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**CERTIFICATION OF WILD POLIOVIRUS ERADICATION IN THE AFRICAN
REGION AND SUSTAINING THE GAINS, POST-CERTIFICATION**

Report of the Secretariat

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BACKGROUND

1. In August 2018, the Sixty-eighth session of the WHO Regional Committee for Africa (RC68), endorsed the Framework for certification of polio eradication in the African Region.¹ The Framework outlined the actions to be implemented and set milestones for achieving certification.
2. A scorecard was developed, based on the milestones, to monitor the progress of countries towards regional certification. The scorecard feedback was shared with all Member States during the Seventy-second session of the World Health Assembly (WHA 72) in May 2019 and the Sixty-ninth session of the Regional Committee for Africa (RC69) in August 2019.²
3. By December 2019, no wild poliovirus type 1 (WPV1) case or environmental isolate had been confirmed in the African Region for more than three years. The Global Commission for Certification of Polio Eradication (GCC) had declared the global eradication³ of the other serotypes of WPV: type 2 in 2015 and type 3 in 2019.
4. To meet certification-standard surveillance performance, geographic information system (GIS) innovations for real-time reporting had been established in 44 (91.4%) out of 47 Member States by December 2019. The platform was also used for institutionalizing an accountability framework for all polio-funded staff to improve overall programme performance.
5. By December 2019, in line with resolution WHA71.16 adopted in May 2018, all Member States in the African Region had completed containment of polioviruses and poliovirus infectious and potentially infectious materials (PIMs) according to the WHO Global Action Plan (GAP III). The GCC had recognized the National Institute for Communicable Diseases (NICD) in South Africa as the only poliovirus-essential facility (PEF) in the African Region⁴ to retain type 2 polioviruses for future research and possible vaccine development purposes.
6. By June 2020, the African Regional Certification Commission (ARCC) for Polio Eradication had accepted national wild polio-free status documentation from all 47 countries in the Region. The ARCC is planning to certify the African Region as the fifth WHO region⁵ to have eradicated wild polioviruses in August 2020.
7. This report summarizes the progress made towards certification of eradication of wild polioviruses in the African Region since the endorsement of the regional certification Framework and proposes to Member States priority interventions towards certification and post-certification. These include preparing documentation for certification; strengthening surveillance and routine immunization; implementing the new polio eradication and post-certification strategic plans; improving the quality of WPV and circulating vaccine-derived poliovirus (cVDPV2) outbreak responses; intensifying resource mobilization; and legacy planning.

¹ Final report of the Sixty-eighth session of the WHO Regional Committee for Africa <https://www.afro.who.int/sites/default/files/sessions/final-reports/AFR-RC68-17%20Report%20of%20the%20Regional%20Committee%20-%20Final-Web.pdf>

² Final report of the Sixty-ninth session of the WHO Regional Committee for Africa <https://www.afro.who.int/about-us/governance/sessions/sixty-ninth-session-who-regional-committee-africa>

³ 14th Global Certification Commission meeting reports, 21-23 September 2015; and 20th Global Certification meeting report, 17-18 October 2019: <http://polioeradication.org/tools-and-library/policy-reports/certification-reports/global-certification-commission/>

⁴ <http://polioeradication.org/polio-today/preparing-for-a-polio-free-world/containment/>

⁵ www.polioeradication.org/polio/news/special/edition2020/en.pdf

ISSUES AND CHALLENGES

8. **Insecurity and inaccessibility:** Despite the progress made, localized insecurity and inaccessibility⁶ continue to negatively affect implementation of planned surveillance and immunization activities. Insecurity along border areas also hampered implementation of cross-border activities planned for synchronization among Member States. Additionally, logistic challenges due to weak infrastructure in some countries has also affected accessibility and delivery of immunization services to some underserved areas.

9. **Surveillance gaps and population movements:** In spite of the progress made in strengthening surveillance, gaps remain in localized areas in some countries. With the increase in wild polio transmission in some parts of the world outside the African Region, there is still a risk of importation of wild polioviruses that may reverse the gains made and result in re-established wild poliovirus transmission in the African Region. Surveillance gaps coupled with huge population movements have resulted in wider geographical spread of cVDPVs in recent years.

10. **Increase in cVDPV2 outbreaks:** The number of cVDPV2 cases and affected Member States have been increasing since the year after the global switch from trivalent oral polio vaccine (tOPV) to bivalent OPV (bOPV) in routine immunization programmes.⁷ In 2017, a Member State⁸ reported 22 cVDPV2 cases, and the number increased to 65 cases in four countries⁹ in 2018, and 13 countries^{10 11} with 315 cases in 2019.¹² There had also been an increase in genetic divergence¹³ and the number of affected districts within Member States during the stipulated period. The continued emergence of cVDPV2 outbreaks, suboptimal outbreak response and international spread pose a risk for certification as the efforts of national programmes and resources are being directed towards responding to outbreaks.

11. **Complexity of communicating wild poliovirus-free status while experiencing cVDPV2 outbreaks:** The persistence of the cVDPV2 outbreaks in the African Region has complicated communication on certification of wild poliovirus. Some stakeholders have raised concerns that communities, including parents or caregivers, may not differentiate between acute flaccid paralysis caused by wild polioviruses and that caused by cVDPVs.

12. **Weak routine immunization systems and suboptimal performance:** Stagnation of routine immunization performance¹⁴ at around 70% coverage, for close to a decade, has resulted in the accumulation of cohorts susceptible to polioviruses and other vaccine-preventable diseases. The low population immunity is contributing heavily to the emergence and uncontrolled transmission of cVDPV2 outbreaks. Similarly, with the low population immunity, should the Region experience importation of wild polioviruses¹⁵ post-certification, large outbreaks could occur.

⁶ <https://www.afro.who.int/news/polio-last-lap-experts-applaud-nigerias-achievements-caution-more-work-required>

⁷ Update on Vaccine-Derived Poliovirus Outbreaks — Worldwide, January 2018–June 2019 [MMWR Morb Mortal Wkly Rep. 2019 Nov 15; 68\(45\): 1024–1028](https://www.cdc.gov/mmwr/mmwr6845a4). Published online 2019 Nov 15. doi: [10.15585/mmwr.mm6845a4](https://doi.org/10.15585/mmwr.mm6845a4)

⁸ Democratic Republic of the Congo

⁹ Democratic Republic of the Congo, Mozambique, Niger and Nigeria

¹⁰ Angola, Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Democratic Republic of the Congo, Ethiopia, Ghana, Niger, Nigeria, Togo and Zambia

¹¹ Circulating vaccine-derived poliovirus type 2 – African Region: <https://www.who.int/csr/don/31-july-2019-polio-africa-region/en/>

¹² Weekly global polio update, 6 May 2020

¹³ Poliomyelitis eradication report by the WHO Director General: Seventy-third session of WHA, A73/12, May 2020; <https://apps.who.int/gb/ebwha/pdf-files/WHA73/A73-12-en.pdf>

¹⁴ Challenges of immunization in the African Region: [Pan Afr Med J. 2017; 27\(Suppl 3\): 12](https://doi.org/10.11604/pamj.supp.2017.27.3.12127). Published online 2017 Jun 21. doi: [10.11604/pamj.supp.2017.27.3.12127](https://doi.org/10.11604/pamj.supp.2017.27.3.12127)

¹⁵ <https://www.cidrap.umn.edu/news-perspective/2019/12/six-nations-report-more-polio-cases-pakistan-tops->

13. Reduction in Global Polio Eradication Initiative (GPEI) funding and ramp-down of polio personnel: As the Region gets closer to certification, it is anticipated that polio funding and resources for personnel will be diverted globally to Member States which are still experiencing huge wild poliovirus outbreaks. By December 2019, there had been a 31% reduction of WHO polio-funded staff in the African Region¹⁶ since 2016. Furthermore, although Member States have developed national polio transition plans, local resources have not been mobilized for implementation of these plans. This may result in the loss of experienced polio staff, innovations used by the programme, lessons learned, support to other health interventions and platforms that used to benefit from the polio programme.

14. Negative impact of the COVID-19 pandemic on the polio programme: Polio funded personnel, at all levels, have been deployed to assist with preparedness and response to the COVID-19 pandemic. According to a survey¹⁷ conducted by AFRO in April 2020, almost 60% of polio-funded personnel reported spending more than 50% of their time on COVID-19 response activities such as surveillance, contact tracing, communication and training. In line with the global guidance of social distancing and safe hygiene practices, planned bOPV preventive polio campaigns in 13 Member States¹⁸ were cancelled in early 2020. Furthermore, the cVDPV2 outbreak response campaigns planned for the period March–June 2020, targeting 14 million children in 11 Member States¹⁹ were also postponed. Due to the prevailing travel restrictions, the planned ARCC meeting to review the national polio-free status documentation of the remaining Member States in March 2020 was postponed. The postponement has affected the timeline for certifying the African Region as the fifth WHO region to have eradicated wild polioviruses in 2020.

PROPOSED ACTIONS

15. Preparing certification documentation and strengthening surveillance: Member states will submit robust national documentation of polio-free status to convince the ARCC that indigenous wild poliovirus transmission has been interrupted in the African Region. With the ongoing transmission in some countries outside the African Region, Member States will also ensure that surveillance performance is maintained post-certification, to detect any WPV importation in a timely manner.

16. Implementing the GPEI Polio Endgame Strategy 2019–2023: This strategy²⁰ lays out a roadmap for achieving and sustaining a world free of all polioviruses. It focuses on three key pillars: eradication; integration; and containment and certification, as well as critical enabling factors such as gender and research. Member States will implement the strategy as it builds on and optimizes the use of the proven lessons and tools from the GPEI Polio Eradication and Endgame Strategic Plan 2013–2018.

17. Implementing the polio post-certification strategy: Endorsed by EB142 in January 2018 and WHA71, the strategy²¹ specifies the technical standards for functions that are essential to maintaining a polio-free world following certification. The strategy has three goals: (1) contain polioviruses; (2) protect populations from polioviruses; and (3) detect and respond to

¹⁶ Polio transition and post-certification, Report of the WHO Director-General, Seventy-first WHA A71/9, May 2018 https://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_9-en.pdf (updated with AFRO data for 2019)

¹⁷ Contribution of polio resources to the COVID-19 preparedness and response survey: <https://rebrand.ly/polio2covid>

¹⁸ Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Congo, Democratic Republic of the Congo, Equatorial Guinea, Ethiopia, Mali, Madagascar, Niger and South Sudan

¹⁹ Angola, Benin, Burkina Faso, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, Niger, Nigeria and Togo

²⁰ <http://polioeradication.org/wp-content/uploads/2019/06/english-polio-endgame-strategy.pdf>

²¹ <http://polioeradication.org/wp-content/uploads/2019/06/english-polio-endgame-strategy.pdf> 20180424-2.pdf

polioviruses. To ensure implementation of the strategy as well as effective, differentiated technical assistance and monitoring of performance post-certification, a scorecard showing performance by Member State will be developed. The main polio surveillance and immunization performance indicators and the listing of locations where outbreaks are occurring, as shown in the Annex, will be used for the scorecard.

18. Introduction and roll-out of novel oral polio vaccine type 2 (nOPV2) for cVDPV2 outbreak response: The GPEI has funded the development of a more stable novel OPV2 (nOPV2) vaccine,²² and a decision²³ was adopted by EB146 to expedite the Emergency Use Listing (EUL) of nOPV2 based on robust scientific evidence of its safety and efficacy. As with other vaccines approved for EUL, the data has been extensively reviewed by the WHO Regulation and Pre-Qualification Team (PQT) and the WHO Scientific Advisory Group of Experts (SAGE), who recommended that nOPV2 could be used as EUL.²⁴ The process of introducing nOPV2 in countries will involve WHO working closely with ministries of health, national immunization technical advisory groups (NITAGs), national regulatory authorities (NRAs) and the African Vaccine Regulatory Forum (AVAREF).

19. Strengthening routine immunization: Member States should quickly strengthen routine immunization to build population immunity that is capable of sustaining the gains made in polio eradication. Additionally, strong national routine immunization programmes will mitigate the emergence of cVDPVs of all types, and stop the current outbreaks.

20. Expanding the use of technological innovations: As the GPEI polio-funded resources reduce and eventually stop, technological innovations will play an important role in providing evidence in real time of implemented post-certification activities and institutionalization of an accountability framework. Geographic information system (GIS) platforms, for example, can be used for micro-planning and assessment of surveillance, supplementary immunization activities and outbreak response without a huge deployment of manpower and logistics to a targeted area.

21. Funding for polio eradication and post-certification: Member States should locally mobilize adequate resources for certification and post-certification. Domestic resource mobilization, including reaching out to resident development partners, should be conducted for proper transitioning from GPEI funding.

22. Institutionalization of the legacy of the polio eradication programme in the African Region: The polio programme leaves behind a legacy of extensive use of data to drive a programme, stringent monitoring with an accountability framework and evaluation. In addition, the programme consistently conducted research and introduced innovations to surmount challenges faced by the programme. The strong partnership and collaboration, exemplified by the GPEI, was critical in mobilizing resources and providing technical support, beyond polio, to benefit other public health interventions. It is expected that Member States will use the lessons learned from polio eradication to implement current and future health interventions, particularly those targeting elimination or eradication of diseases.

23. The Regional Committee examined the report and adopted the proposed actions.

²² <http://polioeradication.org/nopv2/>

²³ Polio eradication decision, 146th session of the WHO Executive Board, 146/21. Add.1, January 2020: https://apps.who.int/gb/ebwha/pdf_files/EB146/B146_21Add1-en.pdf

²⁴ www.polioeradication.org/polio/news/special/edition2020/en.pdf

ANNEX: Polio surveillance and immunization performance indicators, and reported circulating vaccine-derived poliovirus type 2 (cVDPV2) outbreaks by Member State in the African Region, 2018–2019

	Main polio surveillance indicators		Polio immunization coverage indicators WHO-UNICEF estimates (WUEIC)		circulating vaccine derived poliovirus type 2 (cVDPV2) outbreaks	
	Country (in alphabetical order)	Detection: Non-polio acute flaccid paralysis (AFP) rate, 2019	Quality: Stool adequacy rate, 2019	Oral Polio Vaccine (OPV3) coverage rate (%), 2018	Inactivated Polio Vaccine coverage rate (%) (IPV), 2018	Number of laboratory confirmed cases in 2019
1	Algeria	4.4	97%	91	94	0
2	Angola	2.2	84%	56	40	130
3	Benin	5.1	92%	75	60	8
4	Botswana	3.1	67%	96	95	0
5	Burkina Faso	3.8	83%	91	45	1
6	Burundi	1.6	93%	90	50	0
7	Cameroon	5.5	83%	78	78	0
8	Cabo Verde	2.0	100%	98	96	0
9	Central African Republic	5.0	70%	47	47	21
10	Chad	9.1	88%	44	41	10
11	Comoros	2.5	100%	94	84	0
12	Congo	7.2	85%	75	68	0
13	Côte d'Ivoire	3.6	83%	82	67	0
14	Democratic Republic of the Congo	6.8	86%	79	79	88
15	Equatorial Guinea	12.5	92%	27	25	0
16	Eritrea	6.5	92%	95	29	0
17	Ethiopia	2.8	91%	67	52	13
18	Gabon	7.4	93%	64	70	0
19	Gambia	4.1	86%	93	61	0
20	Ghana	4.4	87%	98	55	18
21	Guinea	4.0	93%	45	45	0
22	Guinea-Bissau	4.9	89%	89	3	0
23	Kenya	2.5	88%	81	88	0
24	Lesotho	2.1	100%	90	39	0
25	Liberia	3.3	94%	84	73	0
26	Madagascar	5.4	94%	76	70	0
27	Malawi	2.1	88%	91	N/A	0
28	Mali	3.1	84%	73	66	0
29	Mauritania	3.1	96%	81	68	0
30	Mauritius	4.0	100%	98	98	0
31	Mozambique	3.8	71%	80	64	0
32	Namibia	2.3	73%	84	82	0

33	Niger	7.8	85%	79	79	1
34	Nigeria	7.3	92%	57	57	18
35	Rwanda	2.5	88%	97	81	0
36	Sao Tome and Principe	3.0	33%	95	97	0
37	Senegal	2.7	83%	81	72	0
38	Seychelles	ND	ND	99	99	0
39	Sierra Leone	3.8	82%	90	60	0
40	South Africa	3.4	80%	74	81	0
41	South Sudan	12.5	90%	50	34	0
42	Eswatini	4.5	100%	90	90	0
43	United Republic of Tanzania	3.6	92%	91	56	0
44	Togo	4.7	71%	66	20	8
45	Uganda	2.7	88%	88	84	0
46	Zambia	2.7	82%	90	36	2
47	Zimbabwe	2.8	87%	89	N/A	0

Key / definitions:

Annualized non-polio AFP rate is a proportion of acute onset of paralysis in children (who tested negative for polioviruses) per 100 000 children under 15 years of age (target $\geq 1/100,000$).

Stool adequacy rate is a proportion of two specimens collected 24-48 hours apart within 14 days of onset of paralysis and reaching the designated laboratory in good condition.(target $\geq 80\%$).

N/A for IPV coverage is for countries that had not yet introduced IPV in their routine immunization schedule in 2018.