiror
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Medical Officer
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Dr Arun Thapa
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WHO Secretariat

Dr Mohamed H. Wahdan, Special Advisor to the Regional Director for Poliomyelitis Eradication
Dr Faten Kamel, Medical Officer, Poliomyelitis Eradication
Dr Humayun Asghar, Virologist, Poliomyelitis Eradication
Dr Hala Safwat, Technical Officer, Poliomyelitis Eradication
Mr Jalaa Abdelwahab, Medical Officer, Poliomyelitis Eradication
Dr Abdualla Elkassabany, Short Term Professional, Poliomyelitis Eradication
Dr Javid Hashmi, Short Term Consultant, Poliomyelitis Eradication
Dr Naveed Sadozai, Medical Officer, Poliomyelitis Eradication, WHO Office Afghanistan
Dr El Sadig Mahgoub, AFP Surveillance Coordinator, WHO Office Sudan
Mr Kareem El-Hadary, Helpdesk Assistant, Information System Management
Mrs Fatma Moussa, Senior Secretary, Poliomyelitis Eradication
Mrs Rasha Naguib, Secretary, Poliomyelitis Eradication
Ms Mariam Adly, Secretary, Poliomyelitis Eradication

Annex 3

FORMAT FOR FINAL NATIONAL DOCUMENTATION FOR REGIONAL CERTIFICATION OF POLIOMYELITIS ERADICATION

Name of Country: _____

Submitted to WHO/EMRO on: _____

World Health Organization
Regional Office for the Eastern Mediterranean
Cairo, Egypt

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

Introduction

The Eastern Mediterranean Regional Commission for Certification of Poliomyelitis Eradication (RCC) at its Twelfth Meeting held in Cairo on 13–14 October 2004 approved this format. As a prelude to Regional Certification, the countries will use this format to prepare their Final Reports

The Final Reports will, unlike the National Documents and the Annual Updates, be largely, supported by a number of tables, graphs and maps. In some ways the Final Reports are syntheses of reports submitted earlier by the NCCs and they should be written from the point of view of also providing summarized historical records of polio eradication in the countries.

The Final Report will consist of the following 11 sections. ***Section 1 will be prepared by the NCC and sections 2 to 10 will be prepared by the national authority.***

1. Executive summary (by the NCC)
2. Country background information
3. Description of the eradication 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 poliovirus
9. Lessons learnt from the activities related polio the eradication initiative and their implications for control of other vaccine preventable and communicable diseases
10. Future utilization of the infrastructure for polio eradication
11. Feasibility of sustaining 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 the relevant tables and maps included in the National Document and/or the Annual Update. *Data up to the end of the year previous to submitting the Final Reports should be included in the Final Report.*

1. Executive summary (to be prepared by the NCC)

The NCC in preparing its executive summary:

a) Will give a brief account about how it implemented its terms of reference, in particular, its interaction with the polio eradication programme and the National Expert Committee (NEC)

b) Will briefly describe how critically and objectively it reviewed the Final Report

c) Will state its conclusions about the Final Report, citing the evidence in the Final Report upon which it bases its conclusions and conviction that:

✓ the country remains polio-free

✓ the AFP surveillance is sensitive enough to detect early any wild poliovirus importation into the country

✓ the plan of action for the detection of and response to wild poliovirus importation is up-to-date and adequate

✓ the country has completed the activities listed under Phasel of the Global Action Plan, 2nd Edition, for laboratory containment of wild poliovirus and infectious and potentially infectious materials

d) Will indicate any constraints it might had encountered and if and how such constraints were overcome

e) Will, if deemed appropriate, make recommendations for the country.

NB. All the members of the NCC will sign the Executive Summary.

2. Country background information

2.1 Demographic data: Please use the most recent year for which population data is available, (as in item 1of the National Document).

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

2.2 Please attach a map of the country showing the major urban centres, population density and geographically remote and relatively inaccessible areas.

2.3 Give an account of the socio-economic and health indicators for the country. (Check and modify, as necessary, the enclosed list of indicators available in EMRO).

2.4 Describe briefly the organization of the health system, including the immunization services, and indicate what role the private sector plays in the polio eradication activities in the country.

3. Description of the eradication process

3.1 When was the National Certification Committee(NCC) established ? _____

3.2 List the NCC names, specialist fields and number of years served.

Name	Specialist fields	Number of years served

3.3 When was the National Expert Committee (NEC) formed ? _____

3.4 List the NEC names, specialist fields and number of years served.

Name	Specialist fields	Number of year served

3.5 Describe any support the polio eradication programme extended to both the NCC and the NEC.

3.6 List the names of the persons and their designations who were responsible for the national polio immunization policies and activities as well as polio surveillance activities since the time polio eradication activities were started in the country.

Name	Designation	Role played

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.

4.1 Describe briefly poliomyelitis as a public health problem in the country over the years.

4.2 Provide **a line chart** showing the incidence of polio in the country for as many years back as possible, (as in item 18 of the National Document).

4.3 Give the details of the last confirmed case of wild poliovirus in the country, (as in item 19 of the National Document):

Date of onset (day / month / year): _____

Geographic location: _____

Age: _____.

History of vaccination against polio:

Number of routine OPV doses: _____

Number of doses received during NIDs: _____

Number of doses received during sNIDs: _____

Virological findings: _____

Travel history: _____

Probable origin of virus: _____

Additional investigations to rule out ongoing indigenous transmission (attach sheet if necessary): _____

Immunization response activities: _____

4.4 Which year was WHO-virological classification scheme introduced ? _____

4.5(a)Number of vaccine-associated paralytic poliomyelitis (VAPP) and polio compatible cases in the last 10 years, (as in item 21 of the National Document)

Year	Vaccine-associated polio cases	Polio-compatible cases

4.5(b)Describe briefly activities carried out following the detection of the last 5 polio compatible cases.

4.6 Map of polio cases. (as in item 22 of the National Document).

Please provide a map showing, by year, the location of all polio cases which were either virologically confirmed or clinically diagnosed for the 5 years proceeding the year the National Document was accepted by the RCC. Differentiate the cases by year, using different symbols or colours for each year.

5. Performance of the AFP surveillance

This section should describe when and how the AFP surveillance activities were initiated and developed over the years, mentioning the important milestones.

5.1 How were the staff of the AFP surveillance activities selected and trained?

5.2 What were the criteria used for selecting the sites for active surveillance?

5.3 What were the problems involved in establishing active surveillance and how they were resolved?

5.4 Summarize efforts made to ensure certification quality AFP surveillance in areas considered at high risk for undetected wild poliovirus transmission.

5.5(a)Completeness of routine reporting from health facilities in the last 5 years (as in item 40 of the National Document)

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

5.5(b)Summary of the completeness of active surveillance visits for AFP in the last 5 years, (as in item 43 of the National Document)

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

5.6 Performance of AFP surveillance over the last 10 years in the population under 15 years of age (as in item 46 of the National Document).

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

*per 100 000 population aged less than 15 years.

5.7 What were the criteria used for referring AFP cases to the NEC ?

5.8 Summary of the final diagnoses of the AFP cases discarded as non-polio by the NEC, since the NEC was established, (as in item 52 of the National Document).

Year	GBS** (# and %)	Transverse myelitis	Trauma	Other (please specify)	Unknown	Total AFP cases discarded as non-polio

**Guillain-Barre Syndrome

5.9 If any supplementary surveillance activities had been carried out during the last 10 years, please provide a summary description of these activities and the results obtained.

5.10 In case any WHO/EMRO sponsored AFP surveillance review(s) had been carried out in the last 5 years, please attach the **conclusions** and **recommendations.**

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

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

6.1 Summary of the National Laboratory Accreditation Results since 1997 (as in item 63 of the National Document)

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

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

6.1(a)Summary of specimens submitted for poliovirus studies since 1997, (as in item 65 of the National Document)

Year	Specimens from AFP cases	Specimens from AFP contacts	Other* stool specimens	Other clinical specimens**	Environmental specimens	Total

*Other stool specimens such as stools 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

6.2(b)Summary of polioviruses isolated from specimens and processed for intratypic differentiation since 1997, (as in item 68 of the National Document)

Year	Total polioviruses isolated from specimens	Source of polioviruses isolates		Number of isolates sent for intratypic differentiation	Intratypic Differentiation (ID) Results		
		AFP cases	Other specimens		Sabin like	Wild	Mixed W+SL

6.3 Summarize the genomic sequencing data, if available, on the most recent wild polioviruses in the country.

6.4 Describe how coordination was effected with surveillance staff, including communication of results

6.5 Provide a summary of the final report on completion of activities listed under Phase 1 of the Global Action Plan (2nd Edition) for laboratory containment of wild poliovirus and potentially infectious material.

Please complete the table below:

National inventory of laboratories with wild poliovirus infectious or potentially infectious materials							
Department Government	**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**

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 target population covered at each round. The following tables should be included in this section:

7.1 Annual routine immunization coverage by first Administrative level (i.e. State, Region, Province, etc) for the last 10 years (as in item 82 of the National Document)

Immunization OPV_3 coverage (%)						
1st Admin. level	**Year:**	**Year:**	**Year:**	**Year:**	**Year:**	**Remarks**

7.2(a)NIDs and sNIDS Coverage (%) for the last 10 years, by first Administrative level, (i.e. State, Region, Province, etc.) (as in item 90 of the National Document)

	Year				Year				Year			
	Date 1st Round and cover. %		Date 2nd Round and Cover. %		Date 1st Round and cover. %		Date 2nd Round and Cover. %		Date 1st Round and Cover. %		Date 2ndRound and Cover. %	
1st Admin. Level.	Date	Cover.	Date	Cover.	Date	Cover.	Date	Cover.	Date	Cover.	Date	Cover.

7.2(b)Summary of 'Mopping-up' activities for the last 5 years (as in item 92 of the National Document):

Year	Reason for Mopping up	Geographical Areas included	Age group	Date 1st round	Date 2nd round	Number Immunized 1st round	Number Immunized 2nd round

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

8.1 Please attach to the report the latest version of the national plan for an effective response to an importation with wild poliovirus.

8.2 In case there had been importations during the last ten years, please provide a summary report on the detection of and response to each importation.

9. Lessons learnt from the activities related to the polio eradication initiative

9.1 Please describe if and how the national polio eradication initiative contributed to the national health services, in particular in the field of prevention and control of communicable diseases

9.2 Please indicate if and how the polio eradication initiative contributed to meeting some of the health needs of hitherto underserved communities in the country.

10. Future utilization of the infrastructure for polio eradication

Considerable infrastructure has been created for the polio eradication. Once the polio eradication has been achieved and certified, such infrastructure will be available for other uses. Please describes briefly the Government's intention of the future utilization of:

10.1 The national personnel trained for the AFP surveillance

10.2 The surveillance system (adapted as appropriate) developed for the AFP surveillance

10.3 The polio laboratory and other resources (where such laboratory exists) and the national personnel trained for the laboratory

11. Feasibility of sustaining the polio-free status

11.1 Please comment on the Government's commitment to making available the necessary resources (both human and material) needed to maintain high standard of polio eradication activities, particularly AFP surveillance, until such time that Regional and Global eradication of wild poliovirus has been achieved and certified.

11.2 Please describe any major constraints likely to militate against maintaining the polio-free status in the country and indicate how such constraints might be overcome.

Checklist

1. Executive summary

2. Country background information
2.1 demographic data
2.2 map of the country showing major urban centres, etc.
2.3 socio-economic and health indicators
2.4 organization of the country's health system

3. Description of the eradication process
3.1 when NCC was established
3.2 names, qualifications and years served of the NCC
3.3 when NEC was formed
3.4 name, qualifications and year served of NEC
3.5 support of the polio programme to both NCC and NEC
3.6 persons responsible for immunization policies since polio eradication started

4. History of poliomyelitis in the country
4.1 polio as public health problem in the country
4.2 line chart of polio incidence
4.3 last confirmed case of wild poliovirus (WPV) in the country
4.4 when polio programme shifted to virological classification
4.5 (a) cases of VAPP and polio-compatible cases
(b) response to last 5 polio-compatible cases
4.6 map of polio cases

5. Performance of the AFP surveillance
5.1 selection and training of the AFP surveillance staff
5.2 criteria for selecting sites for active AFP surveillance
5.3 any problems involved in item 5.2 above
5.4 areas at risk for WPV
5.5 (a) completion of routine reporting
(b) completion of active surveillance reporting
5.6 performance of AFP surveillance
5.7 criteria for referring AFP cases to NEC
5.8 final diagnoses of AFP cases discarded as non-polio by NEC
5.9 any supplementary surveillance activities
5.10conclusions and recommendations of WHO/EMRO sponsored AFP surveillance review(s)

6. Laboratory activities, including laboratory containment of WPV and potentially infectious material
6.1 national laboratory accreditation results
6.2 (a) specimens submitted for polio studies
(b) polioviruses isolated from specimens
6.3 sequencing data on most recent WPV in the country
6.4 coordination with AFP surveillance staff, including communication of results
6.5 completion of Phase1 of laboratory containment

7. Immunization activities carried out by polio eradication
7.1 annual immunization coverage (%), by 1st Administrative level
7.2 (a) NIDs and sNIDs coverage (%)
(b) mopping-up activities

8. Updated national plan of action for responding to an importation with wild poliovirus
8.1 the plan to be attached to the Final Report
8.2 report on imported WPVs

9. Lessons learnt from the activities related to polio eradication initiative
9.1 any contribution of the initiative to the health services
9.2 any contribution of the initiative to the health needs of underserved communities

10. Future utilization of the infrastructure for polio eradication
10.1 national personnel trained for the AFP surveillance
10.2 surveillance system developed for AFP surveillance
10.3 polio laboratory and personnel

11. Feasibility of sustaining the polio-free status
10. Government commitment to polio-free status
10.2 any constraints likely to work against the polio-status.