WORLD HEALTH ORGANIZATION
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Report of the 21st Meeting of the European Regional Certification Commission for Poliomyelitis Eradication

Copenhagen, Denmark, 9-11 June 2008

ABSTRACT

The 21st Meeting of the European Regional Certification Commission for Poliomyelitis Eradication (RCC) reviewed updates on the national polio eradication programme and laboratory containment activity from all Member States of the WHO European Region. The Region has sustained its polio-free status but the risk of importation of wild poliovirus is still high and may be increasing. In spite of high poliovirus immunization coverage and good performance indicators for polio surveillance reported by most Member States, data suggest that the quality of AFP surveillance has been slowly declining throughout the Region since 2002 and that high-risk sub-populations and underserved areas remain, for which polio surveillance and immunization indicators are weak. This situation calls for strong political and financial commitment from all Member States to address these issues to assure global eradication of poliomyelitis.

Keywords

POLIOMYELITIS – prevention and control
CERTIFICATION
IMMUNIZATION PROGRAMS
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EPIDEMIOLOGIC SURVEILLANCE – standards
CONTAINMENT OF BIOHAZARDS – standards
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Glossary

AFP	acute flaccid paralysis
AFP index	non-polio AFP rate up to 1.0 (percentage of AFP cases with at least one adequate stool specimen within 14 days)
cVDPV	circulation of a vaccine-derived poliovirus
IPV	inactivated polio vaccine
iVDPV	vaccine-derived poliovirus isolated from immunodeficient patient
mOPV1, 3	monovalent oral polio vaccine types 1, 3
MECACAR	Mediterranean and Caucasian countries and central Asian republics
NCC	national certification commission
OPV	oral polio vaccine
RCC	Regional Certification Commission for Poliomyelitis Eradication
SIA	supplementary immunization activity
tOPV	trivalent oral polio vaccine
VDPV	vaccine-derived poliovirus

Introduction

The 21st Meeting of the European Regional Certification Committee (RCC) for the Eradication of Poliomyelitis was held at the World Health Organization (WHO) Regional Office for Europe, Copenhagen, Denmark, from 9 to 11 June 2008. Dr Nedret Emiroglu delivered a message from the WHO Regional Director, noting that this was the tenth year since the last indigenous case of poliomyelitis caused by a wild virus had occurred in the Region. This remarkable achievement had been accomplished through the dedicated efforts of all countries in the Region and their international partners. Dr Emiroglu welcomed Professor Salisbury as the new chairperson of the RCC, following Sir Joseph Smith. She also noted with regret that Dr Walter Dowdle would be resigning from the RCC following this meeting. Dr Bruce Aylward, WHO Director for the Response to Polio, welcomed the participants on behalf of Dr Margaret Chan, Director-General of WHO, and noted her personal recommitment to achieving global polio eradication following a programme review the previous week. Dr Harry Hull served as rapporteur. The programme is contained in Annex 1 and the list of participants is in Annex 2.

Scope and purpose of the meeting

The scope and purpose of the meeting were as follows:

- to brief the European RCC on the regional and global status of polio eradication and national plans of action;
- to review annual updated certification documentation on poliomyelitis in all Member States for 2007;
- to discuss the current situation regarding the sustaining of polio-free status in selected Member States;
- to review the current status of regional laboratory containment;
- to review working procedures of the RCC and to discuss a plan of activities for 2008–2009;
- to brief the members of the RCC on recent meetings, including the Advisory Committee on Poliomyelitis Eradication (ACPE, Geneva, November 2007); the Strategic Advisory Group of Experts (SAGE, Geneva, November, 2007 and April, 2008); the European Technical Advisory Group of Experts on Immunization (ETAGE, Copenhagen, August 2007); European Immunization Week (April 2008); the 60th World Health Assembly (Geneva, May 2007) and the Eastern Mediterranean RCC meeting (Cairo, April 2008).

Progress towards global eradication of wild poliovirus: challenges and perspectives

As the global polio eradication initiative enters its 21st year since the goal was originally established in 1988, the challenge ahead is whether the transmission of wild poliovirus can be stopped globally by the end of 2009. An intensified polio eradication initiative was recently launched by the Director-General to meet the challenges ahead. The intensification relies on

developments in three areas. The first is to use existing tools better as well as new tools, most notably the use of monovalent oral polio vaccines and improved laboratory techniques. The second is to employ more effective tactics tailored to meet area-specific problems, and the third is to improve advocacy, with the Director-General personally leading these efforts. Progress against type 1 wild poliovirus has been remarkable in India as a result of the use of monovalent oral polio vaccine type 1 (mOPV1), with only five cases so far in 2008. Type 3 wild poliovirus increased because mOPV1 provides no protection against it. There is cautious optimism that supplementary immunization activities (SIAs) with mOPV3 in 2008 are bringing that outbreak to an end. Wild polioviruses are circulating in only limited areas of Afghanistan and Pakistan. The situation in Nigeria is of great concern with the number of poliomyelitis cases at twice the level of four years ago. Importations into Angola, the Democratic Republic of the Congo and Sudan have still not been controlled. It appears that type 1 wild poliovirus transmission may be halted in Asia by the end of 2009 but will be delayed in Africa by one year. Planning for the post-eradication era continues to move forward. The long-term containment plan (*WHO Global Action Plan for Laboratory Containment of Polioviruses*, 3rd ed. – GAP III) has been drafted and is under review. The current challenges for the polio-free regions, including Europe, are: to maintain high vaccination coverage and high quality, sensitive surveillance; to ensure response capacity to detect and respond to any importations; and to keep abreast of plans for containment of polioviruses. International commitment and capacity to finish polio eradication is now at an all-time high. Polio-free countries are, however, increasingly and inappropriately complacent about the risks of poliomyelitis.

Progress towards regional certification of the WHO Eastern Mediterranean Region

The Eastern Mediterranean Region has continued intensified efforts to eradicate wild poliovirus. Only 58 cases of poliomyelitis were reported from four countries in 2007, the lowest level ever reported. Accute flaccid paralysis (AFP) surveillance indicators are high throughout the region and all laboratories in the network are accredited. SIAs are being conducted every 4–6 weeks in the two endemic countries (Afghanistan and Pakistan) as well as in Somalia. Advocacy efforts have been initiated with the new government and local authorities in Pakistan as well as with both sides of the conflict in Afghanistan. Basic documentation for certification has been accepted from 19 countries, including final documentation from the 14 countries that have been polio-free for five years or more. In addition to stopping ongoing wild poliovirus transmission and preventing its importation into more countries, the priorities for the region are to ensure completion of Phase I of laboratory containment and preparing for regional and global certification.

Sustaining the poliomyelitis-free status of the European Region, and strategic plan of action for 2009–2013

As it celebrates its tenth year since the last indigenous case of poliomyelitis (in Turkey in 1998), the European Region is continuing its efforts to strengthen national immunization programmes within the context of overall health systems development, with an emphasis on sustaining polio-free status, eliminating measles/rubella by 2010, supporting the introduction of new and under-used vaccines and strengthening national vaccine-preventable disease surveillance systems, including laboratory networks. Most countries in the Region report polio immunization coverage at 95% or more. Prompt provision of immunization is, however, a problem in several countries. There is an overall

trend in the Region to move from OPV immunization to either OPV/inactivated polio vaccine (IPV) schedules or IPV-only schedules. An analysis of data at subnational levels often reveals districts that are under-performing. The provision of immunization services to vulnerable and hard-to-reach populations is a particular challenge. Most countries conduct AFP surveillance but some industrialized countries rely exclusively on enterovirus and environmental surveillance. A slow decline in the quality of AFP surveillance has been evident since the Region was certified polio-free. Guidelines on responding to the detection of wild poliovirus in the WHO European Region have been published.[1] Seventeen countries have revised their national plans of action to sustain their polio-free status and submitted new plans of action for 2008–2010. Key areas for action by the Regional Office are: to ensure continuous political commitment and support for eradication of poliomyelitis; to maintain high-level immunity against poliomyelitis; to sustain high-quality AFP surveillance; to preserve and expand (if necessary) supplementary virological surveillance for polioviruses; to assure an appropriate response to possible importation of wild polioviruses or detected cVDPV circulation; to meet requirements for laboratory containment of wild polioviruses; to prepare for cessation of OPV; and to assure appropriate financial and human resources. The European Regional Strategic Plan to Sustain Polio-Free Status of the Region 2008–2013 has been finalized and is being published.

Regional overview for 2007

Because of the diversity of the 53 Member States in the Region, the information provided by countries was reviewed by six geographical zones. Three countries (Luxembourg, Monaco and San Marino) had not submitted reports since 2003. Indicators analysed for each country included: the number of meetings of their national certification commissions (NCC) in the period 2004–2007; immunization coverage (percentage of children vaccinated with three doses of polio-containing vaccine by one year of age reported in the WHO/UNICEF joint reporting form for 2000–2006 and provisional data for 2007); and the immunization policy reported in the annual country update. Surveillance indicators analysed included: the AFP index for 2000–2007, the AFP index for 2007 mapped by subnational areas, and the quality indicators for AFP surveillance for 2007, including the non-polio AFP rate, the percentage with one stool within 14 days of onset, the percentage follow-up within 60–90 days and the percentage of cases for which an immunization history was recorded. Additional indicators reviewed were surveillance for wild poliovirus in AFP cases (number of non-polio enterovirus and poliovirus isolates in 2007) and supplementary surveillance for wild poliovirus (enterovirus surveillance and environmental surveillance). The quality of the reports provided by some countries was substandard, with incomplete or unclear information. It is of particular concern that the membership of NCCs is often not clear and their role in preparing the reports is ill-defined. In some instances, it was not even clear that the NCC had reviewed the report prior to its submission. The quality of NCCs' work must be substantially improved if the Region is to meet the requirements for global certification.

Nordic/Baltic zone

Denmark and Norway did not hold any NCC meetings from 2004 to 2007. Iceland did not hold an NCC meeting in 2006; it was unclear if a meeting was held in 2007, and no report was submitted on immunization coverage for 2007. Most countries in this zone use IPV. Estonia will switch from OPV to IPV in 2008. Latvia used a mixed IPV/OPV schedule in 2007. Immunization coverage has

[1] *Guidelines on responding to the detection of wild poliovirus in the WHO European Region*. Copenhagen, WHO Regional Office for Europe, 2007.

been universally high (>90%). Denmark changed its methodology for measuring immunization coverage in 2007 and reported coverage of 65%. The extent to which this drop in reported coverage is an artefact is unclear. Denmark, Finland, Iceland and Sweden do not conduct AFP surveillance. AFP surveillance declined in Norway after having improved in 2006. Estonia did not report any AFP cases in 2007. Latvia and Lithuania had high-quality AFP surveillance. Many subnational geographical regions have small populations that could not be expected to report one AFP case per year, although some continue to report no cases after five years. All countries conduct enterovirus surveillance. Three countries conduct environmental surveillance. Sweden conducts aseptic meningitis surveillance.

Conclusion

There is apparently no NCC activity in three countries. The majority of countries have sustained high immunization coverage and high-quality surveillance through AFP and/or supplementary surveillance. The major challenges for all of these countries are to maintain their political commitment, update and implement plans of action to sustain their polio-free status, sustain high-quality poliovirus surveillance and strengthen the activities of their NCCs.

Western zone

Overall, NCC activity in the western zone is low. No reports had been received from Ireland, Luxembourg or Monaco. NCCs met in Austria, Belgium, France and Germany. NCCs in the Netherlands and Switzerland did not meet in 2007. All countries are using IPV exclusively and coverage is universally high. However, Belgium, France, Luxembourg and Monaco did not submit coverage data for 2007. High-risk populations exist in many countries. Of particular concern is the frequent contact with endemic countries and countries with re-established transmission due to imported virus. Five countries conduct AFP surveillance but the quality of AFP is low and declined precipitously in Austria and Ireland. Areas reporting zero AFP cases are a concern. The collection of stools is not prompt and follow-up is incomplete. All reporting countries have enterovirus surveillance.

Conclusion

NCC activity has declined in five countries. Most countries maintain high levels of immunization coverage. The quality of surveillance is inadequate in all countries conducting AFP surveillance. Supplementary surveillance is well-established in most countries. The major challenges for these countries are to: strengthen NCC activities; maintain or regain political commitment; maintain high coverage, particularly in high-risk subpopulations; and sustain good-quality poliovirus surveillance with regular, continuing collection of supplementary surveillance data, particularly in countries without AFP.

Southern zone

No report was received from Andorra or San Marino. It is unclear if NCC meetings were held in Malta or Portugal in 2007. Immunization coverage is high in most countries with the exception of Malta, where it is only 80%. Most countries are using IPV, although a mixed IPV/OPV schedule is used in Croatia and Cyprus and Malta uses OPV alone. Andorra and Greece did not report coverage data for 2007. AFP surveillance is suboptimal in most of the zone, with only two countries achieving medium-quality surveillance standards. The use of supplementary surveillance is

expanding, with six countries now conducting enterovirus surveillance and five conducting environmental surveillance.

Conclusion

NCC activity has declined in three countries. The majority of countries sustained high immunization levels and continued a combination of AFP and supplementary surveillance. The quality of AFP surveillance remains, however, suboptimal. Major challenges for the countries in this zone are to: strengthen and sustain NCC activities; continue to provide good-quality surveillance and immunization for high-risk subpopulations; strengthen the sensitivity of surveillance, focusing on case reporting and prompt reporting; and continue regular collection of supplementary surveillance data.

Central-eastern zone

The number of countries in this region has increased in recent years. Montenegro has not had sufficient time to set up an NCC and submit a complete report. Although an NCC has been formed in Bosnia and Herzegovina, no formal meeting has been held and no report submitted. WHO has encouraged partners to prepare a unified report but this has not yet been accomplished. NCCs are active in the remaining Member States with the exception of Ukraine, where it is unclear if the NCC has met since 2004. Routine immunization coverage is high in all reporting countries. Serbia did not provide specific data for Kosovo. Bosnia and Herzegovina, Romania and Serbia all have subpopulations with 50–60% coverage. All countries are using OPV with the exception of Ukraine, which has a combined IPV/OPV schedule. While AFP surveillance was good to excellent in most countries, Bosnia and Herzegovina, Romania and Serbia all experienced a severe decline in the quality of their AFP surveillance systems. Albania has greatly improved its AFP surveillance. Montenegro did not report any AFP cases. Five countries conduct enterovirus surveillance and two conduct limited environmental surveillance. Sabin polioviruses continue to be isolated in countries using OPV.

Conclusion

NCC activities have declined in three countries. The majority of countries sustained high immunization coverage. Good-quality AFP surveillance was maintained by four countries, while a marked decline in AFP quality was noted in three countries. This zone hosts significant minority populations which may be at high risk. Major challenges for the countries are to: maintain or regain political commitment; strengthen their NCCs' activities; sustain or achieve high-quality surveillance covering all territories and targeting high-risk groups/territories; and maintain high levels of immunization coverage, particularly in high-risk subpopulations.

Central zone

Poland and Slovakia have inactive NCCs. It is unclear if Hungary held an NCC meeting in 2007. Polio vaccination coverage is uniformly high. Belarus, Bulgaria, the Czech Republic, Hungary, Slovakia and Slovenia use an all-IPV schedule. Poland uses a mixed OPV/IPV schedule. All countries conduct AFP surveillance, but only in Belarus and Bulgaria is the quality high. In the four remaining countries it is medium-quality. Falling quality of surveillance is of concern for the Czech Republic and Poland. Many districts do not report AFP cases. Isolates of Sabin-like polioviruses were identified in several countries using OPV. Enterovirus surveillance is conducted in all countries except Belarus. Environmental surveillance is carried out in three countries.

Conclusion

NCC activities have declined in three countries. All countries sustained polio immunization in all subnational areas at a high level. Only two countries sustained high-quality AFP surveillance. The most important weakness is the low non-polio AFP rate. Major challenges for the countries are to: maintain or regain political commitment; sustain high levels of immunization in all high-risk subpopulations; and maintain high-quality poliovirus surveillance with regular, continuing collection of supplementary surveillance data.

MECACAR zone

This is the largest zone in terms of both geography and population. With the exception of Kazakhstan, NCCs met in all MECACAR countries in 2007. However, the number of NCC meetings fell in most countries. All countries continue to use OPV. The Russian Federation will move to an IPV schedule in the next year and Turkey will move to a mixed IPV/OPV schedule. Vaccination coverage was high with the exception of Armenia, Georgia and Tajikistan (all between 80% and 90%). There are, however, subnational areas where coverage is low, particularly Georgia, Tajikistan and Turkey. SIAs were conducted in Azerbaijan, the Russian Federation, Tajikistan and Turkmenistan in 2007. AFP surveillance was generally good and in Armenia it notably improved. In both Azerbaijan and Georgia there are areas where surveillance reports are provided by international organizations. The quality of AFP surveillance in Turkey has improved at the national level but remains suboptimal in some high-risk areas. Follow-up of AFP cases was good except in Armenia. Many isolates of Sabin-like poliovirus were reported, consistent with the use of OPV in the zone. Six countries conduct enterovirus surveillance and five conduct environmental surveillance.

Conclusion

NCCs continue to be active, except in Kazakhstan. The majority of countries maintained high routine immunization coverage and high-quality AFP surveillance, although some failed to meet standard criteria at subnational level, particularly in the Caucasus. Areas of suboptimal immunization coverage remain in certain countries. Four countries conducted SIAs and two employed outreach strategies for increasing immunization coverage in high-risk territories. Major challenges for the countries are to: sustain political commitment, particularly in the light of restructuring in some ministries of health; sustain national surveillance activities in the face of decreasing funding; update national plans of action to sustain polio-free status and to respond to an importation of wild poliovirus; assure prompt delivery of stool specimens to national and regional reference laboratories; sustain the accuracy and promptness of reporting and classification of AFP cases; and maintain high levels of immunization coverage, particularly in high-risk subpopulations.

Performance of the Regional Poliomyelitis Laboratory Network (LabNet) in 2007–2008

The LabNet plays a central role in maintaining the polio-free status of the Region by documenting the absence of wild poliovirus and rapidly detecting any importations of poliovirus. All Network laboratories are fully accredited and passed their annual laboratory proficiency test in 2007. Member States reported that 156 988 samples were analysed in 2007 from predominantly three sources – cases of AFP and contacts, patients with suspected enterovirus infection and environmental (sewage) sampling. Approximately 2500 of these samples were collected from AFP

cases and their contacts. The majority of samples (98.6%) were investigated promptly. The vast majority of samples were from enterovirus surveillance (123 199, 78.5%). The Network continues its efforts to improve the sensitivity of enterovirus surveillance for poliomyelitis, for example, by recommending that Member States should collect faecal samples and cerebrospinal fluid.

The Network detected 1 imported wild poliovirus, 1688 Sabin-like viruses and 8 vaccine-derived polioviruses. The wild virus was a type 1 that apparently originated in Chad, based on the 98.8% nucleotide homology (VP1 genomic region) with the recent isolates from this country, and was imported into Switzerland. It was isolated from sewage in the canton of Geneva in August 2007. The virus was never detected again despite continued sampling and there was no spread in humans.

A type 2 iVDPV (1.88% nucleotide divergence from Sabin 2 in VP1 region) was isolated from an immunodeficient boy in Belarus in May 2007. Recent sampling (June 2008) shows that the patient is currently not excreting the virus. There are two known long-term immunodeficient excreters in the Region, one in the United Kingdom (iVDPV type 2, 17.4% divergence) and one in Germany (iVDPV type 1, 10.5% divergence).

A highly diverged type 2 VDPV continues to be seen in sewage samples collected in north Tel Aviv, Israel. The virus was first identified in 1998 and was last seen in February 2008 (highest divergence is 15.06%). The genomic properties of these viruses as well as pattern of excretion and a relatively small geographic area where they are isolated indicate that the most likely source of these viruses is an immunodeficient person.

LabNet also played a crucial role in establishing the etiology of multiple aseptic meningitis outbreaks and sporadic cases, and isolated 11 187 non-polio enteroviruses. Its involvement in surveillance for enteroviruses is a key factor in maintaining high-quality laboratory-based surveillance for poliomyelitis in the Region.

Review of national updates for 2007 and presentations by selected countries

Armenia

Armenia reported its last polio case in 1996. Routine immunization coverage was above 90% until 2004, when it fell to 85% as a result of a vaccine shortage. Immunization coverage as determined by administrative methods currently stands at 86%. However, the country believes the percentage of children immunized is actually higher based on a lot quality survey conducted in 2006, which found national coverage at 95%. Concern remains, though, about several regions that have coverage as low as 50–60% by the administrative method. AFP surveillance was initiated in 1996. While at high levels at the time of regional certification, compliance with AFP indicators fell in 2006, when only eight AFP cases were reported. Sixteen AFP cases were reported in 2007. The non-polio AFP rate in 2007 was 2.5, up from 1.1 in 2006; 87.5% of AFP cases had one adequate stool specimen within 14 days of the onset of paralysis, while 56.2% had two stool specimens taken one day apart. AFP cases were reported from 8 of the 11 regions in 2007. The country has active AFP surveillance at infectious and neurological hospitals: 144 samples were tested under enterovirus surveillance, yielding five non-polio enteroviruses and one ECHO virus. Environmental surveillance was conducted at a single child care home with no positives among 25 samples collected. A national

plan for maintaining polio-free status has been formally adopted by the government. An SIA is planned for 2008.

Country-specific feedback from the RCC

The evidence presented by Armenia provides confidence that there is no polio in the country and that if there were, it would be found. The NCC meets and is functioning well. The report is complete and provides details of the individual members of the committee. The RCC is concerned over the drop in immunization coverage, initially due to shortage of vaccine, and notes the possibility that it might occur again. The RCC requests the government to review the security of the national vaccine supply and consider what can be done to prevent recurring shortages.

Bosnia and Herzegovina

Representatives of Bosnia and Herzegovina were unable to attend the meeting. No presentation was submitted.

Switzerland

Switzerland provides universal access to health care. Five doses of IPV are recommended in infancy and early childhood. The latest survey data are from 2006 with national IPV3 coverage averaging 94%. Four central cantons had 85–89% coverage. The last indigenous case of polio was in 1982 and the last imported case was in 1987. There has been voluntary notification of AFP cases since 1995. The AFP rate has been >1 /100 000 for the last two years. Adequate stool collection rates were, however, below 20% in both of those years. There has been mandatory reporting of polioviruses from laboratories since 1974. The last virus notified was a Sabin-3 virus in 2007. Containment has been initiated with 13 laboratories retaining either actual or potential wild poliovirus infectious materials. A wild type-1 virus was isolated from sewage samples in Geneva in August 2007 and the Regional Office was notified in October 2007. This virus was very closely related to a virus of Nigerian origin that had been circulating in Chad. An investigation failed to find any evidence that this virus had circulated or caused disease in Switzerland. Continuing sampling of sewage from Geneva identified a Sabin-like type 2 virus in January 2008 but no additional wild viruses. Switzerland has not had a chairperson of its NCC since 2006, and the NCC did not meet in 2007.

Country-specific feedback from the RCC

The RCC commends Switzerland for its prompt and appropriate response to the wild poliovirus environmental isolate by expanding its search for evidence of transmission and finding none. This incident serves as a reminder of the continued risk of wild poliovirus importation. The RCC is pleased that environmental surveillance will continue, but urges Switzerland to give high priority to reconstituting its NCC and improving AFP surveillance, with special attention being given to increasing the rate of stool sampling.

Turkey

No new cases of poliomyelitis have occurred in Turkey since the last case reported in November 1998. After the polio eradication initiative began in 1989, the level of polio cases remained static until national immunization days were initiated in the mid-1990s. Mopping-up immunization activities eliminated the final chains of transmission and subsequent SIAs have kept the country free

of polio. The government recently made a strong commitment to maintaining high levels of routine immunization coverage. As a result, national immunization coverage now stands at 96%. Only seven provinces have coverage between 80% and 90%. SIAs are being planned for provinces with low OPV3 coverage rates and poor AFP surveillance indicators in 2007. Turkey moved to a combination IPV/OPV schedule at the beginning of 2008 with OPV given at doses three and four and a booster at six years of age. The national AFP rate has been close to one or above since 1998 and was 1.1 for 2007. Adequate stool samples are collected in 80% of cases. AFP rates are above one and stool collection rates above 80% in most subdivisions of the country. Phase 1 containment has been completed with only one facility retaining wild poliovirus infectious materials and two facilities retaining potentially infectious materials. A BSL-3/polio laboratory is under construction.Turkey is committed to sustaining its poliovirus-free status.

Country-specific feedback from the RCC

The RCC wishes to compliment Turkey on the overall excellence of its report. The material presented was complete and clear. The NCC was clearly identified. Turkey is also complimented on its progress towards eradicating poliomyelitis and improving routine immunization. Based on the data presented, the RCC is confident that Turkey is polio-free. It is, however, a time of change and there is a need to consolidate the achievements. As the country moves to a mixed schedule of OPV/IPV, it must take care that there is no drop-off in the performance of its routine immunization programme. Because of its geographic situation, there is a high risk that polioviruses will be imported. The country must maintain the high standard of AFP surveillance that it has worked so hard for so many years to achieve.

Containment activities in 2008–2009: policy, strategies, actions

Globally, 168 countries (78%) have completed their Phase I survey and inventory. Ten countries are doing so. The situation with regard to containment has improved, with some laboratories destroying their wild poliovirus infectious materials. Approximately 600 facilities with wild poliovirus have been identified. Within the Region, 90 laboratories in 23 countries are holding wild poliovirus infectious materials, compared with 111 laboratories in 25 countries in 2006, and 201 laboratories currently hold potentially infectious material compared with 265 in 2006. The number of countries reporting no infectious materials currently stands at 29, an increase of two in the past year. In anticipation of Phase II activities, Member States should undertake the following:

- ensure that they have administrative and financial resources for implementing and documenting containment activities required one year after the last detection of wild poliovirus;
- initiate the development of a national long-term policy on polioviruses for post-eradication/post-OPV cessation;
- initiate work on establishing national poliovirus regulations and regulatory infrastructures to ensure their consistency with international regulations;
- initiate the destruction of low-value wild poliovirus infectious materials.

Plans for 2098–2009 include: piloting the WHO global strategy to ensure that the risk of wild poliovirus reintroduction is part of a national biosafety strategy; conducting a survey of facilities

with OPV infectious material; and strengthening biosafety. Plans for risk-elimination and risk-management in facilities that have poliovirus are being developed in France. The results will be shared as a model for other countries.

Key meetings and activities

Advisory Committee on Poliomyelitis Eradication (Geneva, November 2007)

Two major developments were reported to the Advisory Committee on Poliomyelitis Eradication (ACPE): (i) 2007 saw the lowest incidence of wild poliovirus1 ever reported, and (ii) a contribution of US$ 200 million was to be made by Rotary International and the Gates Foundation over the next four years. The ACPE noted that the 84% reduction of wild poliovirus cases was primarily due to the extensive use of mOPV1, particularly in India. They recommended that an appropriate mix of mOPV1, mOPV3 and tOPV should be used for SIAs in endemic areas to interrupt remaining wild poliovirus transmission. All countries re-infected with poliovirus should fully implement the ACPE recommendations on outbreak response. Prevention of cVDPVs required a focus on detection and strengthening routine immunization systems. All polio-free countries should complete phase 1 containment activities by the end of 2008. Exploratory work continues on a bivalent vaccine for types 1 and 3 OPV and a Sabin IPV. Work needs to continue on affordable and safe ways of producing IPV for the period after OPV use is halted.

Meeting of the Global Certification Commission (Geneva, November 2007)

This was not an official meeting of the Global Certification Commission; rather, the chairpersons of the six RCCs met to share experiences and discuss issues of mutual concern. Their primary concern was progress in the endemic regions. Chairpersons from the other regions praised the work of the European RCC. They felt that other regions could learn from European experience with containment. Classification of countries by risk of transmission could be adopted by other RCCs. The European Regional Plan to Maintain Polio-Free Status, 2008–2013 was, again, felt to be a model. The Western Pacific RCC discussed the challenges for the polio-free regions in maintaining the laboratory network and keeping programmes operational in anticipation of global eradication. There was agreement on the need for new terms of reference for the NCCs in the polio-free Regions as both they and the RCCs play a vital role in keeping programmes moving forward and maintaining quality of work.

European Technical Advisory Group of Experts on Immunization (ETAGE) (Copenhagen, August 2007)

The seventh meeting of the European Technical Advisory Group of Experts on Immunization (ETAGE) received an update on maintaining the polio-free status of Europe. The European Regional Strategic Plan to Sustain the Polio-Free Status of the Region in 2008–2013 was reviewed and endorsed. ETAGE also reviewed progress towards the elimination of measles and rubella and discussed the creation of commissions for the certification of such elimination. The meeting concluded that there was a need to remain vigilant and step up efforts for the elimination of measles

and rubella and maintain the polio-free status of the Region. This will prove challenging in the context of communicable disease reform within the Regional Office.

European Immunization Week, 21–27 April 2008

The European Immunization Week is the Region's main advocacy event for immunization. Thirty-three Member States participated in the 2008 Week. The overall message was the need and right of every child to be immunized, with a focus on high-risk groups. During the Week, each country implements its own programme to inform and engage key target groups and to target critical immunization challenges. The 2008 European Immunization Week was held in coordination with the Regional Vaccination Week in the Americas. The ultimate goal is a global immunization week. More information about the European Immunization Week can be found at the Regional Office's Vaccine-Preventable Diseases and Immunization website.[2]

Strategic Advisory Group of Experts (Geneva, November 2007; April 2008)

The last two meetings did not focus extensively on poliomyelitis but heard reports on post-eradication strategies. The Strategic Advisory Group of Experts (SAGE) indicated that future discussions should focus on how to interrupt transmission. The SAGE meeting to be conducted in November 2008 would have polio eradication as a major agenda item. The session was not intended to focus on the nuances of post-eradication strategies but to be an open and frank discussion about barriers and how they will be overcome. SAGE wanted to know what the real prospects were of the challenges being met, so that it could advise the Director-General on the most strategic way to move forward.

Conclusions and recommendations

Conclusions

The RCC reviewed all available country reports and supplementary information provided by the Secretariat, and concluded that the European Region remains free of wild poliovirus transmission ten years after the last indigenous case of poliomyelitis in the Region. The RCC noted that, unfortunately, the performance of many NCCs has declined in recent years and concluded that they must be revitalized both to assure the continuing polio-free status of the Region and to prepare the Region for global certification. The RCC remained greatly concerned that, in spite of progress achieved globally, the risk of importation of wild poliovirus into the Region remains very high due to its continuing transmission in the four remaining endemic countries and countries where transmission of imported viruses has been re-established. Frequent travel between these countries and Europe increases the risk of importation. While immunization coverage is sufficiently high to prevent poliovirus transmission in most areas of the Region, an imported wild poliovirus or vaccine-derived poliovirus could spread in geographical areas and/or subpopulations with low immunization coverage. The RCC was concerned that surveillance indicators had been generally declining throughout the Region and emphasized the importance of all countries within the Region

[2] Vaccine-Preventable Diseases and Immunization [web site]. Copenhagen, WHO Regional Office for Europe, 2008 (www.euro.who.int/vaccine, accessed 20 October 2008).

maintaining high-quality surveillance for poliomyelitis as well as other vaccine-preventable diseases. The RCC commended the minority of countries that had made significant efforts to maintain or improve immunization coverage, identify high-risk populations and conduct high-level surveillance for polioviruses.

The current global situation calls for a strong political commitment by all Member States to stop poliovirus transmission and provide sustained financial support for the global polio eradication programme. Continuing financial support for the global programme by industrialized countries is crucial. The RCC looks forward to the Regional Director continuing to advocate the sustaining of Europe's polio-free status and increasing political and financial support for the global polio eradication initiative.

As the Region celebrates the tenth anniversary since its last indigenous polio case, the RCC wishes to extend its gratitude to Dr Walter Dowdle for his many years of meritorious service on the Commission.

Recommendations

1. The RCC is concerned about the significant number of NCCs that have not held a meeting in recent years and the lack of clear delineation of NCC review and approval of national reports received. Accordingly, the RCC requests the Regional Director to write to all Member States emphasizing the risk of both wild poliovirus importation and VDPV emergence, the importance of maintaining polio-free status, and the central role of the NCC in validating national status. The letter should strongly urge countries to take the following steps.

    a) NCCs should be constituted or reconstituted so that they are clearly independent of the national programme and have a specified membership with clearly defined responsibilities as outlined in the current terms of reference. They should have no operational responsibility for the polio programme. Governments should ensure that their NCCs are active, review programme performance at least annually and approve reports submitted to the RCC. Countries should report back to the WHO secretariat on their NCCs within three months.

    b) The quality of AFP surveillance should be reviewed. Where it does not meet accepted performance criteria, the country should either implement a plan to improve it or consider moving to high-quality, standardized enterovirus surveillance relying on stool samples. In either instance, appropriate funding must be provided to sustain surveillance for the long term. Countries that are unable to conduct effective poliovirus surveillance should provide evidence that their health infrastructure is of such high quality that any case of poliomyelitis would be detected early.

    c) National plans for action in response to a polio importation should be developed/reviewed as part of the emergency response plan under international health regulations. The poliomyelitis annex to the plan should identify people with specific expertise in poliomyelitis who would guide the response. The plan should also specify the vaccine that would be used to control any importation, the rationale for choosing this vaccine and the source for an emergency vaccine supply. By June 2009, countries should conduct an exercise to test the national response plan.

2. Country reports for the 2009 RCC meeting should report on results of the exercise testing the national response to an imported poliovirus or specify dates when this exercise will be conducted before the end of 2009.

3. Country reports for the 2009 RCC meeting should provide specific details of the country plans for sustaining surveillance in the long term.

4. By the end of 2008, the WHO secretariat should review the form used for NCCs to submit their annual information to ensure that the information submitted accurately and completely reflects the polio-free status of each country.

5. The RCC requests ETAGE to address the issue of which vaccines can/should be used for controlling an introduction of poliovirus into one of the Member States and how vaccine can/should be stockpiled.

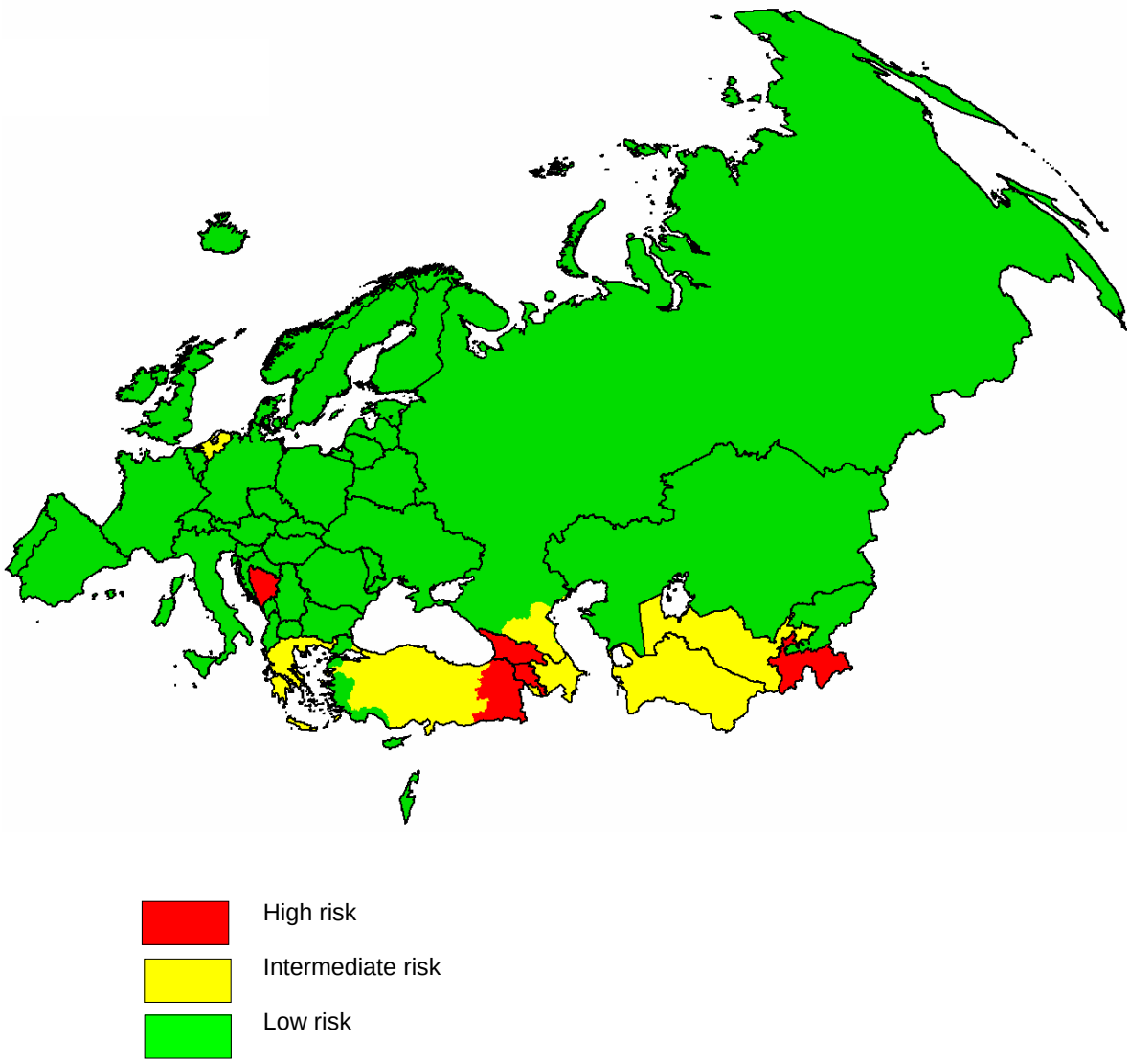
6. The RCC wishes to have more direct communication with the NCCs. The WHO secretariat should keep the chairperson of the RCC informed on progress towards reconstituting the NCCs and assist in establishing communications between him/her and the chairpersons of the NCCs. The latter should have a stronger presence at RCC meetings to communicate more effectively about their national situations. The WHO secretariat should explore alternative RCC meeting formats to facilitate their involvement. WHO should seek additional financial resources should it be necessary to alter sites or increase the frequency and/or size of RCC meetings.

7. The RCC reviewed the data provided by each national programme and reassessed the potential for poliovirus transmission following the introduction of a wild poliovirus or a vaccine-derived poliovirus. The RCC concludes that the Region remains at low risk of poliovirus transmission, with the exception of the following countries (Fig. 1):

High risk	*Intermediate risk*
Armenia	Azerbaijan
Bosnia and Herzegovina	Greece
Georgia	Netherlands
Tajikistan	Russian Federation (northern Caucasus region only)
Turkey (southern and eastern areas only)	Turkey (except the high-risk south and east and the low-risk western coast)
	Turkmenistan
	Uzbekistan

8. The tentative dates for the 22nd meeting of the RCC are 22–24 June 2009.

Fig 1. Risk of transmission following importation of wild poliovirus, European Region, 2008



Annex 2

PROGRAMME OF THE 21ST MEETING OF THE EUROPEAN REGIONAL CERTIFICATION COMMISSION FOR POLIOMYELITIS ERADICATION

Monday, 9 June 2008

	Plenary session 1. Progress towards global polio eradication and sustaining a polio-free Europe
12.30–13.00	Registration
13.00–13.30	Opening WHO Regional Office for Europe Headquarters Chairperson of the Regional Certification Commission
13.30–14.30	Progress towards global eradication. Wild poliovirus: challenges and perspectives (Bruce Aylward) Discussion
14.30–15.00	*Coffee break*
15.00–16.00	Progress towards the Regional Certification of the WHO Eastern Mediterranean Region (MH Wahdan, presented by Magda Aly El Sayed Rakha)
16.00–17.00	Discussion
17.15–18.00	Sustaining the poliomyelitis-free status of the WHO European Region: strategic plan of action for 2009–2013 (Eric Laurent) Discussion
	Reception

Tuesday, 10 June 2008

	Registration
08.30–14.10	Plenary session 2. Sustainability of "polio-free" Europe: review of national updated documents for 2007 by epidemiological zones
08.30–08.40	Introduction to sub-regional zones (Rebecca Martin) Discussion Review of 2007 national data by epidemiological blocs
08.40–09.10	Regional overview: update information for 2007 in the Nordic/Baltic epidemiological zone (eight countries) (Galina Lipskaya) Discussion
09.10–09.50	Regional overview: update information for 2007 in the western epidemiological zone (10 countries) (Rebecca Martin) Discussion
09.50–10.20	*Coffee break*
10.20–11.00	Regional overview: update information for 2007 in the southern epidemiological zone (10 countries) (Eugene Gavrilin) Discussion

11.00–11.30	Regional overview: update information for 2007 in the central-eastern epidemiological zone (eight countries) (David Mercer)
	Discussion
11.30–12.00	Regional overview: update information for 2007 in the central epidemiological zone (seven countries) (Eric Laurent)
	Discussion
12.00–13.00	*Lunch*

Tuesday, 10 June 2008

	Plenary session 2. Sustainability of "polio-free" Europe: review of national updated documents for 2007 by epidemiological zones
13.00–13.40	Regional overview. Update information for 2007 in MECACAR zone (10 countries) (George Oblapenko)
	Discussion
13.40–14.10	Performance of the Regional Polio LABNET in 2007–2008 (Eugene Gavrilin)
	Discussion
14.10–16.40	Plenary session 3. Review of national update for 2007 – presentations by selected countries
14.10–15.10	Armenia, Bosnia & Herzegovina
15.10–15.40	*Coffee break*
15.40–16.40	Turkey, Switzerland
16.40–18.30	Private meeting of the European RCC
	General discussion of update information for 2007 and formulation/drafting recommendations
	Review of risk assessment for potential transmission in the event of a wild poliovirus importation, 2007 (George Oblapenko)

Wednesday, 11 June 2007

09.00–09.30	Private meeting of the European RCC
09.30–10.30	Plenary session 4
09.30–10.00	Containment activities in 2008–2009: policy, strategies, actions (Galina Lipskaya)
	Discussion
10.00–10.30	Feedback to countries
10.30–11.00	*Coffee break*
11.00–12.00	Closed session 5. Private meeting of the European RCC
	Information on key meetings:
	ACPE Meeting (Geneva, November, 2007) (Leo Weakland)
	Meeting of the Global Certification Commission (Geneva, November 2007) (Walter Dowdle)
	Meeting of the European Technical Advisory Group of Experts on Immunization (Copenhagen, August 2007) (Eric Laurent)
	The European Immunization week (21–27 April 2008) (Naroesha Jagessar)
	SAGE (Geneva, November 2007 and April 2008) (David Salisbury)
12.00 – 13.00	*Lunch*

13.00–13.30	Review of a format for country update 2008 Discussion
13.30–14.00	Working procedure of the RCC in 2008 and beyond Terms of reference for the National Certification Committee: post-certification situation in the European Region but before the global certification of poliomyelitis eradication
14.00–14.30	Plan of Action 2008–2009 Country visits (where, who, when and objectives) The RCC meeting in 2009 Participation in meetings
14.30	Closure

Annex 2

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