"Approved"
The Minister of Internally Displaced Persons
From the Occupied Territories,
Labour, Health and Social Affairs of Georgia

D. Sergeenko

3 April 2019

National action plan to maintain polio-free status of Georgia for 2019-2020

Tbilisi, Georgia
2019

Introduction

After certification of Georgia as polio-free country in 2002, the "Action plan to maintain polio-free status of the country" has been developed and approved by the Ministry of Labor, Health and Social Affairs. Updates of the Plan for 2006-2008, 2008-2010, 2011-2012, 2012-2013, 2015-2016 2016-2017 and 2017-2018 were approved in April of 2006, 2008, 2011, 2012, in February of 2015, in April of 2016, 2017 and 2018 accordingly. Until achieving global eradication of polio, Georgia understands the threat of possible importation of wild poliovirus or vaccine derived poliovirus (VDPV) circulation, therefore, the present action plan for 2018-2019 was developed in accordance with the World Health Organization (WHO) recommendations to further maintain epidemiological safety of the country. This plan includes activities which will be implemented by the country in case of wild poliovirus importation or circulation of VDPV.

As Georgia is a polio free country, ANY detection of wild poliovirus or circulation of VDPVs in the country is considered an extraordinary situation in public health and is covered by this plan.

In case of circulation of wild poliovirus or VDPV in neighboring countries, the National Center for Disease Control and Public Health (NCDC) and the National Certification Commission for Poliomyelitis (NCC) will assess the situation and make decision concerning measures to be implemented in country.

National action plan to maintain polio-free status of Georgia for 2019-2020.

1. Activities to prevent reintroduction of wild polioviruses or circulation of VDPV.

1.1 Maintaining high coverage of routine polio immunization to prevent poliovirus spread.

a) Immunization coverage with ≥3 doses of inactivated polio vaccine (IPV3) will be maintained at ≥90% level in each district and monitoring of immunization coverage will be conducted regularly.

b) Special attention will be paid to monitoring immunization coverage in high risk groups, including forced migrants, refugees and minorities, people residing in hard to reach areas, with timely IPV3 coverage <90%.

c) Corrective measures will be implemented promptly to ensure immunization of unvaccinated or under-immunized children including training of health workers, social mobilization in target groups, advocacy and providing opportunities for immunization.

1.2 Ensuring safe laboratory containment of wild polioviruses

National polio eradication program will continue to implement all activities in accordance with the first phase of the "Regional and global program of safe laboratory containment of polioviruses". National Polio Laboratory - the only laboratory in Georgia which stores materials contaminated or potentially contaminated with wild polioviruses, will continue to be regularly controlled. The laboratory has in place special mechanisms ensuring safe containment of all wild poliovirus contaminated or potentially contaminated materials.

When National program commences the second phase of laboratory containment, the Laboratory will follow new methodological and procedural containment standards to be provided by the WHO.

2. Activities to maintain high quality of polio surveillance through acute flaccid paralysis (AFP) surveillance with laboratory confirmation and supplemental enterovirus surveillance

2.1 Maintaining high quality of surveillance for quick identification of any importation of wild polioviruses and VDPV circulation.

a) In order to identify any importation of wild polioviruses or VDPV circulation, high quality poliovirus surveillance including AFP surveillance and environment surveillance, will be maintained. Enterovirus surveillance will be implemented as resources allow.
b) Monitoring of all "hot cases" will be implemented (for case definition see 2.3); each "hot case" will be timely and thoroughly reviewed.
c) Testing of all stool samples from children with AFP will be conducted in WHO-accredited laboratories.
d) National Polio Laboratory will send polioviruses isolated from any source for intra-type differentiation (ITD) to the Regional Reference Laboratory (RRL) and possibly conduct similar studies themselves, to determine whether the isolated virus was wild or vaccine-related.
e) WHO will be informed, within 24 hours, of any identification of poliovirus, which is not Sabin strain, or of uncertain ITD results.

2.2. AFP surveillance quality indicators will be used as a standard to assess surveillance quality.

AFP surveillance quality indicators	Target indicators
Registration of AFP cases	• ≥1 non-polio AFP cases reported per 100,000 children aged <15 years. o ≥2 per 100,000 if the risk of wild poliovirus spread following importation is ranked as "high" or if there is an actual importation of wild poliovirus • ≥80% AFP cases investigated within 48 hours from initial reporting • ≥80% AFP cases classified within 90 days from the onset of paralysis

AFP case reporting on sub-national level	• ≥1 non-polio AFP cases reported per 100,000 children aged <15 years in each group of adjacent regions combined to ensure sufficient population for calculating the meaningful AFP rate
Timely collection of stool samples	• ≥80% AFP cases with 2 stool samples, collected 24-48 hours apart, within 14 days from the onset of symptoms
Timely delivery of stool samples	• ≥80% adequate stool samples from AFP patients delivered to the WHO-accredited laboratory within 72 hours from sample collection
Quality of laboratory performance	• ≥80% of cases have virologic testing completed within 28 days from stool sample delivery to the laboratory • ≥80% polioviruses, isolated from AFP patients are characterized (including ITD) within 60 days from the onset of symptoms.

2.3 In case of AFP case identification, establish if it is a "hot case" and implement following activities:

Definition of a "hot" AFP case.

- Presence of clinical symptoms of AFP in a child aged <15 years (including recently deceased patients) if any of the following signs are present:
  (1) Receiving <3 doses of polio vaccine.
  (2) Recent trip to an area with ongoing or recent circulation of wild polioviruses.
  (3) Possible affiliation with high risk group, or

- Clinical picture of polio-like disease in a patient of any age.

Activities, carried out in case of a "hot case".

1. Investigation should be conducted for all cases and contact persons. Ministry of IDPs from the Occupied Territories, Labor, Health and Social Affairs (below – Ministry of Health) and WHO Regional Office for Europe (WHO/EURO) shall be informed within 24 hours.
   - Two stool samples taken at least 24 hours apart and within two weeks from the onset of disease are to be collected from each patient. "Reverse cold chain" should be maintained during sample storage and transportation.
   - If quality of stool samples from "hot case" is poor, samples from the family or hospital contacts should be collected.
2. Stool samples should be collected, transported to the laboratory and tested in a timely manner.
3. Within 48 hours after isolation, poliovirus strain should be sent to the WHO-accredited polio laboratory for ITD. If possible, ITD will also be conducted at the National Polio Laboratory

4. Quick assessment of the immunization status of persons who were in close contact with the patient (including household Contacts, classmates, and health care workers and other hospital contacts) should be conducted.
5. All unimmunized and incompletely immunized contacts should be vaccinated. If in the affected area IPV3 coverage level is <90%, wider immunization activities will be planned and carried out.

2.4 Activation of the Emergency National Action Plan for Poliomyelitis

Even a single case or episode of wild poliovirus or cVDPV detection in a polio-free country is considered an extraordinary event and requires immediate response. Therefore, the Emergency National Action Plan for Poliomyelitis will be activated if a wild poliovirus or cVDPV is detected from any human or environmental source. Potential human sources include patients with AFP or non-paralytic illness, as well as healthy individuals, including adults. Environmental source includes sewage waters.

3. Activities, implemented in an polio emergency situation

3.1 National Emergency Action Plan for Poliomyelitis

a) Ministry of Health will be informed immediately.
b) National Focal Point (NFP) for International Health Regulations (IHR) will be informed immediately
c) WHO EURO shall be informed immediately of wild poliovirus detection through the IHR NFP in accordance with the IHR Annex 2.

3.1.1. Establishing the Emergency Commission for Poliomyelitis

The Emergency Commission for Poliomyelitis will be created under the National Center of Disease Control and Public Health (NCDC) within 1-2 days of wild poliovirus or circulating VDPV (cVDPV) detection.

Commission members:

	Position	Responsibilities
1	Deputy Director General	Overall coordination of Surveillance and response to communicable diseases and the National Immunization Program
2	Head of the Division of Communicable Diseases	Surveillance for communicable diseases and immunization program
3	Head of the Department of Surveillance	Surveillance for communicable diseases
4	Head of the Department of Immunization (EPI)	Immunization program
5	Head of National Polio Laboratory	Laboratory activities
6	Epidemiologist of the Immunization Group (EPI)	AFP surveillance

Commission responsibilities:

1. Emergency Commission for Poliomyelitis will develop a plan of primary activities, including creation of coordinating body with participation from Inter-Agency Coordination Committee (ICC) - within 24 hours;

2. Sending information to healthcare agencies with the requirement to strengthen surveillance - within 1-5 days.

3. Informing the National Certification Committee for Poliomyelitis (NCC) of the detection of wild poliovirus/cVDPV in Georgia - within 24 hours.

4. Informing of the poliovirus detection partner organizations likely to be involved in response activities (e.g. UNICEF, USAID) – within 1-2 days

5. Making a site visit to the location of the most recent case (or virus detection) - within 1-2 days.

6. Assessing the risk of further spread of poliovirus and producing he risk assessment report - within 1-3 days.

7. Developing action plan, including calendar plan, extent of supplementary immunization, budget, personnel training strategy and advocacy activities, procurement, work plan, monitoring plan and activities in border areas with neighboring countries - within 4 days.

8. The Emergency Commission for Poliomyelitis will carry administrative and technical responsibility for developing action plan and coordination all relevant measures during their implementation.

3.1.2. Carrying out initial investigation

1. Initial investigation will be carried out within 48 hours of wild poliovirus or cVDPV detection
2. An expert group will be put together for full epidemiologic investigation of the case, which will be staffed with members of the Emergency Commission and epidemiologists from the public health center/s of the affected territory;

3. A site visit by the members of the Commission will be organized to collect the following detailed information:

- Determine if symptoms and signs in patients are consistent with the clinical signs of poliomyelitis;
- Determine, if there are additional AFP cases among local population, by conducting retrospective chart review at the local health facilities and major hospitals, especially in large health care facilities in the affected and neighboring districts;
- If there is more than one case, information will be collected on their age, sex and ethnicity, and geographic and temporal links between them;
- Collect information on travel history to determine if current patients (or their close contacts) have been to an area with ongoing or recent circulation of wild polioviruses;

- Collect stool samples from the patient and contacts for virology testing; send them to the WHO-accredited laboratory for urgent (priority) testing and urgent ITD and genetic sequencing of any isolated poliovirus;
- Perform assessment of routine coverage level in the affected population and the coverage during the latest round of supplementary immunization activities if they have been conducted in recent years;
- Collect data on immunization status (received immunizations with inactivated polio vaccine and/or with live polio vaccine) for all close contacts;
- Determine the attitude of the local population toward immunization.
- In case of VDPV detection from a person, the patient should be evaluated to determine the presence of primary immune deficiency conditions
- VDPVs detected form any source should be immediately submitted to WHO-accredited Regional Reference Laboratory for further characterization and determining if they are immunodeficient (iVDPV), ambiguous (aVDPV) or circulating (cVDPV) types of VPDVs. The response activities in this plan apply to the detection of cVDPVs.

3.1.3. Risk assessment

To guide planning of response, risk assessment will be performed by the Emergency Commission for Poliomyelitis within 72 hours from the identification of wild poliovirus or cVDPV confirmation. Risk assessment will analyze the risk of further spread of polioviruses. Following the risk assessment, the age range and geographic extent of the supplementary immunization activities (SIAs) in response to poliovirus introduction will be determined based on the parameters such as extent of the virus spread at the time of assessment, immunization coverage levels, quality of surveillance and epidemiologic data about cases and/or extent of environmental circulation of polioviruses. As situation develops, the risk can be re-assessed so that the plans for response are adjusted accordingly.

1. Because most poliovirus infections are asymptomatic resulting in "silent transmission", it can be assumed that in most circumstances, the virus have spread extensively before the first clinical case or positive environmental specimen are identified. For the purpose of this plan, IPV3 coverage <90% is considered suboptimal and should trigger immunization response. Coverage should be assessed among children aged 0-5 years, as well as in other affected age groups. Known or suspected immunity gaps in some age groups or population subgroups should also be taken into consideration when planning the response. Surveillance quality is determined based on the standard indicators determined by WHO. In addition to standard indicators listed in section 2.2, the following surveillance and coverage indicators should also be analyzed:
   - Presence of districts with sub-optimal quality of surveillance (as assessed by standard indicators);
   - Presence of districts or territories with multiple cases (clusters) of AFP and/or polio-compatible diseases;
   - Presence of districts or population groups with sub-optimal immunization coverage level (<90%).

If necessary, risk assessment will be conducted in collaboration with international partners using risk assessment methodologies developed by WHO/EURO.

3.4. Development of a concrete emergency action plan tailored to the situation.

The action plan tailored to the circumstances of the current emergency situation will be developed by the members of the Emergency Commission for Poliomyelitis within the first 3-4 days. The components of response to be implemented in different situations (depending on the spread, coverage and surveillance quality), are given in Table 1. In general, any of the following - wider spread of the virus, suboptimal coverage or inadequate surveillance – will trigger the supplementary immunization response of the scale dependent on specific circumstances in a given situation.

The concrete emergency plan will include:

- **Supplementary immunization activities (SIAs):**

1. Priority vaccine: Vaccine of choice for response to poliovirus circulation is oral polio vaccine (OPV). Bivalent OPV (bOPV) used in routine vaccination program in Georgia will be used for the initial response. For the larger scale response, the vaccine will be chosen depending on epidemiological situation and availability. Ideally, monovalent OPV (mOPV) corresponding to the implicated poliovirus type should be used. If mOPV is not available, the next best choice is to use of bivalent OPV containing types 1 and 3.
2. Immunization activities: National or subnational immunization campaign or large-scale mop-up immunization in population groups or in high risk groups or territories.

In addition to initial local response, supplementary immunization will be conducted and include at least three large-scale immunization rounds. Large scale immunization campaigns will last until there were at least two high quality immunization rounds after the last detection of wild poliovirus or cVDPV. The SIA which has achieved at least 95% immunization coverage nationwide (or in the subnational area targeted by the SIA) are considered high quality immunization rounds. In districts with immunization coverage of <95%, additional immunization rounds are to be implemented.

3. Target territories

Target territories for the response will include entire country, or, depending on the epidemiological situation, the affected region and all districts/cities where routine IPV3 coverage level was <90%.

4. Potential population groups targeted for SIAs:

The target population will depend upon the scale and the age range of supplementary immunization determined based on the specific epidemiological situation, including the possibility of conducting nationwide SIAs and/or expanding target age groups. The age range will be as a minimum 0-5 years, but could be expanded if needed.

The subnational response will include the entire cohort of children aged 0-5 years (regardless of immunization status) in the affected area and adjacent territories where bOPV3/IPV3 coverage level in any of these cohorts was lower than 90%. In this case, the target population will likely not exceed 150,000 children. In case of nationwide response among 0-5 year-olds (assuming annual birth cohort of approximately 55,000), the target will be 330,000 children. In case of wider age range of SIAs, the target will increase accordingly.

5. Vaccine demand

The country does not maintain a stockpile of OPV for potential polio outbreak response but a buffer stock of bOPV, equal to 25% of annual demand for routine immunization is maintained at all times. At the first stage of response, polio vaccine will be provided from the 25% buffer stock of routine immunization with the understanding that this vaccine will later be replenished to ensure uninterrupted delivery of routine polio vaccination. In addition, the amount of vaccine in the buffer will likely not be enough for the entire response.

In order to obtain entire amount of vaccines required for the SIAs, a request will be made to WHO through IHR NFP on obtaining international assistance. It is expected that the country will be provided with the OPV for the SIAs within 10 days (through MOH, WHO, UNICEF) and the district Centers of Public Health (CPH) will receive the vaccine within 14 days of request.

Total number of doses of oral polio vaccine, required for each immunization round will be calculated in the following way – by multiplying target number of children under 6 by 1.2 (loss ratio 17%), and total number of vaccine vials, required for each immunization round will be determined by dividing total number of OPV doses, required for each immunization round, by 20 and subsequent rounding up of the result. To assess total vaccine need, the resulting number will be multiplied by the number of rounds.

Estimated initial demand for bOPV or other recommended polio vaccine for 3 subnational immunization rounds for ages 0-5 years is 540, 000 doses. The amount will increase if additional rounds are needed, if nationwide SIAs are implemented and/or age groups for SIAs are expanded. In case of nationwide SIAs for aged 0-5 years, the vaccine demand will be 1 200 000 doses.

6. Immunization strategy

When implementing supplementary immunization, fixed post, mobile teams and outreach strategies will be used. House-to-house immunization will be conducted as needed.

The number of immunization teams will be determined in accordance with the following standards:

- With fixed post vaccinations, one immunization team can service about 100-150 children per day; and

- In case of mobile teams, outreach and house-to-house immunizations, one team can service about 60-80 children per day.

7. Timing of immunization campaigns for outbreak response.

First round of immunization campaign will be implemented within 4 weeks from the confirmation of wild poliovirus or cVDPV, taking into account expected date of vaccine arrival in Georgia and time when funds for vaccine procurement and covering other operational expenses. Intervals between rounds will comprise 4 weeks. If mOPV or bOPV is used for SIAs, the short interval strategy can be used to accelerate interruption of poliovirus transmission

8. Cold chain and operational needs

The Emergency Commission for Poliomyelitis will assess the needs for operational aspects for the response and produce the budget of activities within the first 4 days. The budget will include expenses needed for transport, fuel, salaries, per diem, cold packs, additional cold chain equipment etc.

Cold chain, used in the country, generally conforms to the requirements of WHO and State immunization program. There is sufficient capacity to store additional vaccine for SIAs. Prior to SIAs, additional rapid assessment of cold chain will be conducted to identify and address any unexpected deficiencies.

When assessing the needs, the Commission will follow chosen immunization strategy and take into account the following:

- Number of teams and supervisors (at district, regional and national levels).
- Number of vehicles, required for transportation of immunization teams, vaccines and materials in each village. Calculations will be performed based on local conditions.
- Location of fixed health facilities during door to door immunization.
- Needs identified by the rapid assessment of cold chain
- Potential additional activities in case of unforeseen circumstances

9. Microplanning

Microplanning in the districts will be performed by the district and regional PHC within 9-12 days.

- Managers of CPH, health facilities and supervisors appointed from the national level will take part in planning.
- District CPH will put together immunization team within 14-17 days and supervisors will be assigned and attached to groups;
- The micro plan will be sent to the national level for producing final budget of activities;

- The micro plan will cover all children aged under 6 (or wider age groups targeted by the SIA), local conditions and complications, required amount of vaccine, additional materials, personnel, type and number of vaccination points and teams, refrigeration equipment, transport, fuel, etc.;
- All villages, roads, geographical features of a territory (rivers, bridges, mountains, etc.).

10. Finalizing micro plans

To finalize micro plans, supervisors should perform the following activities prior to implementation of SIAs:

- Walk through the territory where immunization teams will be working and make a daily schedule for each team;
- Agree action plans with teams for emergency cases with various situations involving problems, e.g. when to repeat the visit to a particular household if children were not home the first time;
- Provide assistance in mobilizing population, including identification of local leaders, administrators, locally active NGOs, etc.

Required number of supervisors will be determined based on the time required to accomplish their tasks.

Supervisors will visit only locations with working immunization teams. They will pay attention to such important issues as:
- High risk territories;
- Hard to reach populations and territories.

11. Monitoring and evaluation of the quality of SIAs.

Intra-campaign monitoring

Before the implementation of SIAs, supervisors will be carefully briefed on geographic areas to be monitored and the methods of monitoring. A mechanism of communication with the Ministry of Health will be developed for supervisors, which will enable them to make right decisions promptly.

Simple indicators for performance assessment will be used for monitoring:
- No. of vaccinated and missed children - for each particular day of SIA and each territory (can be stratified by age group if needed)
- For missed children - reasons for not getting vaccinated.

The selection of sites for monitoring will depend on the specific situation at the time of response and availability of resources. The sites could be selected randomly, or include the sites at different levels of expected performance (from the worst to the best).

In addition to monitoring by the representatives of the national public health system, independent monitoring by international organizations, NGOs, etc. will be sought. The methodology of independent monitoring will be determined by the groups conducting it in consultation with the national public health authorities and will take into consideration the WHO Global Guidelines for Independent Monitoring and Evaluation of Polio SIAs (http://www.polioeradication.org/Portals/0/Document/Resources/PolioEradicators/IndependentMonitoringGuidelines_20101124.pdf

Post-campaign assessment

Post-campaign assessment of SIA quality will be implemented in collaboration with international partners (e.g. WHO, CDC, UNICEF, etc.). The specific methodology for assessment (e.g. LQAS, coverage surveys, etc.) will be determined in collaboration with the partners. Based on the information obtained during the monitoring and assessment, Ministry of Health will take steps to increase quality of subsequent immunization rounds.

3.1.5. Strengthening surveillance

Within 1-5 days, emergency commission will forward the information to all sub-national healthcare agencies with the requirements to strengthen surveillance.

To strengthen surveillance:

- All districts throughout the country will be reminded that they should provide timely and complete reporting on active weekly surveillance, including zero reporting;
- Active surveillance will be strengthened for the period of wild poliovirus/cVDPV circulation and for at least 12 months after– the last case or the last detection of wild poliovirus/cVDPV, whichever comes later;
- Retrospective search of patients will be carried out by:
  - epidemiological investigation among the local population and/or high risk groups;
  - Retrospective review of hospital charts for the last 6-12 months in priority hospitals.
- Enterovirus surveillance will be strengthened, or if not in place, implemented. Specimens from children with aseptic meningitis aged less than 5 years in priority hospitals will be tested for enteroviruses/polioviruses. The Emergency Commission for Poliomyelitis will determine, depending on the epidemiological situation, the need for and target groups for stool surveys among healthy persons.
- Environmental surveillance for polioviruses will be enhanced by increasing frequency and number and geographic coverage of collection sites

- Potential capabilities of the WHO accredited National Polio Laboratory to test the increased number of samples will be evaluated. If accredited polio laboratory in Georgia will not be able to handle the increased workload, special plan will be developed to send samples to other WHO-accredited laboratories;
- Completeness of reporting will be assessed at the national and regional levels;
- Experts will perform weekly situation analysis using mapping method and other documentary evidence of the scale of surveillance. The target rate for nationwide non-polio AFP surveillance among children aged <15 years will be ≥2/100,000. AFP rate will be monitored at subnational level as well, but due to small populations, individual districts are not expected to be able to consistently reach this target. Therefore, the experts will be reviewing geographic distribution of AFP cases to identify any silent areas or case clusters. The adequacy of stool sample collection will also be analyzed;
- WHO will be informed immediately of all additional AFP cases and clinically suspected polio cases.

Weekly and monthly analysis on surveillance data on district level will be conducted for early identification of high risk situations:

- Assess trends in AFP cases
- Determining districts with insufficient surveillance quality, including "silent" districts not reporting any cases;
- Identification of clusters of polio-compatible AFP cases;
- Identification of unexpected clusters of AFP cases.

Analysis will include mapping all AFP cases, especially polio-compatible, and search for clusters of cases and matching results of surveillance with lab data. Monitoring of timeliness and completeness of reporting (including zero reporting) will also be carried out. An exchange of special information with national level health workers (using various communication channels) and timely delivery of reports to the WHO EURO will be arranged.

3.1.6. Communication and social mobilization strategies

Ministry of Health and its partners will conduct advocacy work, inform local population, and develop press releases and "Q&As" for publishing in mass media within one day and will start developing strategic plan of activities including following key elements:

- Establishing contacts with political leaders for deep understanding by all of the emergency nature of the public health situation;
- Mobilization of district leaders to support polio eradication program;
- Engaging private healthcare practitioners, local health workers and public leaders;
- Informing population through various other channels, including religious institutions (such as churches and mosques) during response activities;
- Ensuring constant dissemination of information;
- Integrating information on routine immunization into various polio-related communications;
- Special attention during planning and monitoring of the program will be paid to high risk territories, training specialists and social mobilization of population in special territories and districts;

Activities on informing, advocacy and social mobilization of population will go during the entire period of response

3.1.7. Training

As part of the response, training activities will target clinicians, public health workers, and vaccinators

- A detailed and complete plan of training will be developed and special materials produced;
- Training materials will be printed within 6-14 days by the Ministry of Health and its partners;
- Training will be done by district and regional CPHs within 19-21 days

3.1.8. Control and monitoring

All aspects of the response will be closely monitored at the district, regional and national levels.

- In addition to post-campaign assessment of quality of SIAs, control and monitoring activities of surveillance and communication will be implemented using specially designed tools on active surveillance, social mobilization and immunization.
- Particular attention will be paid to high risk territories and population groups.

An interim assessment will be conducted 6 months after the detection of wild poliovirus or cVDPV to evaluate the progress towards interrupting poliovirus transmission and help plan further activities.

3.1.9. Budget for action plan implementation

Emergency commission will calculate the estimated budget for the response, including funds for SIA (vaccine and operational costs) and strengthened surveillance, and present it to the healthcare authorities of the country. The emergency appeal to the Cabinet of Ministers of Georgia to purchase polio vaccine and provide operational and other funds needed for the response to wild poliovirus/VDPV circulation will be made. Also, the budget for funding from international sources will be prepared for those activities, which cannot be covered with funds available at the national level. To ensure timeliness of response to wild poliovirus importation or VDPV circulation, procurements of vaccine and other necessary supplies will be carried out in accordance with the existing national legislation related to procurements in cases of exceptional situations.

Expense budget should include all activities planned for the response to wild poliovirus importation or VDPV circulation:

- Strengthened surveillance;
- Additional funding due to increased volume of laboratory activities;
- Supplementary immunization activities – vaccine and operational costs;
- Communication;

- Training;
- Transport;
- Miscellaneous.

3.1.10 Final assessment and report

The Emergency Commission for Poliomyelitis will develop the final report in close conjunction with all national and international experts, who participated in the response.

- The report will include all aspects of the results of epidemiologic investigation and analysis, such as descriptive analysis, trends over time, results of laboratory investigation, immunization campaigns and surveillance.
- The final report for the NCC will be developed when 6 months have passed after the report of the last polio case or the last detection of wild poliovirus/cVDPV.
- Interim reports for the NCC and the European Regional Certification Commission (RCC) or Polio Eradication will also be prepared every 6 months.

3.1.11 NCC review of the final report

The NCC will review the final report. Based on the report, the NCC will produce an official conclusion on whether sufficient evidence exists to prove that the circulation of imported wild poliovirus or cVDPV in Georgia has been interrupted.

3.1.12 RCC review of the situation and determination with regard to the polio free status of Georgia

The national report and the conclusion of the NCC will be submitted to the RCC through the WHO Regional Office. RCC will review the report and supporting data and make the determination with regard to the interruption of poliovirus circulation and the polio free status of Georgia

Table 1. General guidance on activities to be implemented in response to wild poliovirus importation or cVDPV circulation

Response activities	Wild poliovirus or VDPV from human sources		Wild poliovirus or VDPV from environmental sources
	Imported case of poliomyelitis due to wild poliovirus or VDPV	Cases of paralytic poliomyelitis identified through clinical suspicion or AFP surveillance, cases of non-paralytic poliomyelitis, healthy persons shedding wild poliovirus or VDPV	
Case investigation	Yes	Yes	Not applicable
Contact investigation	Yes	Yes	Not applicable
Contact vaccination	Yes, un/under immunized contacts	Yes, un/under immunized contacts	Not applicable
Vaccination in the immediate affected area	Yes - If coverage ≥90% - mop up - if coverage <90% - non-selective immunization	Yes - If coverage ≥90% - mop up - if coverage <90% - non-selective immunization	Yes - If coverage ≥90% - mop up - if coverage <90% - non-selective immunization
Subnational SIAs	Yes, if any of the following applies: - additional cases occurred in the same area - coverage in the area and is <90% - surveillance is inadequate	Yes, if: - single case and any of the following: o coverage in the area is <90% o surveillance is inadequate OR - additional cases occurred in the same area	Yes, if: - single detection and any of the following: o coverage in the area is <90% o surveillance is inadequate OR - repeated detections in the same area
Nationwide SIAs	Yes, if any of the following applies: - additional cases occurred over wider area - There are multiple areas with coverage <90% - Surveillance is inadequate - Transmission continues >6 months	Yes, if any of the following applies: - Additional cases occurred over wider area - There are multiple areas with coverage <90% - Surveillance is inadequate - Transmission continues >6 months	Yes, if any of the following applies: - Repeated detections over wider geographic area - Circulation continues for >6 months
Enhanced AFP surveillance	Yes	Yes	Yes
Enhance environmental surveillance	Yes	Yes	Yes
Enhance/implement enterovirus surveillance	Yes, the area and duration depends on the extent of spread	Yes, the area and duration depends on the extent of spread	Yes, if repeated detections

Comments:

- VDPVs detected form any source should be immediately submitted to WHO-accredited Regional Reference Laboratory for further characterization and determining if they are immunodeficient (iVDPV), ambiguous (aVDPV) or circulating (cVDPV) types of VPDVs. The response activities in this table apply to the detection of cVDPVs
- Coverage should be assessed among children aged 0-5 years, as well as in other affected age groups. If the existence of immunity gaps in some age groups is known/suspected, this should also be taken into account when deciding on the age range of the SIAs. Default age group for supplementary immunization is 0-5 years, but age groups can be expanded if epidemiologic and coverage data suggest immunity gaps in older age groups as well.