WORLD HEALTH ORGANIZATION

REGIONAL OFFICE FOR THE WESTERN PACIFIC

REPORT

THE INFORMAL FIFTH MEETING OF THE SUBREGIONAL COMMITTEE FOR CERTIFICATION OF POLIOMYELITIS ERADICATION IN PACIFIC ISLAND COUNTRIES AND AREAS

Suva, Fiji
18-19 October 2001

Manila, Philippines
March 2002

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REPORT

THE INFORMAL FIFTH MEETING OF THE SUBREGIONAL COMMITTEE FOR CERTIFICATION OF POLIOMYELITIS ERADICATION IN PACIFIC ISLAND COUNTRIES AND AREAS

Convened by the

REGIONAL OFFICE FOR THE WESTERN PACIFIC OF THE WORLD HEALTH ORGANIZATION

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NOTE

The views expressed in this report are those of the participants of the Informal Fifth Meeting of the Subregional Committee for Certification of Poliomyelitis Eradication in Pacific Island Countries and Areas and do not necessarily reflect the policies of the World Health Organization.

Kewords:

Poliomyelitis – prevention and control / Certification / Pacific Islands.

This report has been prepared by the Regional Office for the Western Pacific of the World Health Organization for governments of Member States in the Region and for the participants in the Informal Fifth Meeting of the Subregional Committee for Certification of Poliomyelitis Eradication in Pacific Island Countries and Areas, which was held in Suva, Fiji, from 18 to 19 October 2001.

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1. INTRODUCTION

An informal fifth meeting of the Subregional Committee for the Certification of Eradication of Poliomyelitis in Pacific Island Countries and Areas took place in Suva, Fiji from 18 to 19 October 2001.

1.1 Objectives

The objectives of the meeting were:

(1) to review progress of maintaining poliomyelitis-free status after certification;

(2) to review and make a final classification of all acute flaccid paralysis (AFP) cases reported during 2000 and 2001 (January to September);

(3) to review the draft progress report on maintaining poliomyelitis-free status after certification to be submitted to the Regional Certification Commission (RCC) for its seventh meeting to be held from 25 to 26 October 2001; and

(4) to provide guidelines for the Pacific island countries and areas on technical recommendations made by the WHO Western Pacific Region Technical Advisory Group (TAG) and the RCC.

1.2 Organization

The meeting was attended by four of the five members of the Subregional Committee and a WHO Secretariat (see Annex 1). Dr David Morens, National Institute of Health, United States of America, attended the meeting as a Temporary Adviser to WHO.

1.3 Opening Session

The Chairperson addressed the Committee, requesting Dr Morens to continue to serve as rapporteur. A representative from the United Nations Children's Fund (UNICEF) was present during the meeting.

2. PROCEEDINGS

2.1 Summary of Regional Certification and the Kyoto Meeting

Dr L. Tikoduadua summarized her presentation given to the RCC at its sixth meeting held in Kyoto from 27 to 28 October 2000. The presentation detailed the quality of AFP surveillance, routine immunization and laboratory containment including discussions on areas of special concern and future activities. The presentation is attached as Annex 2.

2.2 Global and Regional Overview of Poliomyelitis Eradication

2.21 Global status

In 2000, there were 23 countries with indigenous wild poliovirus transmission. In 2001, this was reduced to 11 countries. This is attributed to continuous acceleration of activities including a large increase in the number of immunization staff funded by the poliomyelitis eradication programme. Remaining constraints include accessing children in difficult areas, sustaining political support in countries, and a funding gap of US$400 million for the programme globally.

A poliomyelitis outbreak occurred in the Cape Verde Islands from August to December 2000 with 44 cases reported and wild poliovirus type 1 isolated from 11 cases. Sequence analysis revealed 98% similarity of the strain identified with wild poliovirus strains recently circulating in Angola. Seventy-three percent of the cases were under 15 years old and only 38% were fully immunized. Enhanced surveillance found clustering of AFP cases in mainly three islands. Cape Verde had not reported poliomyelitis cases for 15 years; however, since 1995 routine immunization coverage has been below 80%. No supplemental immunization was conducted prior to this outbreak. Two rounds of mopping-up were conducted house-to-house in October and November 2000. The last poliomyelitis case had onset on 13 December 2000 and still had been missed by the supplementary immunization activities.

From 12 July 2000 to 8 February 2001, 12 laboratory-confirmed poliomyelitis cases attributed to vaccine-derived poliovirus (VDPV) type 1 were identified in the Dominican Republic. Of these, 11 (92%) case-patients were under seven years of age and the date of paralysis onset of the last case was 2 January 2001. All case-patients were inadequately vaccinated or unvaccinated. In Haiti, one confirmed poliomyelitis case attributed to VDPV type 1 was reported in an unvaccinated two-year old child with onset of paralysis on 30 August 2000.

The ministries of health of the Dominican Republic and Haiti conducted large-scale immunization responses and active searches for AFP cases to stop the circulation of VDPV.

The outbreak was made possible by very low immunization coverage with poor AFP surveillance that allowed continued viral circulation without detection. The outbreak was controlled by supplementary immunization with oral polio vaccine (OPV). Prolonged circulation of OPV-derived polioviruses in areas of very low OPV coverage had been documented in only one other setting – type 2 VDPV circulated in Egypt for an estimated 10 years (1983-1993) and was associated with over 30 cases.

One implication of circulating VDPV is the overarching importance of emphasizing the need for maintaining high immunization coverage and high quality AFP surveillance. A poliomyelitis outbreak due to VDPV should be treated in a similar way to the importation of wild poliovirus. Further research is being conducted to look at the implications of VDPV circulation for the poliomyelitis programme.

Among the 11 countries with wild poliovirus transmission in 2001, the Republic of Yemen reported one case in February but had no virus isolation in 2000, and Mauritania reported one case in March 2001 with no virus isolation in 2000.

Although the last indigenous poliomyelitis case in the WHO European Region was registered in November 1998, between March and May 2001 an outbreak of imported poliomyelitis was registered in Bulgaria after a 10-year poliomyelitis-free period. Three cases of unvaccinated gypsy children were identified in two neighbouring districts in south-eastern Bulgaria; two cases were confirmed by isolation of wild poliovirus type 1 and the third case was confirmed based on clinical findings. The P1 isolated from the cases was most closely genetically linked to viruses isolated from northern India in 2000-2001.

In the WHO Southeast Asia Region wild poliovirus circulation in India was limited to the states of Uttar Pradesh and Bihar and with a main wild poliovirus transmission focus in western Uttar Pradesh near the capital, New Delhi under conditions of high quality surveillance. Surveillance quality in all other recently endemic countries in the Region appears to have reached certification standards.

In the WHO Eastern Mediterranean Region, wild poliovirus circulation continues in Afghanistan, Egypt, Pakistan, Somalia and Sudan. Transmission in Pakistan appears to be still relatively widespread and surveillance systems in Somalia and Sudan are likely to still underestimate transmission. In the WHO African Region, wild poliovirus was isolated in 2001 in Ethiopia, Mauritania and Nigeria.

Further improvements are observed in the quality of AFP surveillance in terms of completeness of reporting whereas the improvements in adequate stool specimen collection are relatively slower. Geographic priorities continue to be Angola, Democratic Republic of Congo, Egypt, Ethiopia, Nigeria and Pakistan. Identifying high-risk districts through surveillance and targeting them with high quality supplementary immunization remains one of the essential approaches in eliminating poliomyelitis from countries where it is still present.

2.2.2 Regional status

Certification process

The Regional Commission for the Certification of the Eradication of Poliomyelitis in the Western Pacific Region (RCC) submitted its report on certifying the Western Pacific Region as poliomyelitis-free to the Global Commission for the Certification of the Eradication of Poliomyelitis (GCC). During its sixth meeting, held in Washington, D.C., USA, 28-29 March 2001, the GCC reviewed and endorsed the report of the RCC. The GCC congratulated the Western Pacific Region on its achievement and concurred with the Regional Commission's finding that the transmission of indigenous wild polioviruses has been interrupted. The GCC was impressed by the detailed preparations made in the Region to assure that high-quality AFP surveillance and appropriate levels of immunity against polioviruses in the population is maintained in all Member States.

The RCC requires the national and sub-regional certification Committees to continue to function until global certification is achieved in order for the Regional Commission to fulfil its obligations to the Global Commission. This plan was endorsed by the GCC. The Regional Commission will continue to meet on an annual basis to review progress reports from all countries and areas with particular emphasis on progress with laboratory containment of wild poliovirus infectious/potentially infectious materials, ongoing high-quality surveillance and timely analysis of surveillance data, maintenance of high immunization rates, high-quality laboratory performance, capacity to respond to poliomyelitis cases if they are detected and evidence of continued political commitment.

The next meeting of the RCC is scheduled from 25 to 26 October 2001 to be held in Manila. The previous format for country progress reports has been revised and contains new sections on:

- performance of AFP surveillance;
- supplementary surveillance activities;
- laboratory surveillance;
- immunization activities;
- laboratory containment of wild poliovirus infectious/potentially infectious materials;
- areas of special concern; and
- post poliomyelitis-free activities for sustainability.

As in the final national certification documentation, the reports should contain an executive summary, and national certification Committees should particularly contribute to a summary of conclusions and recommendations.

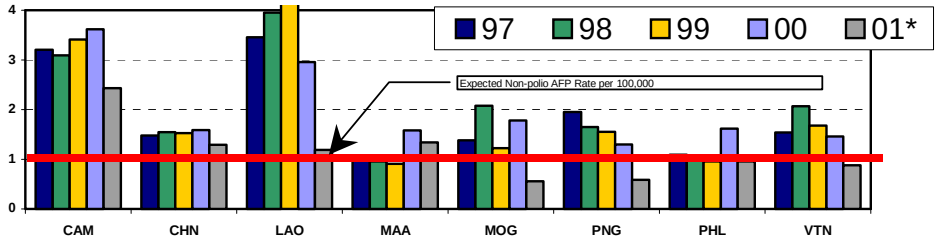
The GCC recommended that progress reports provide data on reported cases of vaccine-associated paralytic poliomyelitis (VAPP), which might serve as an additional indicator of the sensitivity of surveillance to detect and investigate acutely paralyzed children. Following the recent circulation of VDPV in Haiti and the Dominican Republic, any VAPP case should be properly scrutinized to determine whether it represents a unique event or a circulating VDPV. National progress reports should include details of the investigation of any AFP cases associated with VDPVs as well as evidence of an appropriate immunization response to any circulating VDPV. The GCC made clear that prior to global certification, all Regions will need to ensure that updated country level data is scrutinized and verified by the RCC. The GCC expects extended input of National Certification Committees (NCCs) to verify updated national data prior to global certification.

AFP surveillance quality

The RCC as well as the TAG emphasized during their last meetings that AFP surveillance must not be allowed to fall in quality in the critical first year after regional poliomyelitis-free certification when wild poliovirus is circulating in neighbouring regions and there is a high risk of importation. For countries which were poliomyelitis-endemic when the Regional initiative began, continued high-quality AFP surveillance is required. Countries which were non-endemic at the beginning of the initiative will have to continue to conduct whichever method they used to document their poliomyelitis-free status, whether this is accomplished through AFP surveillance, enterovirus surveillance, a combination of both or through other indirect methods.

The annualized Regional non-polio AFP rate for 2001 was 1.15 per 100 000 under 15 years of age (dataset as of 10 August 2001). Most countries achieved or exceeded the target so far, as shown in Figure 1, however, to date lower rates have been reported by Mongolia and Papua New Guinea.

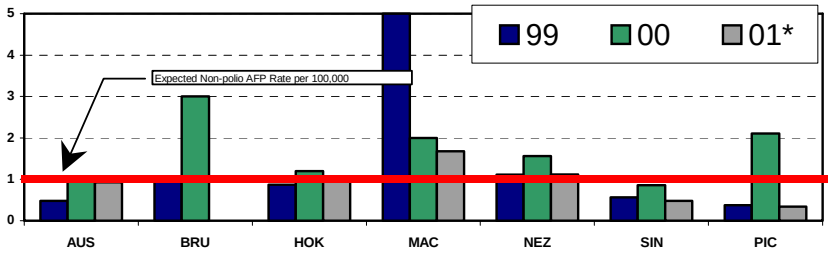
Figure 1: Non-polio AFP Rates Per 100,000 Population <15 years
1997 - 2001*



Notes: Data as of 10 August 2001
CAM=Cambodia, CHN=China; LAO=Lao People's Democratic Republic; MAA=Malaysia; MOG=Mongolia; PNG=Papua New Guinea; PHL=Philippines; VT=Viet Nam

Among the countries that were non-endemic at the beginning of the initiative and conduct of AFP surveillance, non-polio AFP rates have remained at certification standards in most countries (Figure 2). Lower rates up to date have been reported by Brunei Darussalam, the Pacific island countries and areas and Singapore.

Figure 2: Non-polio AFP Rates Per 100,000 Population <15 years
1999 - 2001*



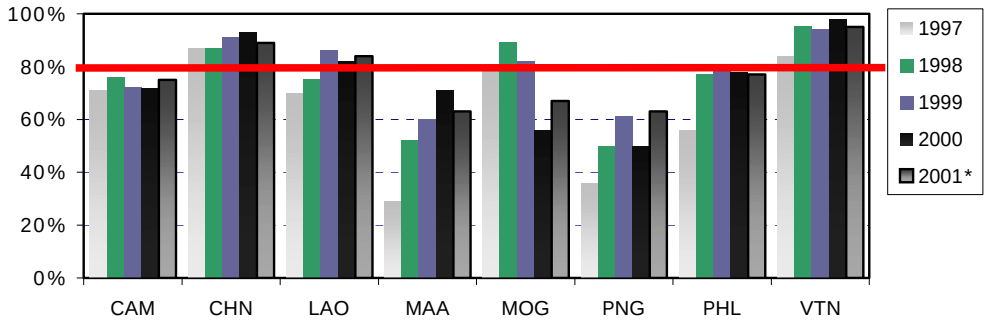
Notes: Data as of 10 August 2001

AUS=Australia, BRU=Brunei Darussalam; HOK=Hong Kong; MAC=Macao; NEZ=New Zealand; SIN=Singapore; PIC=Pacific Island Countries

In countries that were poliomyelitis endemic at the beginning at the Regional initiative, adequate stool specimen collection rates in 2001 have been at certification levels except in Malaysia and Papua New Guinea (Figure 3). Rates in these two countries remain below the levels achieved in 2000.

Notes: Data as of 10 August 2001
CAM=Cambodia, CHN=China; LAO=Lao People's Democratic Republic; MAA=Malaysia; MOG=Mongolia;

Figure 3: % AFP Cases With 2 Specimens Within 2 Weeks 1997 - 2001*



PNG=Papua New Guinea; PHL=Philippines; VT=Viet Nam

Significance of poliomyelitis-compatible cases

To assure the highest possible sensitivity of surveillance activities to rapidly detect and respond to virus importations, it is necessary to continue carefully scrutinizing poliomyelitis-compatible cases. Surveillance data should be monitored and mapped to allow early detection of clusters of compatibles and trigger further field investigations where appropriate. The number of poliomyelitis-compatible cases reported in the Region decreased from 70 cases in 1997 to 12 cases in 2000.

Expert panels should continue to review all cases with inadequate stool specimens which either have residual paralysis or no follow-up (died, lost to follow up) to determine whether or not these should be classified as poliomyelitis-compatible.

Regional data as of 02 March 2001 showed that about 900 AFP cases with onset in 2000 (12.7%) were still pending final classification. On 30 May 2001, the number had decreased to 88 cases (1.3%). As of 10 October 2001, a total of 14 cases were pending.

Timeliness of investigation and final classification

In order to avoid any delays in case investigation and final classification, all recently endemic countries should analyse surveillance data down to the district level at least monthly. This analysis should include AFP surveillance and laboratory indicators.

The Global Technical Consultative Group for Poliomyelitis Eradication (TCG) recommended that the interval between onset of paralysis and receipt of final intratypic differentiation (ITD) results should be reduced to $\leq$60 days (target >80%). Reasons for delays in ITD results should be analysed in detail to identify and correct problems. Specifically, the time needed for each step in the process should be scrutinized to identify bottlenecks (e.g. time from onset to notification, notification to investigation, investigation to specimen collection, collection to receipt in the laboratory, and laboratory to reporting of results).

The TCG also stated that countries and regions must track the number and proportion of cases pending final classification after 90 days following onset of paralysis. Reasons for delays in classification should be identified and corrected. Particular scrutiny should be applied to ensuring timely laboratory results, follow-up (if appropriate) and expert group review.

AFP cases with a high index of suspicion (i.e. fever at onset, age <5 years, asymmetrical paralysis, unvaccinated, minority group) should be prioritized for investigation. Specimens should be immediately transported to a network laboratory for priority processing, and should be tracked through to final results and classification. It is the responsibility of the investigating surveillance medical officer to ensure 'hot cases' receive appropriate attention through final classification.

Stool specimen collection

The TCG reiterated that efforts should be made to maximize or maintain to obtain two adequate stool specimens. The principal aim of countries using the virological criteria should be to obtain adequate specimens from every case. Investigation and follow-up of cases with inadequate specimens should be prioritized. Detailed initial investigation within 48 hours, reliable 60-day follow-up and accurate documentation of such cases are essential to the classification work of the expert group.

The TAG stated during its last meeting that any future modification of surveillance standards can only take place under circumstances of consistently high-quality performance of AFP and laboratory surveillance, together with supportive scientific evidence. The TAG requested that evidence from AFP surveillance and laboratory systems be presented on the question of whether the Region can adopt a one-stool policy. Based on the Regional data, the percentage of poliovirus-positive AFP cases detected by the second stool but not the first stool is 14%; for data from 1996 to 2000 is 14%, with a range among countries from 0%-42%. These results suggest a considerable loss in sensitivity by moving from a two to one-stool policy.

Follow up examination at 60 days

The TCG also confirmed that all AFP cases with inadequate specimens should undergo 60-day follow-up examination. To monitor compliance with this recommendation, countries should track the 'proportion of AFP cases with inadequate stool specimens that have follow up' as a new indicator of surveillance quality. At least 80% of all such cases should receive follow-up. Recognizing the need for some countries to prioritize cases for follow-up examination, countries should give highest priority to "hot cases", cases with no specimens and cases with specimens collected more than 30 days after onset of paralysis.

Surveillance for vaccine-derived polioviruses (VDPV)

Following recommendations of the global poliomyelitis laboratory network, all poliovirus isolates, regardless of origin, should be forwarded to a WHO accredited laboratory for ITD by at least two approved methods, one of which must be antigenic (ELISA preferred) and one molecular (probe hybridization or diagnostic PCR preferred). Isolates of AFP cases should be forwarded for ITD within 14 days after isolation.

All poliovirus isolates showing discrepant ITD results should be immediately sent to a global specialized laboratory (or a laboratory recognized by WHO as having the capacity to carry out poliovirus sequence analysis) for ITD confirmation and analysis of genomic sequence. Timeliness and reporting mechanisms were further discussed during the regional laboratory meeting held in Manila in August 2001.

The national/sub-national AFP surveillance systems should analyse AFP data at least on a monthly basis, looking for evidence of clustering of cases. All poliovirus isolates from identified clusters should be sent to a global specialized laboratory (or a laboratory recognized by WHO as having the capacity to carry out poliovirus sequence analysis) for ITD confirmation and screening for sequence analysis.

After the implementation of the new testing requirements for prospective virus investigations, three AFP cases associated with circulating VDPV (cVDPV) isolates were reported in the Philippines from 15 March to 26 July 2001. The first case-patient, an eight-year old child from northern Mindanao island (500 miles south of Manila) with a three-dose vaccination history, had onset of paralysis 15 March 2001. A second child, a two-year old from Laguna province on Luzon island (60 miles south of Manila) with a history of three doses of OPV, had onset of illness 23 July 2001. A third child, aged 14 months from Cavite province (25 miles from Manila and 45 miles north of Laguna province) with a history of two doses of OPV, had onset of paralysis 26 July 2001. Characterization of isolates from the three cases revealed type 1 polioviruses derived from Sabin vaccine strain type 1, with a 3% genetic sequence difference between Sabin 1 vaccine and the VDPV isolates. The three polioviruses are not identical but are related closely to each other (>99% sequence homology); they also appear to share an identical recombination site with a non-polio enterovirus in the non-capsid region of the genome.

In response to these cases, the Department of Health: (1) enhanced surveillance by active record review for AFP cases in hospitals and other health-care facilities in the affected and neighbouring provinces, (2) established surveillance for virologic investigations of aseptic meningitis at major health-care facilities, (3) conducted field investigations of clustered AFP cases to determine the extent of cVDPV circulation, and (4) assessed polio vaccination coverage in these communities. The investigations have found no unreported cases, although a number of AFP cases remain under investigation. To interrupt cVDPV circulation, a large-scale mass vaccination campaign with OPV is planned.

Wild poliovirus was last reported in the Philippines in 1993, and national vaccination rounds were last conducted in the Philippines in 1997 followed by regional rounds in 1998 and citywide rounds in 1999. Among the cities covered were Cebu, Davao, Manila, and Mindanao; however, coverage did not extend to the three provinces now reporting cVDPV cases. Routine OPV coverage with three doses of OPV has been approximately 80% nationwide since the early 1990s; however, coverage gaps are likely, particularly in slum areas.

Response to circulation of VDPV

If there is evidence for circulation of VDPV, immediate consultation between Ministries of Health and WHO country, regional and global poliomyelitis eradication teams and laboratories involved should commence to conclude on implications and necessary actions to be taken.

The GCC concluded that the investigation and response to a circulating VDPV must be similar to that of an imported wild poliovirus. Contained transmission of a VDPV (i.e. cases for <1 year and limited geographic spread) has no impact on regional certification. Evidence of prolonged (>1 year) or geographically extensive VDPV circulation may postpone regional certification (for the regions not yet certified) or require re-evaluation of regional certification status (in the certified regions). The GCC will re-evaluate the implications of VDPV circulation further in the future.

Immunization activities

The TAG stated during its eleventh meeting that following interruption of transmission, annual full-scale national immunization days are no longer recommended. However, high levels of population immunity must be maintained at all administrative levels of all countries to assure that possible wild poliovirus importations from endemic areas will not spread.

Routine immunization coverage with three doses of OPV for infants has been maintained at high levels in most countries. However, slight decreases in coverage were observed in Cambodia and Lao People's Democratic Republic and generally low coverage levels continue in Papua New Guinea.

Supplementary immunization with OPV has been conducted in China for children less than four years of age in high-risk areas of 11 provinces in December 2000 and January 2001 and again in 52 prefectures in seven provinces in March and April 2001 targeting almost seven million children.

Cambodia integrated OPV in its recent measles campaigns in high risk and remote areas. La People's Democratic Republic conducted supplementary OPV immunization in January and February 2001 in five border provinces.

Laboratory containment of wild poliovirus infectious/potentially infectious materials

It has been continuously emphasized that as circulation of indigenous wild poliovirus in the Region has been interrupted, the only known sources of wild poliovirus remaining are the Region's laboratories. Substantial progress has been made with laboratory containment of wild polioviruses and potentially infectious materials and was acknowledged by the RCC.

However, in order to complete Phase 1 of the containment process, the RCC urged all countries, which have not yet done so to make every effort to complete national inventories before the next meeting of the Commission.

All countries have a national plan of action in place and identified a responsible body for the containment process. Twenty-seven countries have completed the national inventory, and five countries (French Polynesia, Guam, Malaysia, New Caledonia and the Republic of Korea) are close to completing the national inventory. Four countries (Australia, China, Japan and the Philippines) still require more time due to large number of laboratories to be searched and are expected to complete the national inventory in 2002.

Over 17 000 institutions and laboratories have so far been identified to be included in the search, however, response rates are not yet always complete. Wild poliovirus infectious and/or potentially infectious materials have been identified in about 60 institutions/laboratories. Approximately 20% of the identified institutes/laboratories have already destroyed the materials.

Guidelines on the establishment of Regional interim wild poliovirus repositories are currently under development by WHO Geneva. It was noted that the issue of legal ownership of stored isolates must be resolved and advice will be sought from the WHO legal department. Current assessment of requirements for a regional interim repository indicates that the Region might not need one but further discussions will be held.

The GCC during its last meeting restated its previous decision that prior to global certification, all regions will need to provide data demonstrating full implementation of Phase 2 activities of the Global Plan of Action for the Containment of Wild Polioviruses.

2.3 Overview of Maintaining Poliomyelitis-Free Status after Certification in Pacific Island Countries and Areas

The hospital-based surveillance network includes 58 hospitals distributed in all 20 countries and areas and continues to be based on the active involvement of 20 national coordinators, 58 hospital coordinators, and about 200 key paediatric clinicians. The Committee has always concluded that this adequately represents the geography and demography of the Pacific sub-region.

The Secretariat presented results of the monthly reporting for 2000 and 2001 to date. The reporting mechanism in most countries continues to require a copy of the completed monthly form to be sent from the hospital coordinator to the national coordinator and copied to WHO at least every three months. The WHO office received copies of 54% of expected forms for 2000 (373 out of 692), and to date 25% of the forms expected for 2001 up to June (88 out of 348). This represents a very significant decrease in reporting completeness. In 2000, 18 out of 58 hospitals failed to submit reports with six out of 20 countries not reporting (Guam, Niue, Palau, Tokelau, Tuvalu, Wallis and

Futuna). In 2001 so far, 41 out of 58 hospitals have not submitted reports and reports have only been received from American Samoa, Fiji, Nauru, Northern Marianas and the Solomon Islands.

One performance standard relates to AFP surveillance activities:

Standard: At least 80% of expected reports should be received on time.

The standard was not met in either 2000 nor 2001 to date and raises concerns as AFP cases may be missed.

The Committee noted the recommendations on surveillance and immunization requirements made by the GCC, TCG and TAG, especially in light of detected episodes of circulation of vaccine-derived poliovirus in the Hispaniola 2000/2001 and the Philippines in 2001.

2.4 Review of AFP Cases Reported in 2000 and from January to September 2001

The Committee noted that a case with onset in 1998 reported from New Caledonia (9812) that had still be kept pending during the previous meeting was further investigated by a visiting consultant, and based on the additional information obtained discarded as non-polio AFP.

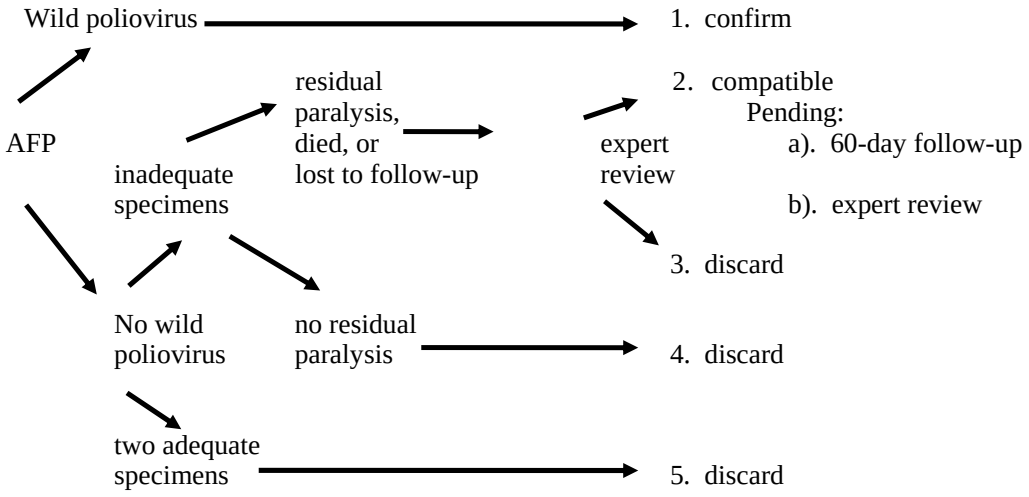
For another case with onset in 1998 reported from Guam (9806), the Secretariat was able to obtain additional information and the child was reported to have fully recovered. The case was finally discarded as non-polio AFP.

One case with onset in 1999 (9904) from the Solomon Islands was also kept pending as quality of clinical data was not yet considered sufficient, and it had been hoped that additional information could have been collected during an upcoming consultant visit. This was unfortunately not possible as the child could not be found. The Committee revisited the clinical information available and came to the final conclusion that the case can be discarded as non-polio AFP.

The virological algorithm was used for case classification. The algorithm and classification categories adopted by the committee are displayed below:

Virological Classification of AFP Cases

Classification categories (1 - 5, a, b)



Of the 20 cases with onset in 2000 and 2001 presented and reviewed, the committee discarded six cases as non-poliomyelitis based on negative laboratory results, for each, of two adequate stool specimens (category 5). Six other cases lacked residual paralysis at 60 days, and were thus discarded (category 4). Six cases were discarded after detailed review and discussion of clinical and laboratory data available. Regarding two cases, either 60-day follow-up information was not available or clinical and laboratory information available was not considered sufficient. These were retained as "pending" (category a and b), and will receive final classification through electronic discussion of the Committee members.

Two cases with onset in 2001 with residence in New Caledonia were reported from the Australian surveillance system as both children underwent cancer treatment at the Children's Hospital in Westmead in New South Wales. Notification was received from Victorian Infectious Diseases Reference Laboratory (VIDRL) (Melbourne), which has also taken over functions as the Australian national AFP surveillance coordinator. The Committee appreciates this excellent collaboration and decided to follow the WHO recommendation that AFP cases are counted under the country/place of residence.

A summary of the Committee's expert review is provided in the table below:

Case Number	Country	Classification Category
00-05	Fiji	5
00-06	Solomon Islands	3
00-07	Fiji	5
00-08	Solomon Islands	4
00-09	New Caledonia	A
00-10	New Caledonia	3
00-11	Fiji	5
00-12	New Caledonia	3
00-13	French Polynesia	4
00-14	American Samoa	3
00-15	French Polynesia	4
00-16	French Polynesia	4
00-17	French Polynesia	4
00-18	Wallis & Futuna	3
00-19	Vanuatu	5
01-01	Kiribati	5
01-02	Fiji	5
01-03	New Caledonia	B
01-04	New Caledonia	3
01-05	New Caledonia	4

The performance standards related to AFP case finding and investigation were variably met in 2000 and 2001 to date, as follows:

Standard: At least one annual case of AFP per 100 000 children under age 15 per year.

This standard was met in 2001 with 19 cases reported resulting in a non-polio AFP rate of 1.9 per 100 000 under age 15. In 2001 up to the end of September, five cases were reported resulting in an annualized non-polio AFP rate of 0.7 per 100 000 under age 15, which remains below the required quality level.

Standard: All AFP cases must be investigated.

This standard was met for AFP cases with onset in 2000 and 2001. Full case investigations were obtained on all reported AFP cases and retrospectively on the AFP cases identified in retrospective case reviews.

Standard: At least 80% of AFP cases should have two adequate stool specimens.

This standard was not met in either 2000 or in 2001 to date. Of the 19 cases with onset in 2000, only seven (37%) had two adequate stool specimens; four cases had two samples obtained, but not within 14 days of onset of paralysis. Seven cases had no specimen taken. For one case the two timely stool specimens collected cold not be counted as adequate as they were analysed at the Institute Pasteur Noumea, which is not an accredited member laboratory of the regional poliovirus laboratory network. The samples were reported to be negative for poliovirus.

For the five cases with onset in 2001, the rate of timely stool sample collection is 40% but for one other case two stool samples are assumed to have been taken but dates of collection are not yet available.

Standard: All stool specimens should be examined in an accredited laboratory.

This standard was met for all cases except one in 2000 as explained above. All other specimens were successfully transported to the Victorian Infectious Diseases Reference Laboratory in Melbourne, Victoria, Australia.

Standard: At least 80% of AFP cases should have a 60-day follow-up examination.

This standard was met for 2000 and 2001 to date. Sixteen (84%) cases with onset in 2000 had follow-up examinations. Eighty percent of AFP cases with onset in 2001 had follow-up examinations.

2.5 Retrospective Reviews

After the last meeting of the Subregional Certification Committee in March 2000, retrospective record reviews for AFP were conducted in Federated States of Micronesia (Chuuk), Samoa (Apia in-patient, Apia out-patient, Savaii), American Samoa (LBJ Medical Centre), Solomon Islands (Honiara Hospital, Kilu'ufi Hospital [Malaita]), and New Caledonia (Magenta).

As a result, six cases of AFP not previously reported through the routine surveillance system were identified, as follows: one case in Chuuk State Hospital, Federated States of Micronesia; three cases in Apia in-patient clinic, Samoa; one case in Honiara Hospital, Solomon Islands, and one case in Kilu'ufi Hospital, (Malaita), Solomon Islands.

The following is a history of retrospective record reviews carried out since 1997:

Summary of Retrospective Record Reviews Conducted to Date (1997 – October 2001)

Year	Month	Reviewer	Country	Hospital	New Cases Found
1997	Nov.	Dr J Wakerman	Vanuatu	Vila Central	0
				Northern Districts	0
			Fiji	Nadi	0
				Levuka	0
		Wakerman/Rousar		Savusavu	0
		Wakerman/Rousar		Labasa	0
	Dec.	Dr J Wakerman	Cook Islands	Rarotonga	0
1998	Sept.	Dr M O'Leary	FS of Micronesia	Chuuk	2
1998	Aug.	Frank Rousar	Fiji	Labasa	0
	Sept.		Solomon Islands	Malaita (Kilu'ufi)	0
				Gizo	0
1999	March	Frank Rousar	Tonga	Ha'apai	0
				Vava'u	0
1999	June	L Waqatakirewa	Vanuatu	Vila Central	1
				Northern District	0
			Solomon Islands	Helena Goldie	0
1999	June	David Saunders	Fiji	CWM	0
				Labasa	1
				Lautoka	1
				Sigatoka	0
1999	June	Frank Rousar	Solomon Islands	Malaita (Kilu'ufi)	0
2000	Jan.	Dr D Lowrance	Tonga	Vava'u	0
				Vaiola	0
			Fiji	Lautoka	0
				Ba	0
				Levuka	0
				Kadavu	0
				CWM	0
2000	Feb.	Dr N Wilson	Kiribati	Tungaru Central	0
				Outer islands	0
			Marshall Islands	Majuro	0
				Kwajalein	0
				Ebeye	0
			FS of Micronesia	Pohnpei	0
	March			Chuuk	1
	April		Samoa	Apia inpatient	3
				Apia outpatient	0
				Savaii	0
			American Samoa	LBJ Medical Centre	0
			Solomon Islands	Honiara	1
				Kilu'ufi	1
2000	May	Dr M Bruce	New Caledonia	Magenta	0

2.6 Laboratory Issues

The Committee reviewed the status of collection and transport of stool specimens to the reference laboratory under reverse cold chain conditions. Currently, all countries use the VIDRL, which continues to provide excellent support.

2.7 Laboratory Containment of Wild Poliovirus Infectious and Potentially Infectious Materials

The WHO Secretariat had made good progress to assemble a sub-regional inventory of laboratories that may store wild poliovirus infectious or potentially infectious materials in the Pacific island countries and areas. The approach used included the assessment of freezer capacity and long-term storage capacity. Eleven laboratories were identified to be at higher risk to retain the materials being searched for, whereas 16 laboratories were considered at lower risk based on the availability of ultra-low temperature freezers. The questionnaire sent out contained questions on type of freezers and type of specimens stored for longer than five years.

Replies were received from nine of the 11 higher risk laboratories and from seven of the 16 lower risk laboratories. Laboratory replies are still to be obtained from Guam, French Polynesia and New Caledonia. To date four laboratories (Fiji, New Caledonia and French Polynesia) have reported to store human specimens for several years but these were serum, genital swabs, cerebrospinal fluid and sputum. The longest storage was since 1985, which was after the last wild poliovirus had occurred.

The Committee discussed that for two of the higher-risk laboratories further assessment should be conducted regarding tissue culture products.

2.8 Progress Report on Maintaining Poliomyelitis-free Status after Certification

The Committee complied, where applicable, with the sections recommended by the WHO Secretariat for the progress report.

2.9 Future Activities of the Subregional Committee

The Committee will comply with the requirements of the RCC and continue to function until instructed otherwise by the commission. The Committee will continue to meet on a regular (i.e. annual) basis but decided to discuss pending AFP cases through regular electronic communication in order to follow the recommendations made by TCG and TAG on timely classification of all AFP cases.

3. CONCLUSIONS

The Committee notes that 58 hospitals in all 20 countries continue to constitute the active AFP surveillance network of the Pacific island countries and areas, encompassing national and hospitals coordinators and over 200 key paediatric clinicians. The commission considers the system a stable one, simple and well understood and with integration in other surveillance systems. The committee is concerned, however, that the required regular reporting to WHO has significantly decreased since 2000 and 18 out of 58 hospitals failed to submit reports in 2000 and 41 hospitals failed to do so in 2001 so far.

The Committee notes that a non-polio AFP rate of 1.9 per 100 000 children under age 15 was achieved in 2000 but that the annualized rate in 2001 decreased to 0.7 per 100 000 children under age 15, which is below the recommended standard. The Committee discussed the risk of complacency and shift of priorities after the Region was certificated as poliomyelitis-free negatively affecting the completeness of reporting.

The Committee continues to be concerned that adequacy of stool specimen collection remains very low with 37% in 2000 and 40% in 2001 so far.

The committee was able to provide final classification for two AFP case with onset in 1998 and one case with onset in 1999 that had been kept pending after the last meeting. The Committee further reviewed 20 cases with onset in 2000 and 2001 and was able to classify all except one from 2000 and one from 2001 awaiting additional information.

The committee noted that the inventory of laboratories that may store wild poliovirus infectious materials or potentially infectious materials has not yet been completed as anticipated.

The committee noted the potential for importation of polioviruses from areas outside the subregion where poliomyelitis is still endemic, such as immigrants from Afghanistan to Nauru, and noted that such immigrants may arrive from other nations and immigrate to other countries in the subregion as well. This poses challenges to poliovirus control and has implications for AFP surveillance and national vaccination policies.

The Committee decided to apply the WHO recommendations on the structure of the progress report for submission to the RCC for its next meeting from 25 to 26 October 2001.

The committee wishes to thank the VIDRL for their continuous excellent cooperation and guidance in virological surveillance for Pacific island countries and areas. From January 2000 to September 2001, specimens for 15 AFP cases were successfully transported in good conditions to Melbourne for laboratory analysis demonstrating the viability of the system.

4. ACTION POINTS

4.1 AFP Surveillance System

Although the Committee strongly supports continuing the hospital-based system for active AFP surveillance and reporting as a mainstay of subregional efforts, it has some specific concerns about sensitivity and specificity of AFP detection. These concerns derive from documentation of reduced or delayed AFP reporting in 2000 and 2001, in the face of increasing risks of importation, and the recognition of the need, based on global eradication circumstances, to retain a high level of AFP vigilance for an extended period of time after subregional certification. The Committee therefore requests that the following actions be taken in 2001 and in future years:

4.1.1 As active ongoing AFP surveillance/reporting is central to subregional polio eradication efforts, the WHO Secretariat will contact national coordinators to enlist their participation in re-establishing and improving quality AFP surveillance/reporting.

4.1.2 To enlist continued support and to express thanks for past efforts leading to certification in 2000, the WHO Secretariat will send copies of the certification certificate and relevant sections of the October 2000 Sub-Regional Document for Certification to all national and hospital coordinators.

4.1.3 In addition to item 2 above, the WHO Secretariat will explore the feasibility of making and sending to all of the above coordinators bound copies of the certificate and certification document.

4.1.4 The WHO Secretariat will ask national coordinators to inform and work with hospital coordinators and to share with them the issues and concerns addressed in items 5-10 below.

4.1.5 To further enlist continuing support, and to provide information about the need for continued high-level AFP surveillance, the WHO Secretariat will provide information to the national coordinators about: (1) the global strategy for poliomyelitis eradication, (2) new concerns arising from

documented instances of reversion to, and community circulation of, AFP-producing strains of VDPV, (3) increasing concerns about the possibility of importation of wild polioviruses from endemic regions, (4) implications of importation risk for national vaccination policies, including the critical need to maintain maximal polio vaccine coverage, and (5) implications of the preceding points for AFP surveillance. The WHO Secretariat will also send to them reminders about AFP criteria, categorization, required documentation, etc.

4.1.6 The WHO Secretariat will communicate with Nauru about the current situation regarding immigrant arrival and will communicate separately with national coordinators to express concern about polio importation from nations outside the subregion, such as Afghanistan, that still harbour circulating polioviruses, and will in addition underscore the consequent need for continued vigilance and optimal vaccination coverage.

4.1.7 The WHO Secretariat will establish electronic communication with all of the national coordinators and will contact them on a regular basis for "monthly reminders" supplemented, when appropriate, by additional information of interest and importance.

4.1.8 The WHO Secretariat will discuss with national coordinators possible changes or additions to the reporting system, e.g. adding meningitis case reporting and threshold-limited rash-disease reporting, and will send them "refreshed" sets of reporting forms with appropriate changes that appear likely to enhance the quality and timeliness of AFP surveillance and reporting.

4.1.9 In contacting national coordinators, the WHO Secretariat will request "catch-up" completion and retrospective record review for 2000 and 2001 (see No. 3 below), to bring the AFP surveillance/reporting system up to the level of 1999.

4.1.10 In contacting national coordinators, the WHO Secretariat will remind them and the hospital coordinators of the importance of obtaining two adequate stool specimens, and will continue to explore ways to improve specimen collection.

4.2 Classification of AFP Cases

The Committee requested that the patient with case number 00-99 be followed up to determine her 60-day outcome status to obtain information bearing on residual paralysis and original and final diagnosis.

The Committee requested that the patient with case number 01-03 be followed up to obtain information bearing on diagnosis, residual paralysis and timing of stool specimens.

4.3 Retrospective Reviews

Retrospective record reviews for 2000 and 2001 should be conducted in countries where reporting has seriously lagged after certification. It is expected that such reviews will be undertaken predominantly by national staff, although consultants and others may need to be involved in some situations.

4.4 Laboratory Surveillance

The committee expresses thanks to the New Caledonia laboratory for its efforts in forwarding stool specimens to the regional reference laboratory.

4.5 Laboratory Containment of Wild Poliovirus Infectious and Potentially Infectious Materials

The committee endorses the prioritizing of subregional laboratories into two categories of presumed risk for receiving or storing polio-containing materials. Although the Committee believes there is little likelihood of risk for any subregional laboratory, it requests the following:

4.5.1 The WHO Secretariat will contact all of the laboratories in all two-risk categories, which have not yet responded to the questionnaire (two "high risk" and nine "low risk"), and ask them to do so.

4.5.2 The WHO secretariat will re-contact two high-risk category laboratories that have already reported but whose responses appear to require receipt of follow-up information.

4.5.3 The Committee will, for the foreseeable future, monitor subregional laboratory practice and poliomyelitis risk by contacting laboratories routinely, approximately every two years, to request information on specimen receipt and storage.

4.6 Progress Report on Maintaining Poliomyelitis Free Status after Certification

The Committee expresses gratitude to the national coordinators, hospital coordinators, key clinicians, laboratory personnel, consultants, and to the many health officials and health workers who have supported their efforts to achieve certification.

Regarding the certification document (Annex 6: detection and response to importation of wild polioviruses), the Committee notes the added potential for poliovirus importation, and requests that the WHO Secretariat and national partners recognize the seriousness of the risk, and respond accordingly, as outlined in Action Point 4.1.1 above.

Regarding the certification document (Annex 7: sustaining surveillance in the "post-polio" period), the Committee endorses use of alternative terminology, such as "post-certification", and endorses the need to maintain and increase vigilance.

The Committee requests that the WHO Secretariat take all necessary steps to support and stimulate the existing AFP surveillance/reporting system in the post-certification era, with the expectation that such efforts will need to be maintained at a high level for a number of years to come.

The Committee requests that it continue to meet to review AFP surveillance data approximately yearly, and that it plan to issue annual progress reports.

4.7 Future Activities of the Sub-Regional Committee

The Subregional Committee will draft a paper for publication, in an appropriate public health journal, documenting particular issues and challenges, and responses to them, in the steps toward certification in 2000.

The Subregional Committee will plan to meet annually, with its next meeting targeted for approximately September or October 2002.

ANNEX 1

INFORMAL FIFTH MEETING OF THE SUBREGIONAL COMMITTEE FOR CERTIFICATION OF POLIOMYELITIS ERADICATION IN PACIFIC ISLAND COUNTRIES AND AREAS SUVA, FIJI, 18-19 OCTOBER 2001

PARTICIPANTS LIST

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ANNEX 2

INFORMAL FIFTH MEETING OF THE SUBREGIONAL COMMITTEE FOR CERTIFICATION OF POLIOMYELITIS ERADICATION IN PACIFIC ISLAND COUNTRIES AND AREAS SUVA, FIJI, 18-19 OCTOBER 2001

PRESENTATION IN

MICROSOFT POWERPOINT

(See separate file)

Certification of the Eradication of Poliomyelitis in Pacific Island Countries and Areas

Dr Lisi Tikoduadua, Chairperson

Pacific Subregional Committee for the Certification of the Eradication of Poliomyelitis

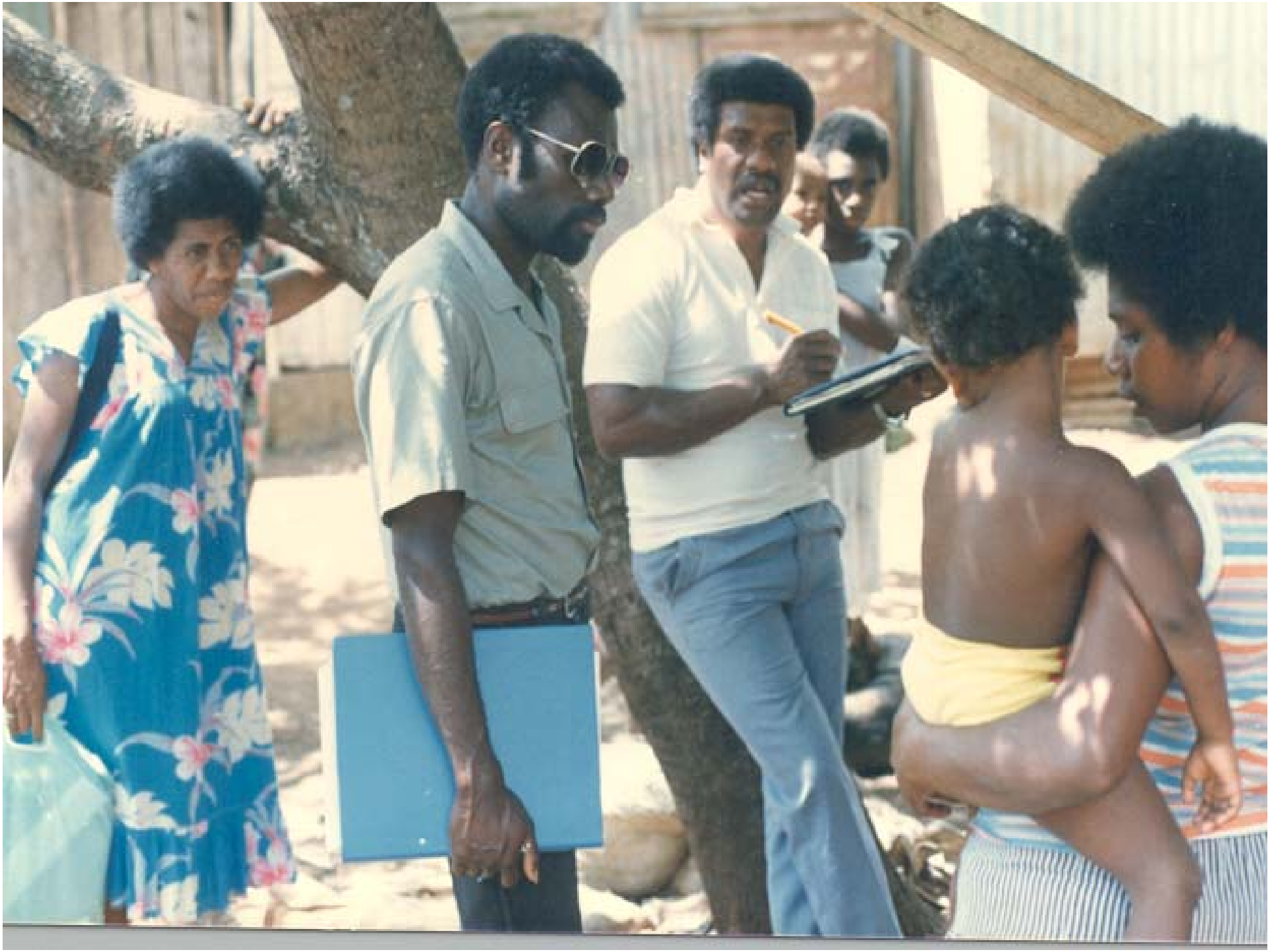
27 October 2000


Philippine Sea
Northern Mariana Islands (U.S.)
Saipan
Guam (U.S.)
Agana
Wake Island (U.S.)
Johnston Atoll (U.S.)
Hawaii
North Pacific Ocean
FEDERATED STATES OF MICRONESIA
Yap
Koror
PALAU
CAROLINE ISLANDS
Pohnpei
Kolonia
Enewetak
Kwajalein
MARSHALL ISLANDS
Majuro
Kingman Reef (U.S.)
Palmyra Atoll (U.S.)
Tarawa
KIRIBATI (GILBERT ISLANDS)
Howland Island (U.S.)
Baker Island (U.S.)
Jarvis Island (U.S.)
Yaren District
NAURU
Banaba
KIRIBATI
RAWAKI (PHOENIX ISLANDS)
LINE ISLANDS
PAPUA NEW GUINEA
Port Moresby
Bougainville
SOLOMON ISLANDS
Honiara
Guadalcanal
SANTA CRUZ ISLANDS
TUVALU
Funafuti
Tokelau (N.Z.)
Arafura Sea
Solomon Sea
Coral Sea
Coral Sea Islands (AUSTRALIA)
VANUATU
Port-vila
New Caledonia (FRANCE)
Noumea
FIJI
Suva
Meta-utu
WESTERN SAMOA
Apia
American Samoa (U.S.)
Pago Pago
Wallis and Futuna (FRANCE)
Cook Islands (N.Z.)
SOCIETY ISLANDS
Papeete
Tahiti
ARCHIPEL DES TUA
ÎLES MARQUISES
TONGA
Nuku'alofa
Niue (N.Z.)
Aitutaki
French Polynesia (FRANCE)
ÎLES TUBUAI
Minerva Reef
Tropic of Capricorn
Cook Islands (N.Z.)
Darwin
Gulf of Carpentaria
Cairns
Townsville
Mount Isa
Mackay
Rockhampton
Gladstone
Alice Springs
AUSTRALIA
Brisbane
Gold Coast
Broken Hill
Darling
Newcastle
Sydney
Wollongong
Canberra
Wagga Wagga
Albury
Wodonga
Wyalla
Adelaide
Murray
Bendigo
Geelong
Melbourne
Great Australian Bight
Bass Strait
Hobart
Tasmania
Tasman Sea
Kingston
Norfolk Island (AUSTRALIA)
Lord Howe Island (AUSTRALIA)
KERMADEC ISLANDS (N.Z.)
South Pacific Ocean
North Island
Auckland
Hamilton
Hastings
NEW ZEALAND
Wellington
Rapa

Updates of
AFP surveillance indicators

Certification criteria: 4 key indicators

1. At least 80% of expected reports will be received on time.
2. At least one case of AFP will be reported per year, per 100,000 children <15 y.o.
3. At least 80% of AFP cases should have two stool specimens within 14 days of onset.
4. At least 80% of AFP cases should have a 60-day follow-up examination.



Indicator 1 (standard: 80%)

Surveillance reports (to WHO)

Monthly reports are expected from all hospital reporting sites
(currently 58 sites = 696 forms annually)

Forms received by WHO, by year:

1997:	75%
1998:	91%
1999:	90%*

* This figure will increase. Some reports have been filed at national level, but not yet forwarded to WHO.

Indicator 2 (standard: 1.0 / 10^5 < 15 y.o.)

Non-polio AFP rate

	Cases	Annual rate
1997	12	1.2
1998	9	0.9
1999	11	1.1
2000 **	17	2.1
Total	49 *	1.3

* 11 cases detected by retrospective record review

** to 15 Oct 00

Pacific island countries and areas

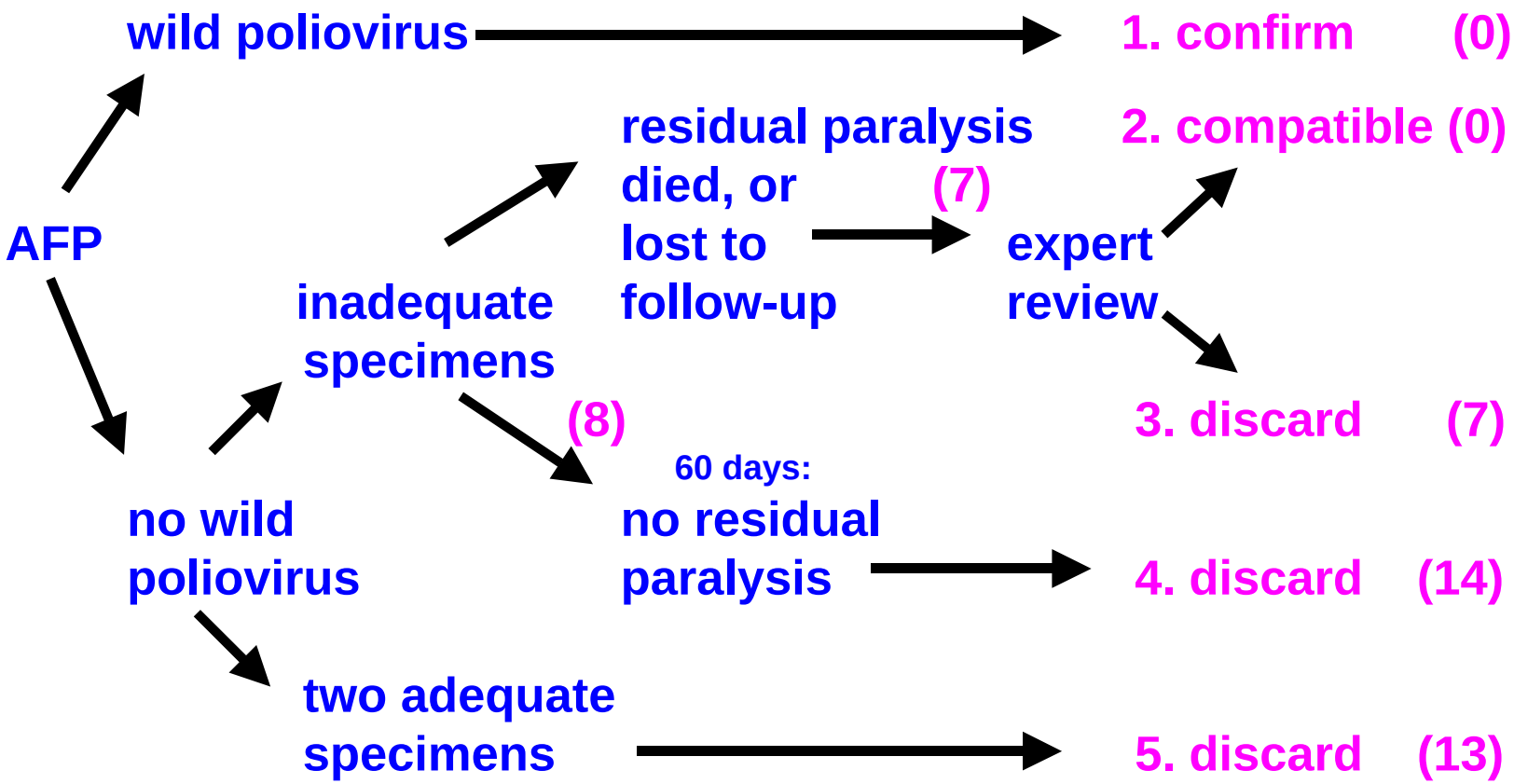
AFP cases expected/ reported 1997 – Oct 2000

Fiji	12 / 15	FSM	2 / 4
Solomon Is	7 / 7	Tonga	1 / 1
Fr.Polynesia	3 / 3	Kiribati	1 / 5
Samoa	2 / 4	Am. Samoa	1 / 1
New Caled.	2 / 6	N. Marianas	1 / 0
Vanuatu	2 / 2	Marshall Is	1 / 0
Guam	2 / 1	Other*	1 / 0

Total: (Expected/ Reported) 38 / 49

* Countries with <10,000 children:
Cook Is, Nauru, Niue, Palau, Tokelau, Tuvalu, Wallis & Futuna

Virologic classification of AFP cases (n=49)
Pacific islands, 1997 – October 2000



Indicator 3 (standard: 80%)

Two adequate stool specimens

	Cases meeting criterion	
1997	3 of 12 AFP cases	25 %
1998	1 of 9	11 %
1999	3 of 11	27 %
2000 *	6 of 17	35 %
Total	13 of 49	27 %

Note: Of the 11 cases in 2000 lacking 2 adequate stool specimens, only 3 (all from the same hospital) had prior experience with AFP case reporting.

* to 15 Oct 00

8 cases in 1999 lacked adequate stool specimens

2 - Had two stool specimens, although only one specimen within 14 days.

1 - Had two stool specimens, but neither specimen within 14 days.

5 - Identified only on retrospective record review.

11 cases in 2000 lacked adequate stool specimens

3 - Solomon Islands

1 died in a few days; 2 had two specimens within 25 days

4 - New Caledonia

Officially part of Pacific surveillance only since May 2000; previously stools sent to Institut Pasteur

3 - French Polynesia

2000: first 3 cases reported from French Polynesia

1 - American Samoa

2000: first case reported from American Samoa

Indicator 4 (standard: 80%)

60-day follow-up examination

	Cases* meeting criterion	
1997	7 of 9 AFP cases	78 %
1998	7 of 8	88 %
1999	9 of 11	82 %
2000**	8 of 15	53 %
Total	31 of 43	72 %

* If alive at 60 days.

** Data still to be returned on recent cases.

Areas of special concern

Areas of special concern

1. Low stool collection rates

- Poor performance in 1997 – 1998.
- Improved in 1999 – 2000, until recently.
- 8 AFP cases since August from hospitals without prior AFP system experience; 2 others had 2 “inadequate” stools.
- 9 other 2000 cases: 6 (67%) had 2 adequate stools; 2 others had 2 stools within 25 days; final case died day 4.


ANUAU
THE UNTOUCHED PARADISE

Areas of special concern

2. AFP cases missed by surveillance

- Hospital-based active surveillance has detected 38 AFP cases since 1997 (1.0 per 100,000 < 15 y.o. per year)
- An additional 11 cases were found during 43 retrospective record reviews.
- 5 of these resulted when new clinicians were not added to the surveillance system.

AFP cases detected by active surveillance / retrospective review

Pacific island countries and areas, 1997 – Oct 2000

Fiji	13 / 2	FSM	1 / 3
Solomon Is	5 / 2	Tonga	1 / 0
Fr.Polynesia	3 / 0	Kiribati	5 / 0
Samoa	1 / 3	Am. Samoa	1 / 0
New Caled.	6 / 0	N. Marianas	- / -
Vanuatu	1 / 1	Marshall Is	- / -
Guam	1 / 0	Other*	- / -

Total: (Surveillance/ Review) 38 / 11

*Countries with <10,000 children: Cooks, Nauru, Niue, Palau, Tokelau, Tuvalu, Wallis & Futuna

Areas of special concern

3. Countries with lower immunization rates

- Overall OPV3 coverage: 83 – 86%
- 3 countries under 80% coverage:
  - Solomon Islands: 69%
    - Overestimated denominator (survey: 88%).
  - Nauru: 72% by survey
    - Only 400 births per year.
  - Fed States Micronesia: 79%

Future activities

Sustaining surveillance: 4 key elements

- SCC and WHO maintain continuing contact with 58 hospital and 20 national coordinators.
- Surveillance reinforced at annual Pacific islands EPI managers' meeting.
- Current initiative on measles elimination; measles/ AFP surveillance already integrated.
- New initiatives underway for integrated communicable disease surveillance in the Pacific, building on the AFP system.

Laboratory containment

- 3 risk levels identified for Pacific laboratories:
  - “Higher risk”: likelihood of ultralow temperature freezers and possibility of long-term storage of specimens.
  - “Low risk”: Probably have storage capacity, but unlikely to store specimens for more than 5 years.
  - “No risk”: Very unlikely to have any long-term storage capacity.


Z/N TOORAK

Laboratory containment (2)

- Questionnaires and inventories underway:
  - 9 “higher risk” laboratories:
    - 6 completed inventories: 0 with stool storage > 5 years.
    - Unlikely that 3 others have long-term storage of stools.
  - 14 “low risk” laboratories:
    - 2 completed inventories; rest expected within 1 month.
  - About 35 “no risk” laboratories:
    - Questionnaires will be completed in the next few months.

Laboratory containment (3)
Timetable

Target date	Activity
31 October 2000	Completed inventories from “higher-risk” laboratories.
30 November 2000	Completed inventories from “low-risk” laboratories.
31 December 2000	Destruction or safe deposit of specimens of concern.
30 June 2001	Follow-up as needed.

Risk of importation

Considered very low because:

- Very little travel to or from any endemic country.
- Other barriers include:
  - Good immunization coverage (83%+)
  - Widespread AFP surveillance

    (average 1 reporting site per 17,000 children)


T CHECKLIST
VACCINE

Response to importation

(Methods to be agreed in principle by all countries)

Following confirmation or strong suspicion of poliovirus importation:

- National outbreak response team convened.
- Importation notified internationally.
- International support provided as needed.

Response to importation (cont.)

- Full epidemiologic and laboratory investigation.
- Case-finding: clinician surveys and record reviews.
- Mass immunization (< age 15) on island of residence, and other islands with possible exposure.
- Other measures as proposed by the outbreak response team, in consultation with WHO.


HEALTHY BABIES
PREVENT SCABIES

Conclusions

- The Pacific has almost surely been polio-free for many years.
- A comprehensive surveillance network is in place.
- Monthly reporting at national level is excellent, although delayed to WHO.

Conclusions (2)

- The Pacific meets surveillance standards for certification, except stool specimen collection.
- Stool collection has improved in each hospital as experience is gained.
- Isolation, good immunization coverage, and the surveillance network provide barriers to re-establishing poliovirus circulation.

Acknowledgements

- International partners:

  WHO, UNICEF, Rotary, Governments of Japan, Australia, and New Zealand.
- National governments of the Pacific.
- Parents of the Pacific, for their ready acceptance of immunizations to protect their children.
- Photos: WHO, UNICEF, F. Rousar