WORLD HEALTH ORGANIZATION

REGIONAL OFFICE FOR THE WESTERN PACIFIC

REPORT

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

Suva, Fiji, 8-9 September 2004

Manila, Philippines
October 2004

(WP)/ICP/EPI/5.2/001-A

Report series number: RS/2004/GE/42(FIJ)

English only

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Convened by:

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC

Not for sale

Printed and distributed by:

World Health Organization
Regional Office for the Western Pacific
Manila, Philippines

October 2004

NOTE

The views expressed in this report are those of the participants in the Informal Eighth 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.

The Expanded Programme on Immunization, WHO Western Pacific Regional Office, would like to thank the Ministry of Health, Labour and Welfare of Japan for providing financial support for the meeting including the production of this document.

Keywords:

Poliomyelitis - prevention and control, classification / Immunization programs / Certification / Pacific Islands

This report has been printed by the Regional Office for the Western Pacific of the World Health Organization for the participants in the Informal Eighth Meeting of the Subregional Committee for Certification of Poliomyelitis Eradication in Pacific Island Countries and Areas, which was held in Suva, Fiji, from 8 to 9 September 2004.

CONTENTS

Page

1. INTRODUCTION 1

1.1 Objectives 1
1.2 Organization 1
1.3 Opening session 1

2. PROCEEDINGS 1

2.1 Global and regional overview of poliomyelitis eradication 1
2.1.1 Global status 1
2.1.2 Regional status 4
2.1.3 Summary of recent PIC EPI/surveillance meetings and activities 7

2.2 Maintaining poliomyelitis-free status in the PICs 8
2.2.1 Performance of AFP surveillance 8
2.2.2 Supplementary surveillance activities 13
2.2.3 Laboratory surveillance 15
2.2.4 Immunization activities 15
2.2.5 Detection and response to importation of wild poliovirus 16
2.2.6 Areas of special concern 16
2.2.7 Sustaining poliomyelitis-free status after certification 16
2.2.8 Laboratory containment of wild poliovirus infectious and potentially infectious materials 16
2.2.9 Progress report on maintaining poliomyelitis-free status after certification *17*

3. CONCLUSIONS 18

4. ACTION POINTS 19

ANNEXES:

ANNEX 1 - LIST OF PARTICIPANTS

ANNEX 2 - POPULATION FIGURES BY COUNTRY

ANNEX 3 - NUMBERS OF SITES FAILING TO SUBMIT A MONTHLY ACTIVE SURVEILLANCE (MAS) REPORT FORM

ANNEX 4 - PERCENTAGE OF MAS FORMS SUBMITTED BY COUNTRY

TABLES:

TABLE 1 - SUBMISSION OF COMPLETED FORMS

TABLE 2 - ACUTE FLACCID PARALYSIS (AFP) CASES BY YEAR

TABLE 3 - STOOL SPECIMEN COLLECTION RATE

TABLE 4 - 60-DAY FOLLOW-UP OF AFP CASES

TABLE 5 - PERCENTAGE OF AFP CASES WITH INADEQUATE STOOL SAMPLES AND 60-DAY FOLLOW UP AVAILABLE (TARGET: 80%)

TABLE 6 - A SUMMARY OF THE COMMITTEE'S EXPERT REVIEW

1. INTRODUCTION

An informal eighth meeting of the Subregional Committee for the Certification of Eradication of Poliomyelitis (SCC) in Pacific Island Countries and Areas (PICs) took place in Suva, Fiji, from 8 to 9 September 2004.

1.1 Objectives

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

(2) to review and make a final classification of all acute flaccid paralysis (AFP) cases reported during 2003 and 2004 (January to August); and

(3) to develop a draft progress report on maintaining poliomyelitis-free status in 20 PICs, for submission to the 10th meeting of the Regional Certification Commission's (RCC) from 20 to 21 October 2004.

1.2 Organization

The meeting was attended by the five members of the SCC and a WHO secretariat (see Annex 1). Dr David Morens attended as a Temporary Adviser to WHO.

1.3 Opening session

The Chairperson addressed the committee, and requested Dr David Morens to continue to serve as Rapporteur. Representatives from the United Nations Children's Fund (UNICEF) were present during the meeting.

2. PROCEEDINGS

2.1 Global and regional overview of poliomyelitis eradication

2.1.1 Global status

To date in 2004, indigenous wild poliovirus transmission is confined to a limited number of poliomyelitis 'hot-spots' within six countries. These countries are Afghanistan, Egypt, India, Niger, Nigeria and Pakistan.

However, between 2002 and 2004, the number of poliomyelitis-free countries conducting preventive immunization campaigns decreased from 100 to 20, increasing vulnerability to poliovirus importations. This vulnerability is underlined by the recent confirmed importations into Benin, Botswana, Burkina Faso, Cameroon, the Central African Republic, Chad, Cote D'Ivoire, Guinea, Mali and Sudan and the ongoing poliomyelitis outbreak in Nigeria spreading across west and central Africa. That outbreak was exacerbated following the suspension of immunization campaigns in some northern states of the country, most notably Kano, for almost one year.

Importations will remain a risk until poliomyelitis is eradicated everywhere and should be treated as an urgent public health threat. Countries must establish national plans to rapidly respond to potential importations and should strengthen their AFP surveillance systems nationally and regionally, to rapidly detect further potential importations. Upon identification, massive nationwide house-to-house mop-up campaigns must be conducted within four weeks of confirmation of the importation. Strong routine immunization remains the best defence against importations of poliovirus.

The world's vulnerability to re-infection through cross-border importations is increasing fast, highlighting the urgency to end poliomyelitis while there is still a chance. Last year, for the first time, and continuing in 2004, poliomyelitis-free countries reporting poliomyelitis cases due to importations of wild poliovirus outnumbered endemic countries, proving that poliomyelitis anywhere is a threat to children everywhere.

Low rates of routine immunization across Africa and Asia make children living there particularly vulnerable to poliomyelitis and other infectious diseases. Universal access to routine immunization is the best national defence against poliomyelitis.

A funding gap of US$ 100 million must be filled to ensure that activities planned for 2004-2005 can go ahead. The emergency response in Africa will require at least an additional US$ 100 million for 2004-2005. Of the additional US $100 million, US$ 15 million is urgently required by September 2004 and another US$ 35 million by November 2004.

Ministers of Health from the six remaining poliomyelitis-endemic countries are committed to stopping poliovirus transmission by the end of 2004. The success of the US$ 3 billion, 15-year campaign depends upon the quality of immunization campaigns over the next few months. The resumption of poliomyelitis immunization campaigns in Kano in Nigeria provides a great opportunity to stop poliovirus transmission during immunization activities from September to December 2004.

Transmission in Sub-Saharan Africa is five times higher this year than last (563 cases reported to date compared with 127), with 12 countries in the African Region (including Nigeria and Niger) reporting cases, compared with three countries in the same period in 2003. The number of cases in Niger and Nigeria has increased significantly compared with last year (19 vs four in Niger, 491 vs 122 in Nigeria). In addition to countries in west and central Africa, viruses genetically linked to northern Nigerian virus have caused cases in Botswana and the Sudan.

Nigeria poses the highest risk to the end-of-2004 target for the global eradication of poliomyelitis, accounting for 78% of the total number of poliovirus cases reported globally in 2004 (491 out of 630 global cases). At the same point in 2003, Nigeria had only 127 cases. Now that Kano State has rejoined immunization activities, Nigeria has a great opportunity to stop poliovirus transmission over the next few months. High-quality immunization activities in Kano are among the several measures needed to stop transmission of poliovirus in Nigeria and to halt the international spread of the virus. A concerted effort to rebuild public trust around poliomyelitis eradication is critical to ensuring all Nigerian children are immunized. It is critical that every single child is reached during Nigeria's national immunization days (NIDs) in September, October and November 2004.

WHO continues to publicly emphasize that international travellers to Nigeria should protect themselves by being up-to-date with vaccination against poliomyelitis, as outlined in WHO's *International travel an health.* Further potential measures to contain the international spread of poliomyelitis – as recommended by an Ad Hoc Expert Consultative Group on Polio

and Public Health - are outlined in the *Weekly epidemiological record*, 6 August 2004, vol. 79, 32: 289-300.

Niger had reported 19 cases of poliomyelitis caused by wild poliovirus as of 31 August 2004 and is behind schedule for stopping poliovirus transmission by the end of 2004. Niger increased the number of poliomyelitis campaigns to three full NIDs in early 2004 and is planning to conduct an additional three NIDs in the second half of 2004 (October, November and December). It is critical that the quality of the planned supplementary immunization activities (SIAs) be improved to halt the spread of poliovirus in Niger.

Massive, synchronized immunization campaigns will be conducted across 22 west and central African countries in October and November 2004, aimed at reaching 74 million children. It will be critical to ensure all children are reached in order to halt the spread of poliovirus transmission across the region.

A mop-up response campaign was conducted in west, north and south Darfur in response to the imported case in the west Darfur region of the Sudan in May 2004. Four additional cases were reported during the week of 18 August 2004. A second round of mop-ups took place on 29-30 August 2004, targeting 1.3 million children. Nationwide SIAs are scheduled for 10-12 October 2004 and 21-23 November 2004.

Strong progress continues to be achieved in Asia and North Africa, with 67 cases in 2004 compared with 172 year-to-date in 2003. Still, no country can afford to be complacent, particularly during the high transmission season. Strong political and grassroots support for immunization activities will be critical to interrupt transmission by the end of 2004.

At Rotary International's PolioPlus Summit in India (August 2004), the Governments of Afghanistan, India and Pakistan discussed cooperation to stop poliovirus transmission by the end of 2004.

As of 31 August, Afghanistan had three confirmed cases of poliomyelitis. Recognizing the need for intensified activities in response to those three cases, the security challenges in the southern region, and the upcoming October elections, the Government of Afghanistan decided to add two rounds of mop-ups in the southern and eastern region in June and July 2004.

India is on track, having reported only 40 cases as of 31 August 2004 (compared with 115 cases for the same period in 2003). India brought forward its plans for massive house-to-house mop-ups to 22 August 2004, targeting more than 50 million children in selected high-risk districts in Uttar Pradesh, Bihar, West Bengal, Orissa, Andhra Pradesh, Harayana, Uttaranchal and Mumbai. NIDS are scheduled for 10 October 2004 and 21 November 2004.

With only 23 cases as of 31 August 2004 (vs 54 for the same period in 2003), Pakistan is also on track. However, key to success will be ensuring high quality immunization campaigns in the upcoming SIAs. Sustaining political will, oversight and accountability will also be critical to access all children during the upcoming SIAs. Maintaining high-level political commitment will be essential to the success of immunization activities in 2004. NIDs have been scheduled for 24-26 August 2004 and 5-7 October 2004. Political oversight has increased substantially through concerted advocacy at all levels. For example, in May 2004, President Musharraf wrote to district Nazims urging stronger support for poliomyelitis eradication.

Egypt is on track to stop wild poliovirus circulation in 2004, with just one AFP case due to wild poliovirus to date. Maintaining high-level political commitment will be essential to the success of immunization activities in 2004. Since January, two national and one subnational immunization days have been conducted. In Cairo, Giza and Kalioubia, the proportion of children who received ≥ 5 doses increased to 100%. Egypt is implementing massive house-to-house mop-up campaigns targeting all children under five years of age in response to any circulating poliovirus (including positive environmental samples). Egypt will conduct NIDs on 5-7 September 2004, 8-10 October 2004 and 27-29 November 2004.

2.1.2 Regional status

Certification process

Following a thorough review of all submitted country reports during its 9th meeting in Manila, on 12-13 November 2003, the RCC concludes that sufficiently sensitive surveillance systems for AFP and wild or vaccine-derived poliovirus (VDPV) are still in place in most countries and that the Region has remained poliomyelitis-free.

The RCC commends countries for maintaining good quality AFP surveillance, even in view of other, often competing, health priorities and public health emergencies such as the epidemic of Severe Acute Respiratory Syndrome (SARS) earlier in 2003 and the generally declining attention given to poliomyelitis eradication in most poliomyelitis-free countries.

However, while the quality of activities to sustain poliomyelitis-free status is high in most countries, not all countries have been able to maintain certification level surveillance quality or previous levels of routine immunization coverage.

The Commission remains very concerned about the decreasing visibility of activities to sustain poliomyelitis-free status at the regional and country level, and urges WHO, UNICEF and all other poliomyelitis partners to maintain a high profile for the programme, particularly using forums such as the annual sessions of the WHO Regional Committee, for which poliomyelitis eradication should remain on the agenda as a permanent item.

All poliomyelitis partners and national governments in the Region should be reminded that wild virus continues to circulate in neighbouring areas. Recalling how these areas have been the source of importation of wild poliovirus into Western Pacific Region countries in the past, the Commission again highlights that high-quality surveillance and maintenance of sufficient population immunity against poliomyelitis are essential for countries to protect the enormous investment they have already made in poliomyelitis eradication.

The secretariat has been in close dialogue with the Regional Director and Member States to include the expanded programme on immunization (EPI) into the agenda of the next session of the Regional Committee in September 2004. Updates on the global poliomyelitis eradication initiative have been provided to all WHO country representatives to facilitate discussions with senior public health officials, and continue to be included in relevant EPI managers meetings, such as the UNICEF/WHO Expanded Programme on Immunization (EPI) Workshop in the Pacific in New Zealand in March 2004.

AFP surveillance performance:

As of 1 June 2004, a total of 6397 AFP cases with onset in 2003 had been reported, resulting in an annual non-polio AFP rate of 1.38 per 100 000 under age 15. Regional data suggest that management of the international SARS epidemic in areas affected and development

of national preparedness may have impacted on AFP case-reporting. Delays in reporting appear to have been temporary and other quality indicators (e.g. adequate stool specimen collection rates at 88%, AFP cases with follow-up results at 98% and AFP cases with inadequate samples but follow-up results at 96%) were not affected.

As of 30 August 2004, 3602 AFP cases with onset in the current year have been reported, resulting in an annualized non-polio AFP rate of 1.33. Adequate stool specimens were collected for 87% of cases. Less than 4% of cases are pending final classification 90 days after onset of paralysis, and only three cases have been classified as poliomyelitis-compatible so far.

Laboratory results in 2003 (data as of 1 June 2004) were available within 28 days of receipt for 94% of all AFP cases and all but one provincial laboratory in China exceeded the target of at least 80%. The performance level is being maintained in 2004. The provincial laboratory in Tibet has reported all results in a timely manner.

The non-polio enterovirus isolation (NPEV) rate in 2003 was 9%, with several laboratories achieving rates at or below 5%, which may indicate decreased virological sensitivity. This trend is continuing in 2004, with a regional rate of 8%.

All regional reference, national and provincial poliovirus laboratories have been reviewed for 2004 accreditation and all except the provincial laboratory in Tibet are currently conforming to WHO standards.

Intratypic differentiation (ITD) results in 2003 were available within 14 days of receipt for 83% of poliovirus isolates of AFP cases, and for 94% within 28 days of receipt. The rates have been further improved to 93% and 99% respectively in 2004.

ITD results were available for 94% of AFP cases within 90 days of onset of paralysis in 2003, but, although improved compared with 2002, for only 66% within 60 days of paralysis onset. Further gains could be made in 2004, with, so far, 97% of ITD results available within 90 days of onset and 73% available after 60 days.

As part of VDPV surveillance, all poliovirus isolates in 2003 and 2004, regardless of source, have been subjected to two ITD methods. In 2003, 43 polioviruses from AFP cases (total of 482) and non-AFP sources (total of 90) with discordant ITD results were subjected to sequencing and one VDPV was isolated from a healthy child in Mongolia. Review of surveillance and coverage data, as well as epidemiological investigation in the area of the child, did not reveal any longer-term or current virus circulation. To date in 2004, 17 polioviruses (from 175 AFP cases) with discordant ITD results have been sequenced, with 16 identified as Sabin-like and one pending, while, of 54 polioviruses from non-AFP sources, three revealed discordant ITD results but were all classified as Sabin-like upon sequencing.

Immunization activities

Reported national routine immunization coverage remains at similar levels as before in almost all Member States (please refer to country profiles). Several countries have achieved less than 80% or have identified subnational areas of low coverage and have subsequently conducted SIAs with oral poliovirus vaccine (OPV).

In Cambodia, OPV has been included in measles and tetanus toxoid (TT) SIA and coverage results in 2003 exceeded 85 %. Supplementary OPV immunization is being combined with measles SIA in 2004.

China targeted approximately 6.9 million children under age four during the 2003/2004 winter season. The scope originally planned for the season was considerably reduced, as the result of a shortage of external resources and a reduction of SIA globally in poliomyelitis-free countries to focus maximum attention on remaining endemic areas. Main target areas for the SIA were provinces bordering poliomyelitis-endemic countries in western China. The target population was approximately 6.9 million children from zero to three years of age.

In the Lao People's Democratic Republic, the national programme began implementing activities designed to improve immunization service delivery with introduction of the new diphtheria-tetanus-pertussis (DTP)/Hepatitis B vaccine into the routine immunization schedule. During 2003, microplanning at district level, with intensive monitoring and follow-up, was implemented on a pilot basis, resulting in substantial coverage improvement.

Solomon Islands experienced vaccine outages at the national level in late 2002 and early 2003. This was resolved with assistance for vaccine procurement through Japan International Cooperation Agency (JICA). Solomon Islands conducted a national EPI catch-up campaign in November 2003, targeting all children under age five who had missed vaccinations.

Viet Nam conducted SIAs in November and December 2003 in 22 districts of six provinces, targeting almost 230 000 children under five years of age.

While several SIAs are still being conducted, generally in a targeted manner, the scope of SIAs has further declined. The Technical Advisory Group (TAG) on EPI and Poliomyelitis Eradication in the Western Pacific, during its meeting in March 2004, continued to emphasize the importance of strengthening the quality of routine immunization. It recognized that such a reduction, in connection with a very significant decrease globally in preventive SIAs in recently endemic countries, poses a risk of developing large susceptible populations in poliomyelitis-free areas with low routine OPV coverage. The TAG concluded that these developments, impacted by a global funding shortage, require the highest levels of surveillance quality, subsequently resulting in higher surveillance costs.

Although the possibility of wild poliovirus importation will decrease, as the global programme is making progress in endemic areas, the risk will continue to exist as long as there is transmission in other parts of the world. At the same time, the risk of emergence and circulation of VDPV may increase and it will become more difficult for poliomyelitis-free areas to maintain high levels of OPV coverage.

Laboratory containment of wild poliovirus infectious and potentially infectious materials

With China and Japan in the process of finalizing their national inventories, phase 1 of laboratory containment is still to be completed in the Region. Validation of national inventories and the containment process using a standard quality assessment tool has commenced.

After updating the list of national coordinating groups, an information package on all recent developments was provided to national containment coordinators, EPI managers, members of national certification committees (NCCs) and other partners involved to solicit new interest. This included distribution of the second edition of the Global Action Plan (GAP II), with a summary on revisions compared with the first edition.

Following endorsement by the RCC, the validation exercise is being conducted in three groups of countries:

(1) Assessment tools to be filled in by the national containment group and reviewed by the Western Pacific Regional Office secretariat against a standard checklist (Australia, Brunei Darussalam, Cambodia, Hong Kong [China], the Lao People's Democratic Republic, Macao [China], Mongolia, New Zealand, Papua New Guinea, Singapore).

(2) Western Pacific Regional Office staff/consultant assessment visit (Malaysia, Pacific island countries, the Philippines, the Republic of Korea, Viet Nam).

(3) Joint WHO Headquarters/Western Pacific Regional Office assessment visit (China, Japan).

The regional database will be finalized, including management of assessment results to establish institutional memory and manage future information and detailed reporting requirements to the Global Certification Commission (GCC), and definition of the future role/mandate of the RCC in the process will be pursued.

2.1.3 Summary of recent PIC EPI/surveillance meetings and activities

Measles elimination and hepatitis B (HBV) control are the two new pillars to revitalize the EPI within the Western Pacific Region. Considerable progress has already been made in the Region for both these diseases, but measles is still causing significant mortality and morbidity. Hepatitis B is particularly important in the Region as it has over half the HBV-related deaths in the world, but only one quarter of the global population – an estimated 800 deaths per day. There remain countries in the Region that have high rates of chronic HBV infection, with especially high rates in the PICs.

Since the establishment of the EPI in the PICs in the early 1980s, there have been several important achievements:

- Poliomyelitis eliminated and the Region certified as poliomyelitis-free on 29 October 2000.
- Measles transmission interrupted since 1998 (importations with limited outbreaks in French Polynesia [1999] and Guam [2002] and an extensive outbreak in the Marshall Islands [2003]).
- Hepatitis B vaccine fully integrated into EPI of all countries since 1996.
- High reported routine immunization coverage (>90% for most countries).

The PICs have also moved from donor dependence to self-funding for vaccines through the UNICEF Vaccine Independence Initiative (VII). PICs have paid the entire cost for traditional EPI vaccines since 1997 (excluding those that receive support from the United States of America and France). Using a similar mechanism of gradually increasing contributions, those countries have been paying for the hepatitis B vaccine since 2001. However, a recent exception has been Solomon Islands, where payments for vaccines were interrupted in 2001 because of internal conflict. The defaulting of Solomon Islands from the VII may be a precursor for other countries, as there have been requests for donor support for vaccines.

As a result of the success of the EPI in the Pacific, it is receiving less attention now in many PICs and there is a risk of losing some of the gains. Furthermore, EPI management in many PICs requires further strengthening, as evidenced by frequent vaccine outages, inadequate cold-chain equipment management, and concerns about quality of routinely reported coverage and disease data, which may be hiding pockets of low coverage in some countries/areas.

To ensure that sufficient resources are present for countries to achieve the goals of the Regional Committee resolution, and that donor assistance is coordinated, WHO has initiated formation of a body of all agencies involved in health and immunization in the Pacific, under the umbrella of the Pacific Immunization Programme Strengthening (PIPS). These are: WHO; UNICEF; the Australian Agency for International Development (AusAID); the Government of Japan/JICA; the New Zealand Agency for International Development (NZAID); Centers for Disease Control and Prevention, Atlanta, United States of America; and the South Pacific Commission/Pacific Public Health Surveillance Network (PPHSN).

The main focus of PIPS is to assist the Pacific region to achieve and maintain measles elimination status and improve hepatitis B control, in line with the Western Pacific Regional Committee's resolutions of September 2003. Additional benefits will include support in maintaining countries' vaccine procurement self-funding; improving programme management, leading to increased coverage and reduced vaccine wastage; maintaining poliomyelitis-free status; strengthening disease surveillance and the laboratory network (LabNet) for confirmatory disease diagnosis; and introducing new vaccines (rubella and *Haemophillus influenza*e type b [Hib] vaccines).

In 2004, a regional measles laboratory network will be established, based on the poliomyelitis laboratory network. In the Pacific, the measles laboratory network will be developed in coordination with the PPHSN L2 laboratory system, with the national measles laboratories in Fiji, French Polynesia, Guam and New Caledonia. The aim of the laboratory network will be to provide virological support to countries in monitoring and verification of measles virus transmission, confirmation of cases and outbreaks, identification of measles virus strains for molecular and epidemiological data, monitoring of the measles population immunity level, establishment of reference and support mechanisms, provision of training and coordination and performance of quality assurance.

Current activities for measles surveillance being coordinated by WHO include defining measles elimination criteria and establishing measles surveillance standards for countries to measure programme performance. It will be important for the PICs to be actively involved in the development of these standards, particularly given the small population size of some Pacific nations. It might be necessary for the Pacific to be considered as a regional block when implementation of these surveillance standards occurs, as occurred with AFP surveillance. For example, the definition of "re-establishment of endemicity for measles" as being more than 100 cases or greater than three months sustained transmission needs to be considered within the Pacific context, where some countries have populations of less than 10 000 people.

2.2 Maintaining poliomyelitis-free status in the PICs

2.2.1 Performance of AFP surveillance

Active AFP surveillance

As AFP surveillance is focused on children under the age of 15, updated demographic data are included in Annex 2.

The hospital-based surveillance network has remained unchanged from previous years. It includes 58 hospitals distributed in all 20 countries and areas, and active involvement of 20 national coordinators, 58 hospital coordinators and over 200 key paediatric clinicians. The reporting mechanism in most countries continues to require a copy of the completed monthly active surveillance form (MAS) to be sent from the hospital coordinator to the national coordinator and copied to WHO at least every three months. The form also includes reports on acute rash and fever (ARF) and neonatal tetanus (NT) cases.

The WHO office received copies of 21% of expected forms for 2001 (147 out of 696), 70% of expected forms for 2002 (484/696), 57% of expected forms for 2003 (393/696) and 32% of the forms expected for 2004 up to and including June (112 out of 348).

This represents a decrease in reporting completeness in 2004 compared with previous years. In 2003, 18 of the 58 (19%) hospitals failed to submit a report, and 30 (51%) hospitals have not yet submitted a report for the first six months of 2004.. Details can be found in Annex 3. The results for 2004 indicate the sites where the hospital-based surveillance system is functioning as an active surveillance system. Annex 4 outlines the percentage of MAS forms received from countries for 2003 and 2004.

Many forms continue to be held at hospital or national level and untimely and "cluster" signing continue to be common. There still appears to be a decline in commitment for post-certification activities, with often sub-optimal understanding of AFP surveillance procedures.

The submission of completed forms to WHO is indicated in Table 1 below.

Table 1: Completed forms, by year.

Year	Expected monthly forms from all sites	Completed forms received by WHO	% of expected reports received by WHO
1997	367	274	75 %
1998	646	585	91%
1999	672	604	90%
2000	692	377	55%
2001	696	147	21%
2002	696	484	70%
2003	696	393	57%
2004 (until Mar)	174	74	42%
2004 (until June)	348	112	32%
2004 (until Aug)	464	161	25%

AFP case reports

The following tables summarize the PICs experience since 1997 with reporting and investigation of cases of AFP.

Table 2: AFP cases by year

Year	# AFP cases by active surveillance	# Total AFP cases	Annual non-polio AFP rate
1997	10	12	1.2
1998	8	11	1.1
1999	9	13	1.3
2000	18	20	2.0
2001	9	11	1.1
2002	7	8	0.8
2003	12	12	1.2
2004*	7	7	1.0
Average	**10**	**12**	**1.2**

* incomplete year, data only available until Aug 2004.

** figures may have changed from previous reports due to additional cases of AFP being found by retrospective record review, and other cases being reviewed and discarded as non-AFP.

PICs have achieved the expected detection of one AFP case per 100 000 children under the age 15 years. In 2001, 11 cases were reported, resulting in a non-polio AFP rate of 1.1 per 100 000 under age 15. In 2002, eight cases were reported, resulting in a non-polio AFP rate of 0.8 per 100 000 under age 15. In 2003, 12 cases were reported, resulting in non-polio AFP rate of 1.2 per 100 000 under age 15. As of the end of August 2004, seven cases of AFP had been reported, resulting in an annualized non-polio AFP rate of 1.0 per 100 000 under age 15. However, it should be noted that six out of the eight cases were reported from Fiji (one case was discarded as non-AFP after expert review – see below).

From 1997 to August 2004, 94 AFP cases were reported, resulting in an overall non-polio AFP rate of 1.2 for those (almost) eight years.

Table 3: Stool specimen collection rate

Year	# AFP cases by active surveillance	# Total AFP cases	(%) With adequate stools
1997	10	12	3 (25)
1998	8	11	4 (36)
1999	9	13	2 (18)
2000	18	20	6 (32)
2001	9	11	4 (36)
2002	7	8	2 (29)
2003	12	12	6 (50)
2004*	7	7	4(57)
Average	**10**	**12**	**37**

* incomplete year, data only available until Aug 2004.

** figures may have changed from previous reports due to additional cases of AFP being found by retrospective record review and other cases being reviewed and discarded as non-AFP.

The global standard of 80% adequate stool samples has never been reached in the PICs; it was not met in 2002, 2003 or, to date, in 2004. However, since 2003, there has been an

improvement in the number of cases with adequate stool specimens collected. For 2003, 50%, and in 2004, 57% of AFP cases notified had timely stool sample collection, compared with 36% for 2001 and 29% for 2002. Of the three cases notified in 2004 without adequate stool samples collected, one case had stool samples collected >14 days after the onset of paralysis. The second case had stools collected in a timely manner, but the stools arrived at the reference laboratory at room temperature and were of inadequate volume. The last case was notified three months after the onset of paralysis. As required, all stool samples continue to be examined in an accredited laboratory, the Victorian Infectious Diseases Regional Laboratory (VIDRL) in Melbourne, Australia.

Table 4: 60-day follow-up of AFP cases

Year	# AFP cases by active surveillance	# Total AFP cases	# (%) with 60-day follow-up
1997	10	12	8 (67)
1998	8	11	9 (82)
1999	9	13	9 (82)
2000	18	20	15 (79)
2001	9	11	7 (64)
2002	7	8	3 (43)
2003	12	12	11 (91)
2004*	7	8 (5***)	4/5 (80)
Total	**81**	**95**	**5 (70)**

* incomplete year, data only available until August 2004.

** figures may have changed from previous reports due to additional cases of AFP being found by retrospective record review and other cases being reviewed and discarded as non-AFP.

*** of the seven cases notified by August 2004 only five of these cases were due for 60-day follow up to date.

The standard of 80% for 60-day follow-up was met for 2003, with 11 of the 12 cases (91%) having follow-up examinations. Of those AFP cases with onset in 2004 who were due for follow-up at the time of the meeting (four of five cases), 80% had follow-up examinations; for the outstanding case without a 60-day follow-up (due in August 2004), a reminder was sent to the national coordinator.

Additional surveillance quality indicators, as recommended by the TAG, are presented as follows:

Table 5: Percentage of AFP cases with inadequate stool samples and 60-day follow-up available (target: 80%)

Year	# AFP cases	# AFP cases with inadequate stools	# (%) with 60-day follow-up
1997	12	9	5 (56)
1998	11	7	6 (86)
1999	13	9	7 (78)
2000	20	13	10 (77)
2001	11	7	3 (43)
2002	8	5	3 (60)
2003	12	6	4 (80)
2004*	7	3	2 (66)
Total	**95**	**60**	**41**

* incomplete year, data only available until August 2004.

** figures may have changed from previous reports due to additional cases of AFP being found by retrospective record review and other cases being reviewed and discarded as non-AFP.

For AFP cases with insufficient virological information, it is crucial to have additional clinical information from the follow-up examination to facilitate final classification as non-polio AFP. In 2003, the target was met, with 80% of cases with inadequate stools collected receiving a 60-day follow-up. In 2004, 66% of cases with inadequate stools collected who were due a 60-day follow-up at the time of the meeting received follow-up.

Review of AFP cases and final classification

Table 6: Summary of the Committee's expert review

Case number	Country	Classification category
2003-04	Solomon Is.	2
2003-08	Fiji	Discard- not AFP
2003-09	Fiji	5
2003-10	Fiji	5
2003-11	Fiji	5
2003-12	Fiji	Discard- not AFP
2004-01	Fiji	5
2004-02	Fiji	5
2004-03	Fiji	Discard- not AFP
2004-04	Vanuatu	3
2004-05	Solomon Is.	-
2004-06	Fiji	5
2004-07	Fiji	-
2004-08	Fiji	3

Six cases left pending from 2003 were discussed electronically and a final classification made. As it was not possible to obtain further information for case 2003-04 during a country visit in 2004, that case was classified as poliomyelitis-compatible, which mainly indicates a failure in the surveillance system rather that a chance the case may have been poliomyelitis.

The SCC has requested further information from case 2004-05 and, if this becomes available, will make their classification decision electronically. Case 2004-07 will be classified once stool results and 60-day follow-up information are available.

Implementation of recommendations made during the 7th meeting of the PICs SCC, October 2003

The SCC notes that the WHO Secretariat has made significant progress in the implementation of the recommendations from the 7th SCC meeting, despite limited staff capacity and resources in the WHO South Pacific Office. Particular progress has been made with the development and implementation of retrospective record reviews (RRRs) and dissemination of information regarding the poliomyelitis eradication initiative and PIC AFP surveillance performance on PacNET.

A phased programme of strengthening of the AFP surveillance system has commenced. Actions include using opportunistic visits to Palau, Vanuatu, Solomon Islands and Tuvalu by the WHO secretariat to update countries on progress with poliomyelitis eradication and review performance for AFP surveillance. A process of updating records of national and hospital

coordinators has commenced, but requires greater integration into the routine reporting systems, such as the annual requests for information through the Joint Reporting Form.

Protocols for conducting RRRs have been developed, shared with SCC members and finalized, following field tests in Solomon Islands and Vanuatu. Targeted visits were made to Solomon Islands and Vanuatu (underreporting) and to Fiji (high AFP rates) and RRRs were conducted at the National Referral Hospital (NRH) in Honiara, Solomon Islands, and the Colonial War Memorial Hospital (CWM) and Lautoka Hospital in Fiji. In addition, an opportunistic RRR was conducted in Tuvalu by WHO/SCC and at three additional sites in Fiji by the National AFP Surveillance Coordinator (results below).

The WHO secretariat has utilized the PacNET email network for frequent posting on country surveillance performance and this appears to have considerable impact. Telephone contacts have been made with national and hospital coordinators on an opportunistic basis. The SCC has commenced the electronic discussion and classification of AFP cases. However, this requires further development and support from SCC members. An update on the poliomyelitis eradication initiative (PEI) and AFP surveillance was given at the annual PIC EPI Managers meeting in Auckland, New Zealand, in March 2004, which was well received and resulted in two recommendations to improve AFP surveillance and awareness.

WHO conducted a validation process for subregional laboratories that may hold wild poliovirus or potentially infectious material and the draft findings and conclusions were presented to the SCC (details below and in separate report). In addition, WHO is reassessing subregional laboratory compliance in higher-risk laboratories in French Polynesia, Guam (Naval Hospital) and New Caledonia, and is embarking on support from SCC members with follow-up.

2.2.2 Supplementary surveillance activities

As mentioned before, RRRs of inpatient registers were conducted in May at the NRH in Honiara, Solomon Islands, and the CWM in Suva, Fiji, for 2000-2004, as well as in Lautoka Hospital, Fiji, for 2002-2003, to validate the quality of data already submitted and search for possibly missed cases.

RRRs were also conducted in August in Fiji at Sigatoka Hospital (December 2002-December 2003), Matuku Hospital (January 2003-July 2004) and Wainibokasi Hospital (January 2003 to July 2004), as well as at Princess Margaret Hospital (PMH), Tuvalu (January 2002 to June 2004).

The Department of Paediatrics at CWM Hospital admits children up to the age of 14 years and has 90 beds, including cots. An attempt was made in 2003 to computerize patient data and introduce an ICD coding system, but such a health information management system posed various challenges and the staff temporarily returned to the traditional admission register book. Several months were, therefore, not completed in the record book (April, June and July 2003). At the time of review, no entries had been made for February to April 2004.

A total of 9101 admission diagnoses for the period from January 2000 to January 2004 were screened for possible AFP cases and 36 individual case notes were reviewed. All 16 AFP cases reported by CWM during the review period could be identified.

The number of admissions averages 198 per month, with a range of 125 to 269; lower admission numbers are usually seen in the middle of the calendar year. The majority of patients only stay for a few days. Approximately 10% of admitted cases are referrals from other hospitals. A larger percentage of admitted children are male (average 60%). The majority of

patients are young children (30% under one year and 70% under five years old). The number of fatalities ranges from zero to eight per month.

Approximately 15% of admitted children have a central nervous system (CNS) diagnosis (but may have multiple diagnoses). Trends for larger percentages of CNS diagnoses among admitted patients vary greatly between the years, and no consistent peaks can be identified.

Only two possibly unreported AFP cases were identified for a period of four years and investigation forms completed. The first case, with onset in 2000, went through a short period of AFP and thus should have been reported, but it is understandable that no investigation took place. The case was reviewed by the SCC and discarded as non-polio AFP. The presentation of the second case, with onset in 2002, was not totally conclusive of AFP, but the SCC decided to include it, although it was also discarded as non-polio AFP.

The Department of Paediatrics at Lautoka Hospital admits children up to the age of 13 years and currently has 30 medical and surgical beds. There are three paediatricians working there. A computerized hospital information system was introduced in May 2002 and is now using ICD-10; however, due to several problems encountered in the beginning, there was still an overlap between the computerized system and the register book in 2002. Since 2003, the computer system has become more complete, but some data/patients are still missing. During the review both systems were searched.

A total of 2870 admission diagnoses for the period from January 2000 to April 2004 were screened for possible AFP cases, and two cases were extracted for individual review. Both were discussed with the hospital coordinator and were clearly not AFP.

One 10-year-old boy was listed as a case of paraplegia, but the individual case notes revealed that he had been paralyzed since age seven months and had been admitted for surgery on a gluteal abscess. The second case had been listed with weakness and was a 10-year-old girl with cystitis, and not paralysis.

No unreported AFP cases were found and all five AFP cases during the period reviewed could be identified.

No AFP cases were found at Sigatoka, Matuku and Wainibokasi Hospitals.

The Department of Paediatrics at NRH in Solomon Islands admits children up to the age of 12 years and currently has 44 beds. The Head Nurse stated that children aged 13-14 years would most likely first be admitted to the paediatrics ward and later transferred to the medical ward, and an older child with AFP would be brought to the attention of the hospital coordinator.

There are two pediatricians, 12 nurses and one nurse manager, as well as six nursing aides and three ward maids. A computerized hospital information system was introduced in 1997, but is still encountering several problems. The original four staff working in the registration division has been reduced to two, resulting in significant delays in the data-encoding process. Although an ICD-9 coding system has also been introduced, most admission and discharge diagnoses are not yet coded accordingly. Attempts are currently being made to improve the system and upgrade to ICD-10.

A total of 3050 admission diagnoses for the period from January 2000 to April 2004 were screened for possible AFP cases, and 10 cases were extracted for individual review. However, individual case notes could only be provided for six of them. All eight AFP cases reported by NRH during the review period could be identified, although one case was not found in the

registry book, but in the computer system. Generally the computerized hospital information system appears less complete.

The number of admissions averages 59 per month, with a range of 13-110; lower admission numbers are usually seen in the late-middle of the calendar year. The majority of patients only stay for a few days (three to five). A large number of cases are referrals from other hospitals.

One questionable unreported AFP case was identified, but no investigation form was completed as the Head of the Paediatric Department did not classify the case as AFP during discussions. No stool specimens were collected. The SCC concurred with this conclusion after review of all case notes presented.

At PMH in Tuvalu, 1606 admission records were reviewed and five patients with conditions that could present AFP were identified. As paediatric records had not been separated from the general admissions, all records were reviewed. Only one case was found to have presented with AFP (2002). However, the patient had been transferred to CWM Hospital in Fiji, where she was reported as an AFP case. No missed AFP cases were identified for the period reviewed.

2.2.3 Laboratory surveillance

Laboratory testing for AFP cases continues to be conducted at the regional reference laboratory, VIDRL, in Australia. As in previous years, support from VIDRL has been excellent and the laboratory regularly forwards case investigation forms received with stools to WHO offices in Suva and Manila to support case-data management and tracing.

During 2004, 14 stool specimens were received by VIDRL from eight AFP cases notified to date (one case was classified as non-AFP). One specimen was of inadequate volume and that information was fed back to the national coordinator from that country. One specimen was received at room temperature and was of inadequate volume. That specimen was also held at country level for over a month. These issues will be taken up with the country concerned and the timely shipment of stools in a reverse cold chain will be emphasized. The shipment times varied from five to 42 days (date of collection to date of receipt by VIDRL). Most stools arrived at the reference laboratory between five and 10 days after collection.

2.2.4 Immunization activities

Poliomyelitis immunization coverage for the PICs was approximately 90% for 2003. At the time of the meeting, American Samoa, French Polynesia, Kiribati, New Caledonia, Niue, Solomon Islands, Tuvalu and Wallis and Futuna had not reported coverage figures for the third dose of oral poliomyelitis vaccine (OPV3) to WHO/UNICEF. Most countries have maintained OPV3 coverage rates at stable levels over the last three years, although Nauru, Solomon Islands and Vanuatu have reported significant decreases in coverage. However, the SCC notes that reported coverage may be influenced by such factors as the timeliness and accuracy of record-keeping and the accuracy of population denominators.

No vaccine outages of any significance were reported from the Pacific during 2003, and the SCC was pleased to be informed that the vaccine security situation in Solomon Islands has improved. Furthermore, the SCC noted reports from WHO that the national EPI catch-up campaign that was conducted at the end of 2003 in Solomon Islands was well implemented and should boost levels of population immunity. No additional supplemental activities were conducted in other Pacific island countries in 2003/4. Delivery of booster doses for OPV to

children is being planned as part of measles supplemental activities for Kiribati, Solomon Islands and Vanuatu in late 2005 or early 2006.

There is significant variation in the schedules for OPV in the Pacific. Fiji, Kiribati and Tuvalu are still administering a birth dose, despite it no longer being required in poliomyelitis-free countries. In addition, most countries are providing more than three doses of OPV, with the Federated States of Micronesia administering five. To provide guidance on EPI schedule recommendations and standardization of schedules within the Pacific, WHO has developed a generic Pacific EPI policy. There is significant uptake of injectable poliovirus vaccine (IPV) in the Pacific, but this is based purely on the political affiliations of the American-, French- and New Zealand-associated nations.

2.2.5 Detection and response to importations

While noting the alarming global increase in poliovirus importations into poliomyelitis-free areas and countries in 2003 and 2004, the SCC continues to consider the Pacific at relatively low risk of importation. Geographic distances and generally high immunization coverage continue to provide barriers against introduction and re-establishment of wild poliovirus circulation. However, the SCC encourages all national governments and the PPHSN to continue to strengthen mechanisms for outbreak preparedness, detection and response, also in terms of poliomyelitis.

The plan of action, developed in 2000 for detection and response to importation of wild poliovirus in the PICs, should be revisited to determine if it still meets the requirements of all countries and the current situation of the global poliomyelitis eradication programme.

2.2.6 Areas of special concern

Areas of special concern to the SCC are:

- lower reported immunization coverage for OPV3 in some countries;
- risk of misconception that OPV is no longer required after certification; and
- continued problems with surveillance and reporting of AFP cases.

While the SCC acknowledges that some countries have a strong surveillance system, there is continued concern about other countries that are performing less than optimally. Problems still exist in some countries with incomplete and delayed reporting, inadequate stool collection and inadequate follow-up of AFP cases.

2.2.7 Sustaining poliomyelitis-free status after certification

The SCC would like to remind all national governments in the Pacific that wild virus continues to circulate in several areas of the world, including the Indian Subcontinent. Recalling how these areas have been sources of importation of wild poliovirus into countries of the Western Pacific Region in the past, the SCC highlights once more that high-quality surveillance and maintenance of sufficient population immunity against poliomyelitis are essential for countries to protect the enormous investment they have already made in poliomyelitis eradication.

2.2.8 Laboratory containment of wild-poliovirus-infectious and potentially infectious materials

The PIC subregional inventory was completed in 2002. The inventory does not contain any laboratory holding wild-poliovirus-infectious or potentially infectious materials.

However, as there is the possibility that laboratories may still receive materials from areas currently poliomyelitis-endemic or from a time of endemicity, information should be routinely obtained on specimen receipt and storage, particularly from those laboratories with ultra-temperature freezers and tissue-culture capacity. While monitoring subregional laboratory practices and poliomyelitis risk by contacting laboratories routinely to request information on specimen receipt and storage, special attention has to be paid to laboratories with tissue-culture capacity and, in this regard, communication has been sent to the Institut Loius Malarde in French Polynesia, the Guam Naval Medical Hospital, and the Institut Pasteur of New Caledonia.

The world will be declared free of wild poliovirus transmission when the Global Commission for the Certification of the Eradication of Poliomyelitis (GCC) is satisfied that all WHO regions have documented the absence of wild poliovirus circulation for at least three consecutive years and all wild poliovirus materials in laboratories are adequately contained. The GCC has established the requirements for laboratory containment of wild polioviruses, and GAP II describes those requirements in detail.

The GCC requirements for containment of wild polioviruses are described in two phases: the Laboratory Survey and Inventory Phase and the Global Certification Phase. In addition to the number of laboratories retaining wild poliovirus materials, the RCC has requested NCCs, including the PIC SCC, to provide information on the number of laboratories in the National Laboratory List and the number of laboratories surveyed. Information on the types of laboratory listed, the sectors they belong to, and the thoroughness of the survey process, has also been requested.

A review of laboratory survey and inventory data and activities from more than 50 countries revealed the following six essential components of a successful programme:

- Strong political endorsement and support for containment
- A realistic National Plan of Action
- An effective Containment Coordinator and National Task Force
- A comprehensive National Laboratory List
- A high quality Laboratory Survey
- A complete and active National Laboratory Inventory

In this regard, quality assessment of phase 1 of laboratory containment of wild polioviruses in the Pacific was conducted using the guidelines developed by the Global Polio Eradication Initiative (GPEI) and a report prepared, endorsed by the PIC SCC, for submission to the RCC.

2.2.9 Progress report on maintaining poliomyelitis-free status after certification

The PIC SCC has prepared an annual progress report and has complied, where applicable, with recommendations by the WHO secretariat on sections to be included.

3. CONCLUSIONS

The SCC continues to be concerned about the delays in progress with global poliomyelitis eradication, specifically the increasing number of countries that are reporting poliomyelitis cases due to importations of wild poliovirus in previously poliomyelitis-free African States and exportation of cases internally within India. The SCC is acutely aware of the close linkages, particularly between the Pacific and South Asia, and recognizes and is concerned about the real threat that wild poliovirus could still be reintroduced in the Pacific. However, this appears to not be fully appreciated by some PICs, as evidenced by decreasing poliomyelitis immunization coverage, declining AFP surveillance performance and the lack of updated poliomyelitis outbreak action plans.

The SCC recognizes that sustained high coverage of poliovirus vaccine immunization, combined with high quality AFP surveillance, is the best protection that a PIC can provide to its children against the reintroduction of poliomyelitis. Thus, urgent corrective action is needed in some countries to ensure the required high standard is maintained until the final goal of global poliomyelitis eradication is achieved, and beyond. Continued vigilance and support is needed more than ever to ensure that the enormous investment made by PICs in the past in poliomyelitis eradication activities is secured.

Opportunities for greater linkage of AFP surveillance with the increasing role of PPHSN in the Pacific offer promise and should be pursued.

Preparations for a poliomyelitis-free world are increasingly important as the world moves closer to the global interruption of wild poliovirus circulation. An important aspect of those preparations is effective laboratory containment of all wild-poliovirus-infectious and potential infectious materials to ensure that wild polioviruses are not reintroduced to the world after eradication. Even if countries currently do not hold wild-poliovirus-infectious materials, it must be noted that infectious or potentially infectious materials can be brought in from current areas or periods of endemicity, and must be listed as well as handled under appropriate biosafety conditions.

Maintaining the past successes in the PICs in achieving poliomyelitis-free status is a shared responsibility between countries, technical organizations, the SCC and partners. It is critical that all bodies show continued strong support and commitment, not only for maintaining poliomyelitis-free status, but for EPI as a whole, and use the achievements of poliomyelitis elimination as a basis for new disease control and eradication initiatives, particularly for measles and hepatitis B.

4. ACTION POINTS

While several action points from the 2003 SCC meeting are still valid, the following (new) action points are particularly emphasized:

Protecting the Pacific from poliomyelitis reintroduction

(1) Noting with concern the changed global poliomyelitis epidemiology and increased threat of wild poliovirus importations, the SCC urges all PICs to maintain continuous vigilance by ensuring high population immunity, with particular emphasis on timely immunization of each new birth cohort.

(2) Equally important, the SCC continues to emphasize that all PICs should pursue high quality AFP surveillance and aim at integration with surveillance for other EPI and infectious diseases so that systems can support and sustain each other.

(3) While these are primarily the responsibility of national governments, external support, particularly technical but also eventually financial, may be required to implement such high quality activities. The SCC continues to be very concerned about declines in resources provided by various partners in the initiative for the Region , particularly the PICs, and advocates, in this regard, that all of them critically review what the minimum threshold for effective support would be.

(4) The SCC requests the WHO secretariat to review if poliomyelitis eradication strategies are included in curricula and postgraduate education of the Fiji School of Medicine to ensure continued awareness among health care providers trained in the poliomyelitis-free era.

AFP surveillance system

(1) Opportunistic and targeted visits to increase awareness on quality AFP surveillance and advocate integration with other disease surveillance systems should be continued by the WHO secretariat and SCC members, as recommended previously.

(2) As mentioned before, while conducting an audit of national and hospital coordinators and their access to communication technologies, the WHO secretariat should focus particularly on developing an email register of key national and hospital-based collaborators in the AFP surveillance network to be used as regular reporting channels for AFP information/requests, but also for dissemination of updates on developments of the global poliomyelitis eradication programme.

(3) The SCC supports the proposed trial of electronic communication of MAS form submittal through PPHSN and looks forward to the outcome of the trial.

(4) The SCC notes with satisfaction that the UNICEF/WHO PIC EPI Manager's Workshop, held in March 2004, recommended quarterly postings of PICs' AFP/AFR reporting completeness on PacNet to encourage timely reporting, and supports this approach. In order to enhance success and support of that activity, the SCC recommends the WHO secretariat to officially inform all PIC governments about the exercise, obtain their general approval, establish regular time-frames for postings and share the respective draft with national coordinators for their clearance.

(5) The AFP standard case investigation form, as well as all other materials in the (white) MAS information folder, should be reviewed and updated/expanded where appropriate. Where possible, electronic copies of (updated) forms should be distributed to national coordinators.

(6) The SCC advocates including a discussion point in the agenda of the 2005 Pacific Ministers of Health Meeting, not only on the current situation of global poliomyelitis eradication, but also on the need for continued support for maintaining poliomyelitis-free status in the PICs to protect the huge investments already made by Member States.

Retrospective record reviews

(1) The WHO secretariat should finalize the draft protocol for RRRs after comments made by SCC members during the meeting have been incorporated.

(2) While circulating the protocol among PIC National Coordinators for self review, members of the SCC and the WHO secretariat, as well as UNICEF colleagues, should continue, during their country visits or in-country work, to discuss the rationale of RRR and the protocol with national and hospital coordinators and should assist them to undertake reviews of inpatient registers for defined periods of time to validate the quality of data already submitted and search for possible missed AFP cases.

Laboratory surveillance

(1) The SCC wishes to thank all colleagues at the VIDRL Reference Laboratory for their continuous excellent cooperation and high quality guidance in virological surveillance for PICs.

Detection of and response to importation of wild poliovirus

(1) The SCC requests the WHO secretariat to review the generic plan of action and standard operating procedures prepared in 2000 and propose revisions as required, particularly to also include VDPVs in the protocol. After review by the SCC, the revised proposed action plan should be forwarded to all Member States and its adoption recommended to ensure advance awareness and agreement of the basic protocols for response to wild poliovirus importations and identification of VDPVs.

Laboratory containment of wild-poliovirus-infectious and potentially infectious materials

(1) After thorough review of the information provided in the draft report prepared by the WHO secretariat, assessment of the quality of the laboratory survey and inventory process, and confirmation of the accuracy of the Subregional Inventory of Laboratories, the SCC requests the WHO secretariat to finalize the report for submission to the RCC.

(2) The SCC looks forward to receiving follow-up information on specimen storage and receipt from "high-risk laboratories", identified to date as the Institut Louis Mallardé, French Polynesia, the Guam Naval Medical Hospital, and the Institute Pasteur, New Caledonia.

Future activities of the Subregional Certification Committee

The SCC wishes to continue to meet on an annual basis, not only to fulfil its reporting responsibilities towards the RCC, but also to be able to provide targeted guidance to PICs on maintaining quality poliomyelitis immunization and surveillance activities and to conduct/confirm final AFP case classification in its capacity as the PIC expert panel.

The SCC has made progress in preparing a report of the subregion's approaches and efforts leading up to certification and is aiming for publication in the Pacific Health Dialogue in 2005.

The SCC wishes to reiterate once more that maintaining the enormous success of poliomyelitis-free certification and building a solid foundation for other disease control activities is a remarkable achievement of the many key clinicians, hospital coordinators, national coordinators and EPI personnel involved in surveillance and immunization. They all deserve continuous thanks for their considerable efforts to ensure that all children in the PICs are protected from the crippling disease.

In order to maintain high population immunity, as well as active and prospective AFP surveillance, the SCC considers it imperative that national authorities, national coordinators, hospital coordinators, key clinicians and all public health personnel be kept fully aware of the requirements and developments of global poliomyelitis eradication in order to remain vigilant, even although the Region has already been certified poliomyelitis-free for over four years.

ANNEX 1

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ANNEX 2

Population Figures by Country

Region/country or territory	Last census	Mid-year population estimate 2004	Mid-year population estimate 2015
MELANESIA		**1 748 800**	**2 061 800**
Fiji	1996	836 000	891 100
New Caledonia	1996	236 900	291 600
Solomon Islands	1999	460 100	589 700
Vanuatu	1999	215 800	289 400
MICRONESIA		**536 100**	**655 100**
Federated States of Micronesia	2000	112 700	129 000
Guam	2000	166 100	193 800
Kiribati	2000	93 100	119 700
Marshall Islands	1999	55 400	66 100
Nauru	2002	10 100	11 300
Northern Mariana Islands	2000	78 000	109 300
Palau	2000	20 700	25 900
POLYNESIA		**635 700**	**723 000**
American Samoa	2000	62 600	78 000
Cook Islands	2001	14 000	12 100
French Polynesia	2002	250 500	307 200
Niue	2001	1600	1200
Samoa	2001	182 700	201 900
Tokelau	2001	1500	1500
Tonga	1996	98 300	95 400
Tuvalu	2002	9600	10 000
Wallis and Futuna	2003	14 900	15 700
TOTAL		**2 920 600**	**3 439 900**

Source: Pacific Island Populations 2004, Secretariat of the Pacific Community (in print)

ANNEX 3

Numbers of sites failing to submit a monthly active surveillance (MAS) report form

Year	N° reporting sites	N° sites failing to submit a report	%
2000	58	18	31%
2001	58	36	62%
2002	58	9	16%
2003	58	18	31%
2004 (until Aug)	58	30	51%

ANNEX 4

Percentage of MAS forms submitted, by country

Country	2003	2004*	Country	2003	2004*
American Samoa (1 site)	0%	0%	New Caledonia (1 site)	100%	66%
CNMI (1 site)	100%	100%	Niue (1 site)	0%	0%
Cook Islands (1 site)	100%	100%	Palau (1 site)	58%	0%
Fiji (21 sites)	77%	43%	Samoa (3 sites)	0%	0%
FSM (4 sites)	35%	0%	Solomon Islands (5 sites)	43%	20%
French Polynesia (4 sites)	100%	50%	Tokelau (1 site)	8%	0%
Guam (2 sites)	29%	0%	Tonga (2 sites)	83%	66%
Kiribati (2 sites)	50%	0%	Tuvalu (1 site)	100%	100%
Marshall Islands (3 sites)	55%	66%	Vanuatu (2 sites)	0%	0%
Nauru (1 site)	83%	100%	Wallis and Futuna (1 site)	0%	0%

* data for 2004 January-June