WORLD HEALTH ORGANIZATION
EUROPE

Report of the 22nd Meeting of the European Regional Certification Commission for Poliomyelitis Eradication

Copenhagen, Denmark, 21-22 June 2009

ABSTRACT

The 22nd 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. In spite of high routine 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
NATIONAL HEALTH PROGRAMS
EPIDEMIOLOGIC SURVEILLANCE – standards
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LABORATORY INFECTION – prevention and control
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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	circulating vaccine-derived poliovirus
GAP II, III	Global Action Plan for Laboratory Containment of Polioviruses, Versions II & III
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 22nd 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 21 to 22 June 2009. Dr Nata Menabde, the Deputy Regional Director, opened the meeting. She emphasized the commitment of WHO to maintaining the polio-free status of the Region seven years after certification and highlighted significant developments both within the Region and at the Global level. Dr. Naveed Sandozai presented the greetings of Dr. Margaret Chan, the Director General of WHO and Dr. Bruce Aylward, head of the global polio eradication initiative. Professor David Salisbury, the RCC Chair, highlighted difficulty of maintaining a focus on polio in light of the current situation with pandemic influenza. He noted that the experience gained during the polio eradication initiative will facilitate mass influenza immunization campaigns as well as influenza-related surveillance. He cautioned that we must maintain our guard as the risk of polio importations will remain significant for the immediate future. Dr. Rebecca Martin welcomed the Commission on behalf of the Secretariat, requesting that they provide the clear guidance necessary to assist WHO and the Member States in keeping the Region free of polio. 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 global and regional status of polio eradication and national plans of action;
- to review annual updated certification documentation on poliomyelitis for all Member States in 2008;
- to discuss the current situation regarding the sustaining of polio-free status in selected Member States;
- to review the current status of the regional laboratory network and regional laboratory containment;

Progress towards global eradication of wild poliovirus: challenges and perspectives

As the global polio eradication initiative enters its 22nd year since the goal was originally established in 1988, the challenge is sustaining the momentum that has been achieved. Epidemiologic progress in 2009 and 2010 is essential. The past year has seen extensive spread of wild poliovirus within Africa with viruses originating in both Nigeria and India. In Nigeria, type 1 virus is now causing outbreaks in the south of the country. In the north, there are outbreaks of type 3 wild poliovirus and type 2 cVDPV. Type 1 wild poliovirus transmission in India has been reduced and is now focal, but persistent. Transmission is focal in Afghanistan and Pakistan, but control efforts are compromised by the political situation and conflict.

The first priority for the coming year must be to stop outbreaks and halt circulation of at least type 1 wild poliovirus in one major endemic country, possibly India. A second priority is achieving real operations progress in all endemics. Zero-dose children must be <10% in all accessible areas by end-2009. A third global priority is fast-tracking of innovations and research. Bivalent OPV should be introduced and new operational innovations/research must be available by the fourth quarter of this year. The crucial, final priority at the global level is an enhanced role for broader partnership. The advantages of all partners must be exploited for sub-national/national advocacy, resource mobilization and achieving access to all areas at risk of wild poliovirus transmission.

Progress towards regional certification of the WHO Eastern Mediterranean Region

The Eastern Mediterranean Region has continued intensified efforts to eradicate wild poliovirus. Two countries, Afghanistan and Pakistan, remain endemic. While the lowest level ever reported was achieved in 2007 with only 58 cases of poliomyelitis reported from four countries, cases increased significantly in the second half of 2008. Type 1 wild poliovirus was also reintroduced into South Sudan. Armed conflict and the political situation create difficulties in accessing children and assuring safety for vaccinators. Population movement between Afghanistan and Pakistan and internally displaced populations is facilitating the spread of wild polioviruses. Acute flaccid paralysis (AFP) surveillance indicators are high throughout the region. All laboratories in the network are accredited. Advocacy efforts continue with the government and local authorities in Pakistan and Afghanistan. Negotiations are progressing for declaring Days of Tranquillity for polio immunization campaigns in Afghanistan. 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

Eleven years after the last indigenous case in Turkey in 1998, the European Region apparently remains free of circulating wild poliovirus. National health systems are strong within the Region, so that any case of paralytic polio will be detected clinically and subjected to a timely laboratory investigation. Immunization services are well established with high and stable coverage with three doses of polio vaccine in a vast majority of Member States. Only two countries - Georgia and Tajikistan – report national coverage below 90%. At the sub national level, areas of Tajikistan and Ukraine are of concern. Countries are conducting outreach programs for groups at high risk – socially isolated, internally displaced and refugee populations. Overall, surveillance for polioviruses remains strong in the Region with 43 countries employing AFP surveillance, 38 relying on enterovirus surveillance and 21 conducting environmental surveillance. AFP rates remain high at national level for most countries using AFP surveillance. The quality of enterovirus and environmental surveillance has improved. Concerns for the Region include: the timely provision of immunization and under-performing districts in several countries, the slowly declining quality of AFP surveillance and the declining quality of National

Certification Committee work. The priorities for the Region are: ensuring continuous political commitment and support, maintaining high level immunity against poliomyelitis, sustaining high quality AFP surveillance, preserving and expanding (if necessary) supplementary virological surveillance for polioviruses, assuring appropriate response to possible importation of wild poliovirus or detected cVDPV circulation, meeting requirements for laboratory containment of wild polioviruses, preparing for cessation of OPV, and assuring appropriate financial and human resources to support the work of the initiative.

Sub-Regional overview for 2008

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) have not submitted reports since 2003. Andorra, Denmark, and Iceland did not submit updates for 2008. In 2008, the NCC's were requested to write a statement indicating why it believed the country remained polio free. The statement was to cover the following elements described below. Indicators analysed for each country included: the number of meetings of their national certification commissions (NCC) in the period 2004–2008; 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 2000–2007 and provisional data for 2008); and the immunization policy reported in the annual country update. Surveillance indicators analysed included: the AFP index for 2000–2008, the AFP index for 2008 mapped by 1st sub national areas, and the quality indicators for AFP surveillance for 2008, 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 2008) and supplementary surveillance for wild poliovirus (enterovirus surveillance and environmental surveillance). Annual updates to the RCC 2006-2008 were reviewed to determine if Plans of Action to Sustain Polio-free Status had been finalized and to note the duration of the plan. Plans for Preparedness to Control Importation, from annual updates to the RCC 2006-2008, were also reviewed to determine if they specified vaccine policy and the target group for SIAs. A risk assessment for substantial transmission after importation of WPV status was assigned to each country based on the following criteria: health system (very good, good, satisfactory), routine immunization coverage (high and stable), presence of high risk groups, surveillance (stable high quality), preparedness planning and stable health authority support to sustain polio-free efforts.

Nordic/Baltic zone

Denmark and Iceland did not hold any NCC meetings from 2004 to 2008 and did not submit updates for 2008. Latvia and Norway did not hold an NCC meeting in 2008. Most countries in this zone use IPV vaccine. Immunization coverage has been universally high (>90%). Denmark changed its methodology for measuring immunization coverage in 2007 and the current coverage level is unclear. Four countries, Estonia, Latvia, Lithuania and Norway, employ AFP surveillance, but of these, only Lithuania has maintained high quality AFP surveillance. All countries conduct enterovirus surveillance while three conduct environmental surveillance. Estonia, Finland and Sweden have finalized plans for sustaining their polio-free status.

Conclusion

The probability of circulation of WPV in countries of this zone is very low due to strong health systems, high immunization coverage and sustained high quality supplementary surveillance. AFP surveillance has value in some countries of this sub-region. NCC activities continue in only four countries (Estonia, Finland, Lithuania and Sweden). AFP surveillance quality is declining in three countries (Estonia, Latvia and Norway). Only three countries submitted national preparedness plans to contain transmission following importation of wild poliovirus.

Western zone

Overall, NCC activity in the Western zone is low. No reports were received from Luxembourg or Monaco. NCCs in Ireland and Switzerland did not meet in 2008. There is no NCC in the Netherlands. The status of the NCC in the United Kingdom is unclear. All countries are using IPV vaccine exclusively. Coverage is universally high with the exception of Austria, where coverage fell to 85% in 2008. High-risk populations exist in many countries. Of particular concern is the concentrated population of persons who refuse immunization on religious grounds in the Netherlands. Frequent travel between Western zone countries and countries with endemic or re-established transmission poses a high risk for viruses to be imported. Five countries conduct AFP surveillance but the quality is low. The AFP index for Austria and Switzerland fell to 0 in 2008. All countries with the exception of Luxembourg and Monaco have enterovirus surveillance. Three countries conduct environmental surveillance. Austria, Belgium and Germany have finalized plans for sustaining their polio-free status.

Conclusion

The probability of WPV circulating in Western zone countries is very low due to strong health systems, high immunization coverage and sustained good quality surveillance, mainly through supplementary surveillance. AFP surveillance is of limited value in this sub-region. The risk remains for sustained transmission following an importation into the Netherlands. NCC activity continues only in three countries (Austria, Belgium, and Germany). Only three countries (Austria, Belgium, and Germany) submitted national preparedness plan to contain transmission following importation of wild poliovirus.

Southern zone

No report was received from Andorra or San Marino. No NCC meetings were held in Italy and Malta. It is unclear if NCC meetings were held in Croatia or Portugal in 2008. Immunization coverage is above 90% with the exception of Malta and San Marino, at 88% and 87%, respectively. Coverage in Andorra is unclear, but has been high in recent years. Most countries are using IPV vaccine. AFP surveillance is conducted in 8 of the 10 Southern zone countries, with Andorra and San Marino being the exceptions. AFP surveillance is suboptimal in most of the zone, with only three countries achieving an AFP index above 0.5. Six countries now conduct enterovirus surveillance and four use environmental surveillance. Only Israel and Spain have finalized plans to sustain their polio-free status. Spain has not specified targets or vaccine policy in case of an importation.

Conclusion

The probability of WPV circulating in the Southern zone is low due to strong health systems, high immunization coverage and sustained high quality surveillance performance through AFP and/or supplementary surveillance in the majority of countries. The presence of high-risk groups (e.g. minorities, illegal migrants) requires special efforts to maintain high coverage and surveillance systems. AFP surveillance performance has weakened in some countries with limited supplementary surveillance activities. Portugal is of particular concern. NCC activities are in place only in four countries. Only two countries submitted national preparedness plans to limit transmission following importation of wild poliovirus.

Central-eastern zone

The NCC in Bosnia and Herzegovina was able to meet for the first time since 2002 and submitted their report for 2008. Montenegro has not been able to establish an NCC and submit a report. NCCs were very active in the remaining countries, with the exception of Ukraine, where it is unclear if the NCC has met since 2004. Routine immunization coverage is above 90% in all countries. While coverage remains above 90% in Ukraine, this level is significantly below that achieved in the past. There are significant subpopulations with low coverage in several countries. All countries conduct AFP surveillance, which was of moderate to excellent quality except in Bosnia and Herzegovina and Montenegro. There are significant numbers of sub national territories that did not report any AFP cases in 2008. Six countries conduct enterovirus surveillance and two conduct limited environmental surveillance. Sabin polioviruses continue to be isolated in countries using OPV. Albania, Moldova, Romania, Serbia and Ukraine have finalized plans of action for sustaining their polio-free status.

Conclusion

The probability of WPV circulating in Central-eastern zone countries is low due to satisfactory health systems, relatively high immunization coverage and existing AFP and/or supplementary surveillance in all of countries. Coverage has decreased in Ukraine. AFP surveillance is weak in several countries. The presence of high-risk groups (e.g. minorities) requires special efforts to maintain high coverage and to ensure quality AFP surveillance. NCC activities continue in the majority of countries. Five countries developed national preparedness plans to limit transmission following importation of wild poliovirus.

Central zone

While Poland and Slovakia have inactive committees, NCCs in the other five countries of the sub-Region held meetings in 2008. Polio vaccination coverage is uniformly very high with very few sub national territories with low coverage. All countries conduct AFP surveillance. Slovenia reported zero AFP cases in 2008. AFP surveillance quality is low in Poland and Slovakia. The sharp decline of AFP surveillance in Poland is of concern. There are significant numbers of sub national territories reporting no AFP cases. Isolates of Sabin-like polioviruses were identified in several countries using OPV. Enterovirus surveillance is conducted in all countries. Environmental surveillance is carried out in three countries. None of the Central zone countries have a finalized plan of action for maintaining their polio-free status.

Conclusion

Probability of WPV circulating in the Central zone is low due to well-established health systems, very high and stable immunization coverage and AFP and/or supplementary surveillance in the majority of countries. AFP surveillance quality has declined in three countries due to low non-polio AFP detection. Although high-risk groups (e.g. minorities) are generally incorporated into public health services, special efforts are still required to maintain high coverage and to maintain surveillance systems. NCC activities have declined in three countries. No country has a current, final national preparedness plan of action to contain transmission following importation of wild poliovirus.

MECACAR zone

NCCs were active in all MECACAR countries in 2008. All countries continue to use OPV vaccine. Immunization coverage has been traditionally high in MECACAR countries and remains so with the exception of Georgia and Tajikistan (both between 85% and 90%). There are significant sub national territories where coverage is low in Georgia and Tajikistan. SIAs were conducted in Armenia, Azerbaijan, Georgia and the Russian Federation in 2008. AFP surveillance is conducted in all countries and was generally of good to high quality. A significant number of sub national territories reported zero AFP cases in 2008. The quality of AFP surveillance in Turkey remains suboptimal in some high-risk areas. In both Azerbaijan and Georgia there are territories where surveillance reports are provided by international organizations. Many isolates of Sabin-like poliovirus were reported, consistent with the widespread use of OPV in the zone. Six countries conduct enterovirus surveillance and seven conduct environmental surveillance. Six countries (Azerbaijan, Georgia, Kyrgyzstan, Russia, Turkmenistan and Uzbekistan) have finalized plans for sustaining their polio-free status. Azerbaijan, Kyrgyzstan and Russia have not specified target population or vaccine policy in case of an importation.

Conclusion

The probability of WPV circulating in the MECACAR countries is low due to high immunization coverage and sustained high quality surveillance performance mainly through AFP surveillance with additional supplementary surveillance activities in the majority of countries. The presence of high-risk groups (e.g. minorities and displaced populations) requires special efforts to maintain high coverage and quality AFP surveillance. Areas of sub-optimal immunization coverage remain in certain countries (Georgia, Tajikistan and Turkmenistan). Four countries conducted supplementary immunization activities to increase population immunity in high-risk sub-populations or territories (Armenia, Azerbaijan, Georgia and Russia). NCCs continue to be active in all countries. Six countries developed national preparedness plans of action to contain transmission following importation of wild poliovirus.

Performance of the Regional Poliomyelitis Laboratory Network (LabNet) in 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 imported poliovirus or cVDPV. All Network laboratories are fully accredited and passed their annual laboratory proficiency test in 2007 and 2008. Member States reported that 6491 samples were analysed in

2008 from predominantly three sources – AFP cases (3424), patients with suspected enterovirus infection (2210) and environmental (sewage) sampling (857). 97% of samples from AFP cases were analyzed within 28 days. No wild polioviruses or their RNA were detected in 2008. 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. With the expanding use of molecular methods for identifying infectious organisms, the network is conducting a field trial of various PCR methods to validate their ability to detect wild polioviruses, VDPVs and recombinant poliovirus strains. Transportation of infectious poliovirus isolates between network laboratories has proven to be increasingly difficult and expensive. The network is currently evaluating a method for transporting non-infectious RNA from polioviruses between laboratories that would greatly facilitate analysis and validation of specimens while reducing cost. The network has been conducting workshops to improve biosafety and biosecurity and is developing new software to facilitate sharing of information between laboratories. Within the network, concerns are increasing about the turnover of trained personnel due to low wages in the public sector of laboratory services.

Review of national updates for 2008 and presentations by selected countries

Bosnia and Herzegovina

Both the National Committee for Certification of Poliomyelitis Eradication and the National Experts Committee for Poliomyelitis were re-established in Bosnia and Herzegovina in 2008. National immunization coverage fell to 83% in 2008 from 93% in 2007 as a result of shortages of vaccine in some areas. No supplemental immunization activities were conducted in 2008. One AFP case was identified in 2008 with negative virological testing conducted in Rome. DTaP/IPV was introduced to the schedule for children <1 year in 2008. This schedule will be adopted in the Republic of Srpska in 2010. The national plan of action for sustaining the polio-free status of the country will be developed in 2009. The NCC has initiated training of health professionals.

Country-specific feedback from the RCC

1. The NCC report is very complete and well organized, but information from Republic of Srpska appears to be less well documented.
2. An AFP surveillance rate of 0.2 is not satisfactory. Hospital record review is one method for improving surveillance and should be explored.
3. WHO should work with the country to prioritize EU funds for polio activities.
4. The RCC supports an immunization campaign to reach older children and adolescents who may be unimmunized or under-immunized. Including polio immunization in a measles/rubella campaign is one option that could be explored.
5. WHO needs to work with the country to clarify both the funding and source for future polio vaccine purchase.
6. Training should be conducted by the national authorities and is not a responsibility of the NCC.

Georgia

The NCC stated that the country remains free of polio based on high immunization coverage and AFP surveillance supplemented by environmental and enterovirus surveillance. While immunization coverage is above 90% nationally, there are 26 districts with coverage less than 90%. Ten of these districts have coverage below 80%. Supplemental immunization campaigns have been conducted to provide one dose to high-risk children <6 years. Polio vaccine is provided by the government of Georgia to Abkhazia and South Ossetia, territories which are not under government control. While the number of doses provided is known, the government does not have actual coverage data from these territories. AFP surveillance is well established, but the AFP rate fell to 0.8 in 2008 and 0.5 to date in 2009. Timely stool collection rates are high. No AFP cases were reported from Abkhazia and South Ossetia, but the populations of these regions are so small that the expected non-polio AFP rate is substantially less than one case per year. Sabin polioviruses have been identified through both AFP and environmental surveillance. Enterovirus surveillance has identified many non-polio enteroviruses. A national plan of action to maintain the country's polio-free status has been finalized including target populations and vaccine policy in case of an outbreak.

Country-specific feedback from the RCC

1. The NCC report is greatly improved over previous reports and the RCC accepts the report.
2. AFP surveillance performance has declined over the past three years. WHO should work with the country to bring the level of surveillance back to the high level previously achieved.
3. There is incomplete information provided on Abkhazia and South Ossetia. WHO should work with other international organizations and NGOs to secure complete information on immunization coverage and AFP surveillance in these territories.
4. The country is to be complimented on the high quality of their plan for responding to an imported poliovirus.

Netherlands

Average immunization coverage is above 90% in the Netherlands, but there are 38 municipalities with coverage below 90% due to significant and concentrated populations which refuse immunization on religious grounds. There have been three major outbreaks of polio in this group. There is no AFP surveillance in the Netherlands; polio surveillance relies on targeted environmental surveillance and enterovirus surveillance. Environmental surveillance was restarted in the high-risk areas of the country in 2005. In 2008, 107 samples were collected from 16 high-risk sites. Only one Sabin virus was isolated. The origin of this virus was unclear. Environmental surveillance is conducted through 20 public health virology laboratories across the country. 10,836 samples were tested by culture or molecular methods with non-polio enterovirus identified in 9%. Poliovirus was definitively excluded for 97% of samples. Two Sabin polioviruses were identified. One was from a child who had travelled to Syria to visit family and the other from a child from Curacao who travelled to the Netherlands for surgery. The country has a formal plan for responding to an imported poliovirus. The country has inventoried laboratories holding stocks of poliovirus and plans are being developed to contain polioviruses.

Country-specific feedback from the RCC

1. The RCC commends the country for the detailed and high quality report provided.

2. Environmental and enterovirus surveillance data provide a convincing picture that wild polioviruses are not circulating in the country.
3. Environmental surveillance in the high risk areas of the country should be maintained until global eradication is certified.
4. A formal NCC should be reconstituted and meet on a regular basis.
5. The original version of the national plan for responding to an imported or circulating poliovirus should be submitted to the RCC along with a summary in English.

Tajikistan

The country has traditionally had high immunization coverage. However, coverage has declined in recent years. In 2008, 44 sub national territories had coverage <90%, of which eight had coverage <80%. Tajikistan conducted NIDs and SNIDs through 2002. An additional SNID was conducted in 2007 which targeted persons <15 years in regions bordering Afghanistan. AFP surveillance indicators have been improving with completeness of stool collection rising significantly in the last two years. AFP cases are distributed throughout the country. Mobile teams are used for surveillance outreach. Non-polio enteroviruses were recovered from 35% of stools and Sabin polioviruses from 1%. A national plan of action for maintaining polio-free status has been prepared including a plan for responding to an importation.

Country-specific feedback from the RCC

1. The RCC commends the country on the quality of the report submitted. The Plan of Action for responding to an imported virus should be submitted as soon as possible.
2. SIAs in the border areas of Tajikistan will be very important for preventing the introduction of wild poliovirus into the Region. Campaigns coordinated with SIAs in neighboring areas of Afghanistan would be ideal. While the country has apparently done a very good job in conducting these campaigns, the NCC report does not provide a full picture of the Supplementary Immunization Activities. Future reports should give a more detailed description of these activities so that the impact can be fully appreciated by the RCC.
3. WHO should work with the country to conduct a more formal assessment of the use of mobile teams for AFP surveillance.
4. Routine polio immunization coverage is below desired levels. The RCC urges to WHO work with the country to seek ways that coverage can be improved. Continued low coverage will result in the accumulation of a cohort of susceptible children that may eventually pose a risk for the entire Region.

Uzbekistan

Polio immunization coverage has been above 95% for more than a decade in Uzbekistan. During the 2008 European Immunization Week, mop-up immunization was conducted for children with contraindications or who were temporarily absent during routine immunization. 150,000 children were vaccinated against polio. Non-polio AFP rates remain above 1.0, but have declined in 2008. Stool collection rates are high, as are other surveillance indicators. Both Sabin polioviruses (2) and non-polio enteroviruses (13) were isolated from 102 AFP cases in 2008. Fourteen non-polio enteroviruses were isolated from environmental samples in 2008, but the number of samples tested was not presented. Laboratories have been inventoried for materials potentially containing polioviruses, but these materials have not been transferred to Moscow.

Country-specific feedback from the RCC

1. The RCC accepts the report of the NCC as meeting the requirements of the RCC.
2. The RCC is concerned that there appears to be inadequate funding available for purchase of polio vaccine. Inadequate vaccine supply in Uzbekistan poses a potential risk to the entire region.
3. There is a high risk of importation into Uzbekistan from Afghanistan and Pakistan and migrant populations. WHO should work with the country to secure funding for Supplementary Immunization Activities and to assist with coordination of cross border activities.
4. The RCC is concerned about the decline in AFP surveillance indicators, particularly because of the strategic location of the country in relationship to polio endemic countries. WHO should work with the country to bring AFP surveillance back to a high standard.

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

GAP III is now available to further enhance the activities specified in GAP II. The global strategy for minimizing poliovirus facility-associated risks consists of risk elimination by destruction of poliovirus materials in all but a few essential facilities and risk management of such facilities by strict adherence to required safeguards. Successful global risk elimination requires each country to establish national poliovirus policy and promulgate enforceable legislation or regulations prohibiting retention of poliovirus materials in all non-essential facilities. Risk management of designated essential facilities is achieved through the establishment of international standards for: primary safeguards of facility containment; secondary safeguards of an immunized population: tertiary safeguards of facility location, and national and international accreditation to ensure that the required safeguards are met.

Inventories of laboratories updated by Member States of the European Region show that 23 countries report 93 laboratories storing wild poliovirus infectious materials; 103 labs storing potentially infectious materials (wild + vaccine); and 289 labs storing poliovirus infectious or potentially infectious materials. France, the United Kingdom and Switzerland report 93 labs storing vaccine poliovirus infectious materials. Twenty-nine countries confirmed that they had no labs with wild poliovirus infectious materials. WHO is working with Member States to develop an inventory of laboratories retaining OPV/Sabin containing materials in the Region.

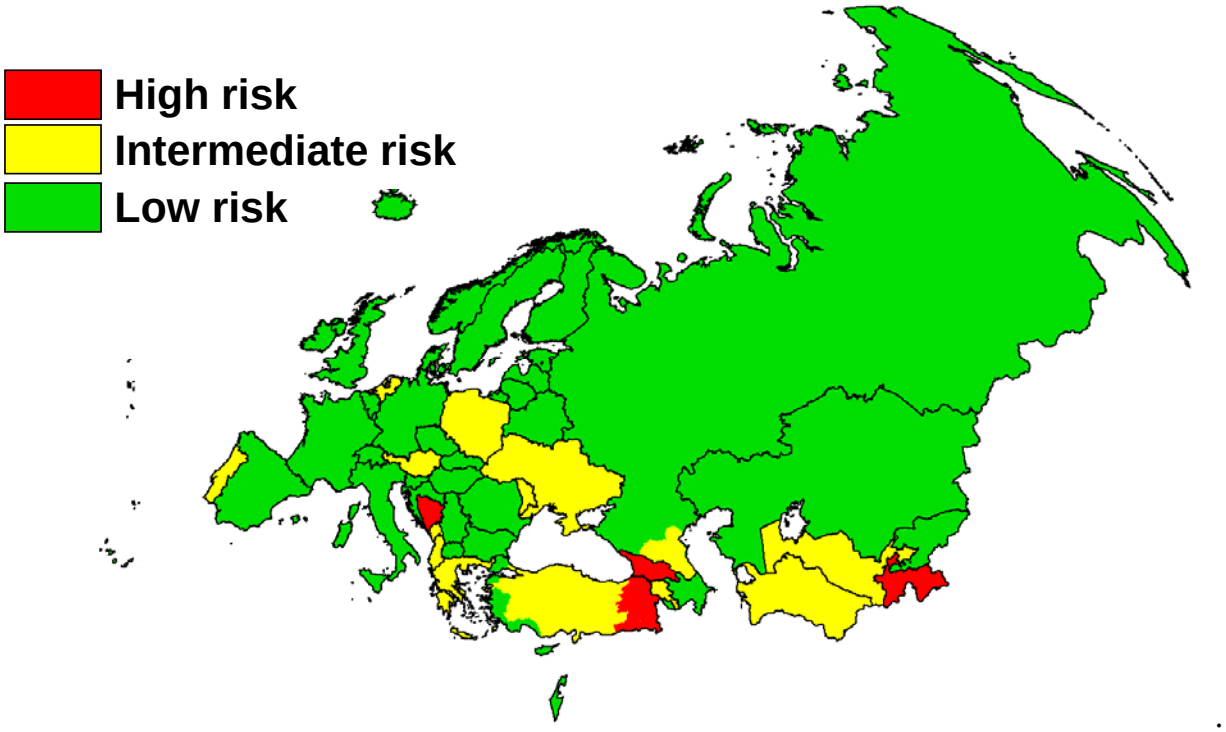
WHO and the government of France are implementing a pilot project on Phase II using French regulations on biosafety and biosecurity to develop a legal framework for polio containment. WHO is planning to work with the polio working group in the United Kingdom on the initiation of Phase II containment.

Conclusions and recommendations

Conclusions

1. Despite the shortcomings of the evidence presented by some NCCs, the RCC concludes that wild polioviruses are not circulating within the Region. The RCC remains 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. Tajikistan is to be commended for their efforts to minimize the risk of importation from Afghanistan and Pakistan and is urged to continue these efforts.
2. 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.
3. The risk categorization of each country according to the assessment of risk provided by the secretariat based on immunization coverage, surveillance quality, presence of risk groups, and health system quality adequately reflects national risks and is approved as in Fig. 1 and the table below.

Fig 1. Risk of transmission following importation of wild poliovirus, European Region, 2009.



High risk	*Intermediate risk*
Bosnia and Herzegovina	Albania
Georgia	Armenia
Tajikistan	Austria
Turkey (southern and eastern areas only)	Greece
	Moldova
	Montenegro
	Netherlands
	Portugal
	Poland
	Russian Federation (northern Caucasus only)
	Turkey (except the high-risk south and east and the low-risk western coast)
	Turkmenistan
	Ukraine
	Uzbekistan

4. RCC is concerned that many NCC reports are not convincing and would be inadequate for the purposes of final certification.
5. National plans of action for responding to an imported or circulating poliovirus are missing or incomplete for many countries.
6. The laboratory network is central to maintaining the polio-free status of the Region. The RCC notes the following achievements of the LabNet.
    a. No live wild polioviruses or wild poliovirus RNA were detected in 2008
    b. The quality of laboratory network was maintained in 2008
    c. Progress was made in implementing EV surveillance in several countries
    d. Progress was made in development of molecular methods for wild type and VDPV detection
    e. Potential alternative for live virus referral was identified and is being evaluated.
    f. Training was provided for improved biosafety and biosecurity with advocacy further development.
7. Containment of polioviruses is the final, essential step in polio eradication. The RCC is encouraged by the progress made in developing and implementing GAP III. It also appreciates the efforts made to pilot the framework in France. It concurs with the plan for inventorying laboratories that contain materials potentially contaminated with Sabin polioviruses.
8. The RCC congratulates Bosnia and Herzegovina for their response to prior RCC recommendations, esp. organizing a new NCC in spite of the many challenges faced.

Recommendations

1. The secretariat must provide stronger guidance to countries for NCC reports and set clear standards for what constitutes an acceptable report. A clear summary indicating the evidence-based rationale for the absence of wild poliovirus circulation in the country is an essential component of every NCC report. Data should be internally consistent. All reports should include a current plan of action for responding to an imported or circulating poliovirus. National preparedness plans should be improved in line with the Regional guidelines. Specifically, plans should 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. Individualized feedback will be provided to countries on the quality of their reports and how they can be improved.

2. The Regional Office should continue its efforts to revitalize the NCCs in countries where they are inactive. The new Terms of Reference should be used to clarify the role of an NCC. NCCs 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.
3. By the end of 2009, 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.
4. MECACAR was an extremely successful approach to controlling polio. In light of the increased movement of populations across borders and the persistence of endemic polio in Afghanistan and Pakistan, this approach should be reinvigorated. Accordingly, EURO and EMRO should promote coordinated immunization activities in high risk border areas.
5. WHO should continue efforts to ensure that molecular methods will accurately and reliably detect wild, Sabin and recombined poliovirus strains.
6. WHO should continue development of methods to ensure rapid transport of viral isolates within the laboratory network in light of the constraints faced regarding transport of infectious materials.
7. The WHO LabNet should continue their work to advocate and provide training for improved biosafety and biosecurity.
8. WHO should advocate for increased investment by respective national governments into the public health laboratory services.
9. WHO should continue the Phase II Pilot Project on containment in France and should initiate the Phase II containment project in the UK and/or another country as soon as is appropriate and practicable.
10. WHO should work with countries to develop an inventory of laboratories in the Region retaining OPV/Sabin polioviruses.
11. WHO should consider conducting a formal test of the national preparedness plan in one or more appropriate Member States.
12. 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.

Annex 1

PROGRAMME OF THE 22ND MEETING OF THE EUROPEAN REGIONAL CERTIFICATION COMMISSION FOR POLIOMYELITIS ERADICATION

Monday, 22 June 2009 (Conference room CH-2)

Plenary session 1: Progress towards global polio eradication and sustaining polio free Europe

08.30 – 09.00	REGISTRATION
09.00 – 09.30	**OPENING**

- WHO Regional Office for Europe –
  Dr Nata Menabde, Deputy Regional Director
- WHO Headquarters – ***Dr Naveed Sadozai***
- Chairperson RCC – ***Professor David Salisbury***

09.30 - 10.00	**Progress towards global eradication WPV: Challenges and perspectives** ***Dr Naveed Sadozai*** Discussion
10.00 - 10.30	Coffee break
10.30 - 11.00	**Progress towards the Regional Certification of the WHO Eastern Mediterranean Region** ***Dr Hala Safwat*** Discussion
11.00 - 11.30	**Sustaining poliomyelitis-free status of the WHO European Region: and strategic plan of action for 2009-2013** ***Dr Rebecca Martin*** Discussion

Monday, 22 June 2009(Conference room CH-2) *(continued)*

***Plenary Session 2*: Sustainability of "polio-free" Europe: Review of national updated documents for 2009 by epidemiological zones (10 min. presentation and 5 min. discussion)**

11.30 – 11.40	**Introduction to sub-regional zones overview**
	Dr George Oblapenko
11.40 – 12.10	**Sub-regional overview: Update information for 2008 in the Nordic/Baltic (8 countries) and Western (10 countries) epidemiological zones**
	Dr Sergei Deshevoi
12.10 – 13.00	Lunch
13.00 – 13.30	**Sub-regional overview: Update information for 2008 in the Southern (10 countries) and Central-Eastern (8 countries) epidemiological zones**
	Dr Dragan Jankovic
13.30 – 14.00	**Sub-regional overview: Update information for 2008 in the Central (7 countries) and MECACAR (10 countries) epidemiological zones**
	Dr Shahin Huseynov
14.00 – 14.40	Discussion of high risk countries

***Plenary Session 3*: Review of national update for 2008 – presentations by selected countries (10 min. presentation and 20 min. discussion)**

14.40 – 15.10	**Bosnia and Herzegovina**
15.10 – 15.40	Coffee break
15.40 – 16.10	**The Netherlands**
16.10 – 16.40	**Tajikistan**
16.40 – 17.10	**Uzbekistan**
17.10 – 17.40	**Georgia**
17.45 – 18.30	**Private meeting of the EUR/RCC**
18.30 – 19.30	*Reception in the lobby on the occasion of the 22nd Meeting of the European Regional Certification Commission for Poliomyelitis Eradication*

Tuesday, 23 June 2009 (Conference Hall 1)

08.15 – 09.00	**Private meeting of the EUR/RCC *(continued)***
09.00 – 09.30	**Feedback to countries**
09.30 - 10.00	**Performance of the European Polio Laboratory Network in 2008-2009** ***Dr Eugene Gavrilin*** Discussion
10.00 – 10.30	**Containment activities in 2009-2010: policy, strategies and actions** ***Dr Galina Lipskaya*** Discussion
10.30 – 11.00	Coffee break
11.00 – 12.00	**Review of the Regional Plan of Action for 2009-2010** ➢ **National plans of action in the event of a wild poliovirus importation** ➢ **Operational activities: milestones** ➢ **Revision of the Terms of Reference of the EUR/RCC**
12.00 – 12.30	**Drafting of recommendations and general discussion on future format of updates**
13.00	Closing

Annex 2

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