Pan American Health Organization

World Health Organization
REGIONAL OFFICE FOR THE Americas

Final Report

First Meeting of the Regional Certification Commission for the Polio Endgame in the Region of the Americas (RCC)

11 – 12 June 2015

Washington D.C., PAHO Headquarters

RCC Members

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Dr. Carlos Godoy Artega ***Unable to attend**
Presidente, Comisión Nacional de Erradicación de la Poliomielitis (CONEPO), Hospital Centro Medico Hondureño

Invited Guests

Dr. Rudolf Tangermann, WHO

Dr. Steven Wasssilak, CDC

Secretariat

Dr. Cuauhtemoc Ruiz Matus, PAHO

Dr. Cristina Pedreira, PAHO

Dr. Gloria Rey, PAHO

Ms. Elizabeth Thrush, PAHO

Acronyms

AFP	Acute flaccid paralysis
bOPV	Bivalent oral polio vaccine; containing serotypes 1 and 3
cVDPV	Circulating vaccine-derived poliovirus
IPV	Inactivated polio vaccine
OPV	Oral polio vaccine
PAHO	Pan American Health Organization
SAGE	Strategic Advisory Group of Experts on Immunization of the World Health Organization
TAG	Technical Advisory Group on Vaccine-preventable Diseases of the Pan American Health Organization
tOPV	Trivalent oral polio vaccine
VAPP	Vaccine-associated paralytic poliomyelitis
WHO	World Health Organization

First Meeting of the Regional Certification Commission for the Polio Endgame in the Region of the Americas (RCC)

The *First Meeting of the Regional Certification Commission for the Polio Endgame in the Region of the Americas (RCC)* was held from 11 to 12 June 2015 at PAHO Headquarters in Washington, D.C.

The main objectives of this meeting were to familiarize RCC members with the history and legacy of polio eradication in the Americas, review the objectives of the *Polio Eradication and Endgame Strategic Plan, 2013-2018* (the Endgame), and provide a global and regional context on the implementation of the Endgame requirements.

Dr. Arlene King, RCC Chair and Dr. Cuauhtemoc Ruiz Matus, Chief of the Immunization Unit at PAHO/WHO opened the meeting, welcoming the members and invited guests to the first meeting of the Commission that will be responsible for certifying that the Region of the Americas has fulfilled the necessary requirements for the Endgame. Following introductions, Dr. King presented the roles and responsibilities of the Commission, which were further discussed and agreed upon at the end of the meeting.

History of Polio Elimination in the Americas

In 1985, the PAHO/WHO 31st Directing Council passed a resolution declaring to eradicate polio in the Americas by 1990. The last endemic case of wild polio virus in the Region occurred on 23 August 1991 in Pichinaki, Department of Junín, in Peru, and in 1994, the International Commission for the Certification of Poliomyelitis Eradication (ICCPE), an independent commission tasked with overseeing regional polio eradication efforts, declared the Americas to be polio-free.

The Region achieved polio eradication through high vaccination coverage, active and high quality AFP surveillance, laboratory diagnostic capacity, and aggressive outbreak control. The countries of the Americas did not create a special structure for polio eradication, but rather eliminated polio through strengthening the routine immunization programs that were already in place. This created a lasting legacy that not only impacted immunization programs, but also supported other health systems in the Americas, which was documented in the 1995 Report of the “Taylor Commission”.

Following the leadership and success of polio control in the Americas, the World Health Assembly passed a resolution in 1988 aiming to eradicate polio by the year 2000. The Americas Region has now been free of wild polio for almost 24 years.

Global Update – Polio eradication

Tremendous progress has been made towards the global eradication goal. 80% of the world's population now lives in WHO Regions certified as polio free: the Americas in 1994, the Western Pacific Region in 2000, the European Region 2002, and the South East Asia Region, which includes India, in 2014. Only 3 countries remain endemic: Pakistan, Afghanistan and Nigeria, with the possibility of Nigeria begin declared non-endemic over the next 1-2 months.

Update on the Endgame Implementation in the Region

In the last 20 years since the certification of eradication, the Region has had only one outbreak of circulating vaccine-derived poliovirus (cVDPV), which occurred in Haiti and Dominican Republic, between 2000 and 2001.

To maintain polio eradication, countries should continue surveillance of acute flaccid paralysis (AFP) cases in children under 15 years and implement strategies to achieve and maintain high vaccination coverage against this disease. However, the Region of America is not achieving all of the surveillance quality indicators. Similarly, vaccination coverage varies between and within countries and regional coverage has been declining in recent years.

To fulfill the guidelines of the Endgame, and in preparation for the switch from tOPV to bOPV, the countries of the Region will be introducing at least one dose of IPV, by the end of 2015, in their routine immunization program as part of a sequential schedule: IPV followed by OPV.

The countries of the Region are forming National Certification Committees (NCCs) composed of independent experts in different areas of public health. NCCs will assess, verify and present the required national documentation to the RCC. To date, only 9 countries in the Region were reported to have operational NCCs in place.

GAP III and the containment of wild and Sabin poliovirus

The WHO has a global action plan (GAPIII) to minimize poliovirus facility-associated risk after polio eradication that includes the containment of all polioviruses: wild, VDPV and Sabin.

In ~~March~~ April 2015~~2014~~, a small working group meeting was convened in Washington DC to review and discuss the adaption of the containment plan for the Americas; two issues were extensively considered: 24 years without AFP cases caused by wild poliovirus and OPV use in most of the countries.

Similar to the Global Action Plan, the Regional GAPIII is implemented in three phases that are linked to national and international milestones in polio eradication. This containment plan is sequential and will begin with the containment of all wild polioviruses (WPV) and potential infectious material of WPV by December 2015, followed by Sabin poliovirus type 2 (Sabin 2)

and potential infectious material of Sabin 2 by July 2016, and finally Sabin poliovirus types 1 and 3 containment, tentatively planned for 2019 after the withdrawal of bOPV.

Preparing for the tOPV to bOPV Switch

The switch or the replacement of all trivalent oral polio vaccines (tOPV), which contains vaccine-poliovirus types 1, 2 and 3, to bivalent oral polio vaccines (bOPV), which contains vaccine-poliovirus types 1 and 3, is tentatively scheduled to occur in April 2016 during a two-week window that will be defined by SAGE in October 2015. SAGE recommended the switch because WPV type 2 has not been detected since 1999, and now tOPV generates more risks than benefits and undermines global polio eradication. Around 90% of polio cases due to cVDPV and 40% of all vaccine-associated paralytic poliomyelitis (VAPP) cases are caused by poliovirus type 2.

After the decision is made by SAGE for the switch date, in October 2015, there will be no turning back, even if a new cVDPV2 is detected.

The countries of the Region have received guidelines to develop switch plans and should have already started working on their plan to ensure that all requirements for a safe switch will be met.

Following OPV2 cessation, there will be a relatively higher, but time-limited, risk of the emergence of cVDPV, and there is a lower, but long term risk of poliovirus re-introduction from a manufacturing site or laboratory. For these reasons, all countries must maintain sensitive surveillance systems in order to rapidly detect and interrupt any circulating poliovirus. Detection of any poliovirus type 2, in any sample of any source, will be considered a Global Public Health Emergency that requires rapid and high-quality response. A protocol for notification, risk assessment, and response following detection of poliovirus type 2 after the switch has been developed to support countries.

Agreements and Action Points

1. RCC members agree with the proposed name for the Commission, amended (as above), as well as the terms of reference and information flow (NCC to RCC to GCC).

2. Consideration will be given to increase the frequency of in-person meetings, at least initially, to enable members to familiarize themselves with the Endgame and its implementation in the Americas, in light of the intensity of deliverables from 2015-2016 (IPV implementation, WPV2 and Sabin-virus containment, tOPV-bOPV switch).

3. PAHO Secretariat will consider RCC participation at the Regional Polio Meeting August 17-19 in Bogota, Colombia, dates of subsequent meetings and potential country field visits by members.

4. PAHO Secretariat will ensure that all RCC members receive the weekly Acute Flaccid Paralysis Surveillance/Polio Bulletin, and consider other mechanisms to ensure that RCC members are fully acquainted with AFP indicators in the Region, to subnational levels.

5. PAHO will consider conducting a Region-specific Risk Assessment, using standard global methods, related to the emergence of wild and circulating vaccine derived polioviruses.

6. RCC Chair convened a small group discussion among PAHO, WHO, CDC and RCC at the conclusion of the RCC meeting to obtain a greater understanding of the challenges related to the implementation of GAP III in the Region. PAHO will consider options to address the challenges identified.

7. PAHO Secretariat will follow up with Member States for the official response on the last date of type 2 wild poliovirus detection, or if that information is unavailable, the last date of wild poliovirus in the country, and present this information to the RCC by the beginning of August.

8. PAHO Secretariat will draft a letter from the RCC to GCC, stating that the RCC believes that the Region of Americas remains free of wild poliovirus type 2. The letter also will contain the evidence to support this conclusion. The draft letter will be sent to the Chair by early August, for circulation to RCC members for comment and completion by mid-August.

9. RCC notes that the establishment of NCCs in every country or sub-region is critical to the work of the RCC. PAHO Secretariat will encourage all countries to finalize the establishment of NCCs by August 2015 and give an update to the RCC on the formation of these Committees.

10. WHO will provide a template to the PAHO Secretariat for consideration and/or modification by the Region, for the purpose of NCC documentation. This will be circulated to RCC members for review and comment.

11. PAHO Secretariat will create an electronic information sharing mechanism by which RCC members can receive updates, pertinent scientific papers and other documents.

12. When published, PAHO will share the results of the studies conducted in the Americas on IPV-OPV sequential schedules with the members of RCC.