GPEI ORAL HISTORY COLLECTION

The Reminiscences of

Georgey P. “George” Oblapenko, MD

Global Polio Eradication Initiative History Project

2018

PREFACE

The following oral history is the result of an interview with Georgey P. "George" Oblapenko, MD, conducted by Christine McNab on March 12, 2018. It was recorded in video as part of the oral history collection of the Global Polio Eradication Initiative (GPEI) History Project.

Initiated upon request from the Polio Oversight Board and funded by the Global Immunization Division (CDC), the GPEI History Project documents global polio eradication, the GPEI partnership, and lessons learned through oral histories, artifacts, and records. The interviews in the oral history collection provide insight into turning points and lessons learned in polio eradication and how they are remembered. Views and opinions shared here represent the individual interviewee and do not reflect the views of the GPEI core partners.

This transcript represents a spoken exchange and reads differently than written prose. It privileges the interviewee's intended meaning, and the interviewee has reviewed, edited, and approved its content. Clarifying text appears in brackets. The transcript has been edited based on guidelines adapted from the Chicago Manual of Style.

Video recordings are available. For more information on the GPEI History Project, please visit polioeradication.org.

Georgey P. Oblapenko, doctor, at his home in St. Petersburg, Russia, March 11, 2018

Hana Crawford for the GPEI History Project

Interviewee:	Georgey P. “George” Oblapenko, MD
GPEI Affiliation(s):	World Health Organization (WHO), European Regional Office (EURO)
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MCNAB: Today is March the twelfth. It’s a Monday. We’re here in Saint Petersburg [Russia]. My name is Christine McNab. I’m here for the Global Polio Eradication Initiative [GPEI] History Project. I’m here with Dr. George [P.] Oblapenko [MD]. We’re at his home here in Saint Petersburg. Dr. Oblapenko had one pre-interview session with Hana Crawford in preparation for today. As requested by the project, we’re going to give a little contextual information.

Dr. Oblapenko worked in polio eradication in the European region [of the World Health Organization, EURO] from 1990 to 2002 in positions as coordinator of the polio eradication program for the European region of WHO [World Health Organization] and as a medical officer. Later, Dr. Oblapenko coordinated the preparation of the European region’s fifty-three countries for polio-free certification. It’s worth noting that Dr. Oblapenko worked in the European region after the dissolution of the Soviet Union and during times of conflict, also in the Balkans.

Dr. Oblapenko, I hope I captured that correctly. I really want to thank you for being here. I just have to ask you that we have your permission to ask questions and record this interview.

OBLAPENKO: Yes. Sure.

MCNAB: OK. Just to get started, a simple one to begin: please introduce yourself by name. State where and when you were born, as well. Maybe if you could also share a little bit about your early life here in Russia.

OBLAPENKO: What does that mean, life? How long should I go?

MCNAB: We're talking five minutes here or so, to give an introduction.

OBLAPENKO: OK, fine. I just would like to confirm that my name is Georgy Oblapenko, and I was born in Ukraine in small town, Gorlovka, which is Donetsk region, in 1938. My father is a doctor—or was a doctor. He has gone now. My mother was also a doctor. They met together in Kharkiv Medical Institution. I traveled when I was a young boy, too much from my point of view, because from Gorlovka my father was transferred to Chisinau, which his capital of Moldova. Moldova was just new republic which was organized I believe in 1939.

We met the war, Second World War, there. Then with mother I moved back to Donetsk, and then to Siberia, where mother was working as malariologist in one of malaria control institution. We were there until 1946 when the war was over, and Father was able to collect us, Mother and me, and we joined to my father in Poland, where he was as army officer. He went as a volunteer when the war had started, and then all [through the] war, he was in the war. He was a medical officer in air force. **[00:05:02]**

Then schools in Poland were closed—I mean the school for Russian speakers. I joined to my grandfather, who was during that time in Donetsk, and then my grandfather was transferred to Moscow. In 1949, I believe, or early 1950, I started life in Moscow. I finished school in Moscow. Meantime, my father moved to Saint Petersburg, where he was receiving additional training, because he was a physiologist at the department of air force and cosmic medicine.

I came to pass through exams to the medical institution [Leningrad Medical Institute of Sanitation and Hygiene], and after graduating from the medical institution I was receiving postgraduate special training in epidemiology and control of infection disease at the department of epidemiology [at Leningrad Medical Institute of Sanitation and Hygiene]. Yesterday we demonstrated photo with my professor, Professor Viktor [A.] Bashenin [phonetic].

Then I was sent down to Pasteur Research Institute of Epidemiology and Microbiology [in Leningrad]. I worked all time in the Pasteur Research Institute with few exceptions. One was smallpox eradication activities in India in ’75 and ’76, ’77. Then it was work for WHO headquarters as a medical officer, as a training officer on diarrheal disease control program.

Then I returned to Pasteur Research Institute, and I joined the WHO again in 1990 as Christine already mentioned, because by that time I received a very interesting proposal from Dr. Rafe [Ralph H.] Henderson [MD, MPH, MPP] to start to join global polio eradication program. I was thinking that if I participated in the eradication of smallpox—for epidemiologist, it’s exciting to start work for eradication for another disease. That’s why I agreed, and I was elected or selected

in Copenhagen [Denmark, headquarters of the EURO] regional office as a medical officer and started to work on May of eight there.

I worked until 2003 when I retired, and after that I still traveled a few times to the Copenhagen region office to assist them to conduct meetings of the regional certification commission [European Regional Commission for the Certification of Poliomyelitis Eradication], because the commission continued to work, as still the war with poliomyelitis, globally, was going round. It's not brief. I'm sorry, but hey.

MCNAB: It would have been a hard childhood, those ten years where you moved so much, and there was war, and it sounds challenging. How did you get such a passion for public health? You had two parents who were both medical professionals. Did that come from them? Where did that come from?

OBLAPENKO: I don't know, really. I didn't think about it. I think that public health, partially, I picked up from my WHO experience. I remember the first course on public health [I took] that I can say, generally. It was conducted in Moscow. I don't remember the year now. **[00:10:00]**

It was a course so-called for national EPI [Expanded Program of Immunization] managers. [It] was called a course on how to organize a program, how to plan a program, how to monitor a program, how to estimate efficacy of the program, and how to modify it. It was for me like fresh air from an open window, because I was a researcher, and I was definitely mainly busy with some kind of research project. I was involved in the investigation of outbreaks, because there

were outbreaks here and there in Russia, and our institution was responsible for the northern part of Russia. Very often, the Ministry of Health called us up on the telephone and not recommended but ordered [us] to go here or there. They were mainly the day of disease. That was how I started to learn public health activities, if I understand and can recall it.

MCNAB: When you went to India for smallpox what lessons came from smallpox that you could also apply to polio eradication?

OBLAPENKO: Lessons from smallpox: lessons from smallpox, I think there were few. One, that to achieve something like disease eradication is really hard work, because we were working since very early morning. I started to work in India, and it was March. It's the dry season. Temperature was very quickly growing up, and that's why we worked sometimes only until midday, until twelve o'clock, and then went back to somewhere where it is shadow [shady], and then worked again in the evening. Also, in the evening, it was better to work because people were coming from the field back to villages. Really, it was very hard work, very dusty, rough, and very problematic.

I was staying in Bihar State [India] and in a newly organized district, which was calling Nawada. Very good name, but the district was practically without water, because it was a problem for India generally, but for [this] district, especially. Water we were receiving from five to seven [o'clock], and very often at five o'clock, I already was down the road. That's why I requested a local policeman, which name is *chowkidar*, to pull two buckets of water. I requested the police, "You'll provide me with two buckets of water?" Coming down from the field covered with dust,

because roads were dusty, I was carrying two buckets of water. I washed myself and still kept a little bit of water, because overnight it was possible to sleep only when the ventilation [fan or air conditioner] was on. Very often it was on strike or something happened with the electricity, and ventilation was stopped, so then I put bedclothes in the water and covered myself until it was still wet. It was possible to sleep. Otherwise, it was poor, too hot.

MCNAB: In the day when you were doing the work, what did the work look like? Describe a bit the daily activities.

OBLAPENKO: Still smallpox activities?

MCNAB: Yes. **[00:14:51]**

OBLAPENKO: OK. There were few tasks. First of all, we were looking and searching for cases of smallpox, because there was no reporting, and public health was not so—how I can say it—sensitive. Surveillance was not so sensitive yet during that time. We were just going around places where people were gathering. First of all, it's market. There were daily markets, but there were also weekly markets which were more crowded. We organized a tent, specially decorated with pictures of smallpox. I'm sorry. I promised to give you a picture of smallpox, and I've forgotten.

MCNAB: It's OK.

OBLAPENKO: Coming down to these tents, we were talking to people about smallpox, demonstrating [showing] this picture. Keep asking. Also, our paramedical assistants were going around and talking to people. We keep asking, "Did you see such cases somewhere around? If you saw it, where is it? Can you show where it was?" That's way how we collected [case and surveillance information].

The second way of collecting, it was collection of rumors. It was a more official way, because every doctor or somebody who saw this case was obliged to report such case to the local health office. Sometimes was called the smallpox office. Then we collected addresses from that book, and we were going around, already knowing addresses and tried to show these cases in order to diagnose: is it smallpox, or it is chickenpox, or it is measles, because there were many. It was an outbreak of measles during that time. Then it was outbreak of chickenpox. It was possible to mix. But for experienced people who saw all these diseases, it was easy to say what was it.

Number three, while cases of smallpox declined, the government of India and WHO decided to give a reward. First of all it was a reward [of] one hundred rupees for a person who reported a case of smallpox. But then when cases were very, very few or they disappeared, the reward went up to one thousand rupees. That's way how we were able to detect cases, investigate cases.

We were having special laboratory kits which were necessary to use. We collected samples from a smallpox case and were sending this sample to three laboratories. One, it was New Delhi [India]. From New Delhi, it was coming over to Atlanta CDC [U.S. Centers for Disease Control and Prevention] or to London or to Moscow. It was also an important surveillance tool, because

there were plenty of such kinds of laboratory investigation, finally, and no one was able to detect virus of smallpox.

Another story, but it was later: when I was coming the second time, it was really something very impressive. There are special festivals in India, as you know. One big festival is called Kumbh Mela Prayag, where two rivers come together, Yamuna and [Ganges]. After that, it's "Big Ganges," as they call it. It goes down to Kolkata [India] and then to the sea. Every twelve years at this place which was near to Allahabad [India] city, people were gathering and taking the bus, because there were special days based on the moon calendar. If you take the bus during the day, you will be able to happy for another twelve years minimum. This is [their] belief. **[00:19:59]**

It's a lot of people from the Indian peninsula [who] were coming down to take a bath. They were not only from India. They were coming from Thailand; they were coming from Vietnam; they were coming from many, many places, countries around. We decided at a certain moment to organize a special survey during this festival. We placed a WHO camp, and there were a few teams coming down. We organized special field hospitals in tents, because it was a cold time. There were cases of fever. There were acute respiratory infections, and so hospitals were needed. In this case, we were able to investigate also a lot of people around, and we never saw the smallpox virus on laboratory tests. It was additional proof that there is no smallpox anymore in India.

MCNAB: Yes. With tens of thousands of people there, I imagine—something like that, if not hundreds of thousands.

OBLAPENKO: No, there were hundreds of thousands. I don't remember. I was keeping one article from an Indian newspaper from that time, and they very clearly estimate how many people visited this Allahabad Kumbh Mela Prayag.

MCNAB: Amazing. How do you think that smallpox experience prepared you for polio, or maybe didn't prepare you, as well? How was it the same and how was it different?

OBLAPENKO: Yes, Christine, I think that I started [to describe that], but then I moved.

MCNAB: That's all right.

OBLAPENKO: I learned that number one, it's very hard work. Number two, I learned that it's really very important that we [be] working as a team. It's not just for one person who will be able to do something or to order something. No. It was necessary to organize good, coordinated work. That's in coordination. That's maybe what I picked up from experience in India, because down [in] the field, I very often was working jointly with good coordination with a UNICEF field officer, who was not an epidemiologist at all, but we were in good contact. That's number one.

Number two, we're working with medical doctors, so-called "block medical officers." Block, it is a minimum size, as far as I remember, size of the population, because it's not a village; it's maybe a group of villages. It's I think around [a] ten thousand population; it's called a block. In a block, they do have a block hospital. Small one, but there is usually a medical officer. It was necessary to talk to these people, because these people were also working—as I told you—

searching for cases, and if needed, they conducted immunization. It was Dr. Singh [phonetic], I remember—my first field experience when I started work in Bihar. We were sitting with Dr. Singh, and he was talking to me about his area. Suddenly, he received a telephone call and said, "George, we have to go, because just somebody called me and said that there is case of smallpox." We went down to the village. It was not case of smallpox; it was chickenpox, but we started, because we went down to village, started vaccinating. He was bringing vaccinators with him. It was a vaccination session, started immediately. It was necessary to motivate, to coordinate, to explain how it is important and why it is important. **[00:24:52]**

It's not only medical officers; it's also the general public, because coming down to a village in India, particularly, it's not just like in Europe, I can say. First of all, it is tea party with the chief of the village. It's necessary to have a small glass with tea, and it's general talk about what purpose of your visit is, why you come to see our village, and so on and so on. We brief these people—and we are talking everywhere—that if we come for such and such purpose, but it's not case of smallpox, which we will investigate now in your village, please inform us as soon as possible if you see a similar case next time. It's a lot of such, how I can say it, educational activities—around we're going.

MCNAB: Yes, and those traditions continue today with polio.

OBLAPENKO: Yes, that's right. Similar strategies, if I can say.

MCNAB: If we move to all of a sudden you're sitting in Copenhagen, talk about the team that you had and the budget you had at that time, compared with the amount of work there was to do.

OBLAPENKO: Oh, I can say that I was lucky person, because many [of the] programs in Copenhagen related to communicable diseases [did] not have money at all. But when I started to work, the regional director gave me $20,000. Twenty thousand dollars, I was able to conduct two meetings. Not a big one. I [had a] secretary. That's it. It was my chief doctor, Boris [D.] Bechenko [MD], who was regional adviser on communicable disease, who was having practically no money. It was a time when, if you [conducted] advocacy and [tried] to work to receive certain funds, it [meant] going to WHO, generally, and sometimes this money went down to a special budget, which was kept by the regional director. It was a really difficult time.

I think that our situation started to be more difficult. I started work in 1990, and by the end of 1991, the Soviet Union was disintegrated, as we know. There were fifteen countries [that] started to be members of WHO. In 1990, there were thirty-one countries. It was not just fifteen, because there were also other countries [that] started to be independent. Finally, we went down to fifty-two or fifty-three countries. Imagine, it's more telephone calls, because countries were not aware what [diseases]they can get, what they have to do. Like routine reporting of communicable disease. It was tradition that they should send reports to the WHO. But previously it was only one report, coming from the Ministry of Health of the Soviet Union. Now, it's plenty of other countries. Not plenty, but still many. That's number one.

Number two, you have to go down to countries, here and there, where outbreaks started to appear. Number three, which was more dramatic I think—was a more dramatic event—it was funds for immunization, for vaccines, because many countries were not able to cover their vaccine needs. We were sending missions, and we were going around—too overloaded, sometimes, which was unnecessary. **[00:29:57]**

It was necessary to correct it, make it more as WHO recommended. It's not a simple discussion in many, many places, because in many places, pediatricians did not agree. Also, during that time it's epidemic diphtheria [that] started in the former Soviet Union. Epidemic diphtheria was partially because of the antivaccination lobby. We were coming down to Moscow, for example, trying to organize discussions with people who were behind, who were very active to challenge vaccination. But they would not agree. Usually, they were afraid to come down to tea. That's why the situation was not easy. That's why our experts, which we requested, were preparing special articles which were published in Russian language in a few countries of the former Soviet Union. That's the difficulties which I face when started to work.

In 1991, the regional adviser left, and so I was just alone. It was decided by WHO authorities that I will be the acting [director]. I was in shock, really. I will try to explain. My situation was very special. My position was paid by Rotary International. It was not WHO money, per se. There were Rotarians who paid for me. I was considering the possibility that if Rotarians would see that I'm working now for the entire region and not just for polio eradication, they [would] cancel it, and polio eradication will be out of discussion in the European region. I talked to Dr.

Nicholas [A.] Ward [MBChB], who was during that time coordinator for the global polio eradication program [at WHO]. We tried to figure out what we could do.

Finally, we arrived with a proposal that my first priority [would] be polio eradication. My second priority [would] be to work as an emergency case, if [there was an] epidemic or outbreaks which affected certain countries. All other activity related to communicable disease [would] be just put aside, or if necessary, it [would] be minimum level. Nick Ward was able to negotiate with the regional director, and the regional director accepted this one. That's what's happening.

I [had] to work, because I told you I started in May 1990. I [had] to prepare a plan of action, because [there] was no plan of action for polio eradication in the region, and then suddenly what I drafted in 1990 started to be useless [laughs] in 1991. That was another problem.

Then when I started to prepare such a kind of plan of action, I realized that at a certain moment we will move down—not to a strain, then, but to establish surveillance for wild poliovirus. It will be surveillance for AFP [acute flaccid paralysis] as one tool, but also within Europe, there were options. There were a few countries which conducted environmental surveillance of sewage, and it was sensitive. They were able to demonstrate that it's a good result. They can detect virus. It's not clear where [the virus is] from, but still, if [there is] virus there, it's not possible to certify such countries in future. **[00:35:00]**

That's why we had to organize few scientific sessions, if I can say [it], to discuss and to decide what to do, what would be the policy for such an option. We agreed that it can be used as a

supplementary surveillance [system], but still we gave priority to surveillance for acute flaccid paralysis. That was another problem, if I can say [it]. In many newly independent state countries, the calculation of target populations of newborns was not correct. There were plenty of kids were [diagnosed] with strange diagnoses and strange diseases, which already were not used all over Europe. I think that two years before the European meeting of national EPI managers discussed this matter and they already revised the list of contraindications, and it was published in *Weekly Epidemiological Record*. But still, it was [best] practice—accepted in many countries.

Coverage, for example, which countries reported was eighty percent. But apparently you have to count that it's eighty, but [it's] not really eighty, because there were still a lot of children who were not included at all. If you [were to] recount it correctly, so the coverage might be down to forty or sixty percent. It was necessary to work with countries to brief them that they [did] understand how to calculate appropriate figures and [let the countries know] we're reporting these figures to WHO. We're not interested in pumping something [inflating numbers], which does not exist. But it was tension from beginning.

Later on, they did understand. We conducted a lot of technical meetings during this time.

MCNAB: How did you get them to understand? Was there an example of a moment when the lights went on for a certain country or a meeting you remember, or did things just happen over time?

OBLAPENKO: There are many meetings. I definitely did not participate in all of them. I was in [the country] Georgia; I was in Ukraine. But our team went down to Uzbekistan, where it was very intensive discussion. Dr. Artur [M.] Galazka [MD], if you know this name, who was a scientist at WHO Geneva, he went down to Uzbekistan. He recalled how people were shouting that they were forced to follow WHO recommendations.

In Ukraine, also. In Georgia, it went more or less smoothly. But maybe because Georgians [are] too polite and nice people. In Ukraine, it was more dramatic discussion. Did you meet Dr. Sieghart Dittmann [MD]?

MCNAB: I don't think I have, no.

OBLAPENKO: He was working for a long time for the European region, mainly, but then he came back again to be the coordinator for diphtheria control outbreak. Then he was leading our communicable disease team. Dr. Dittmann was losing his temper and started to shut down. "It's stupid what you're proposing." It was not easy. It was required [sending], again, additional materials, additional articles and to call certain people to talk to them. **[00:40:00]**

We conducted, for example—it was meeting in '93 in Kiev [Ukraine]. Then in '94 German government provided support for two meetings on polio and diphtheria control, so it was '94 in Berlin [Germany] meeting, and then '95, I believe it also was in Berlin meeting. We got technical stuff.

Again, we're talking about this one, because problems were not only with regards to polio, but with regards to diphtheria. In many countries, pediatricians were so much in shock when they saw diphtheria—I'm talking about newly independent states, that they were giving antidiphtheria serum to those patients who already received it but still [who were] in very difficult condition of health. They didn't realize that [there] exists [a] certain level which will be not helpful. You can place half a liter on the top of that, and the serum will not help because intoxication level is very high, and you can do nothing in such cases.

But all over the European region, the situation was [such] that UNICEF, which was distributing this antidiphtheria serum—was distributing this, counting on a level of population—because it was not enough. It was not enough, and we could not increase production, because it required certain technology. There were difficulties.

MCNAB: I was talking with Harrie [G.] van der Avoort [PhD] the other day. We'll just pause there, George, and [the videographer] she's going to change the battery.

[INTERRUPTION]

OBLAPENKO: In the eastern part, where it was mainly [Roma population]. I was surprised that virus was already down to central Bulgaria and somewhere else. It's strange.

MCNAB: It is. It's quite something. I'm going to start up again. We had a pause to change batteries. This is now the second part of the interview after the battery change. We're going to

get to the outbreak in the Netherlands, George. In 1992, all of a sudden there was quite a big outbreak started in the Netherlands amongst I think teenagers at that time in the orthodox Protestant population. How did that outbreak impact the perception maybe of polio or the perception of the need for polio eradication in Europe? Did it help you in a way?

OBLAPENKO: I think it helped because we realized that without switching on mass vaccination, we were not able to stop it. Ministry of Health of Holland was too cooperative. They were calling us and requesting [that we] provide certain information. We were able to send them a lot of documents and a lot of experience of other countries. Problem, I think, was only that the subnational population completely disagreed with vaccination because their beliefs. Finally, I don't remember, I think that somebody from the Netherlands proposed such strategy. They thought, let's keep our clinic vaccination open overnight, and we'll transfer information to this group of population. If they're willing to come anonymously, we will not ask them who they are, where [they're] from, but just for vaccination, we will provide it on the spot. **[00:45:12]**

It was very helpful because people started to come. They were afraid their neighbors or whatever—I don't know—or their priest. But it started to work. With constant control which was conducted by Harrie van der Avoort—sewage water, particularly—from that area, we were able to see that virus was declining. I mean the concentration of viruses in the water was declining and then disappeared. That's the way how we learned more then. Only with vaccination it could be done.

I think that at a certain moment [there] was a little bit of disagreement with Pasteur Merieux, because Pasteur Merieux was trying to promote IPV [inactivated poliovirus vaccine] vaccine, inactivated polio vaccine. Experience from Holland was helpful to us, because we saw that IPV vaccine is rather slow with regards to reduction of circulating poliovirus, because it produced humoral immunity and does not protect—how I can say [it]—local immunity of intestinal [tract], which is very important. It protects the child, which you vaccinate, but it does not reduce the level of circulation because virus still might be in the intestine. It will be not producing disease, but virus still will be excreted and will circulate.

I think that this phenomenon was already known before, because when the polio epidemic started—and I think it was early fifties, when [Albert B.] Sabin [MD] developed his oral polio vaccine—Sabin was not able to start production in the U.S. or even test it in the U.S. because [Jonas E.] Salk [MD]—this is IPV vaccine—was everywhere.

Sabin managed to bring this vaccine down to the Soviet Union, to Moscow, to Professor [Mikhail P.] Chumakov [MD, MPH]. Chumakov studied this vaccine, and they realized that this vaccine's safety and [that it] can produce good immunity. They decided to test it, and it was during this time, [during the] outbreak in Baltic states—active outbreak—with OPV [oral polio vaccine] vaccine they were able to control it pretty fast.

I don't know. Unluckily or luckily, it was in Uzbekistan [that there was an outbreak of type 3 poliovirus. Chumakov produced monovalent vaccine, gave it to Tashkent [Uzbekistan], and Tashkent was able to bring it under control, also, very fast. But then a very interesting story

happened, which I learned just in Copenhagen when I met Dr. Istvan Domok [PhD], who was one of first virologists in Hungary, and Professor [Sergei G.] Drozdov [DMSci], who was director of the Institute of Poliomyelitis [and Viral Encephalitides] during that time. He succeeded Professor Chumakov, Academician Chumakov. **[00:49:52]**

One story is very funny. It was an outbreak of polio in Hungary, and they used IPV vaccine, inactivated polio vaccine. But still, the outbreak was going on and going on, because there were many gypsies. I don't know the reason. I don't know all the reasons which were behind [it]. But I remember they were sitting on a sofa in my room in Copenhagen after one meeting, which we were having. Domok and Drozdov discussed, "Do you remember? Do you remember?"

[The] story is that Professor Chumakov, when he learned that in Hungary, regardless of using of IPV, [there was] still a polio outbreak going [on], he smuggled one suitcase of [oral] polio vaccine. He flew to Budapest, because they were friends with Professor Domok, and he explained to Professor Domok, and he demonstrated to him all the protocols and how they studied vaccine, what happened in Lithuania and so on. He proposed, "I smuggled one suitcase of vaccine. Would you like to have it?"

MCNAB: This is OPV, oral polio vaccine.

OBLAPENKO: OPV, yes. Domok told him, "Sure, I would like [to have it]." After that, the epidemic, very fast, went down, was over.

MCNAB: What year was that, George?

OBLAPENKO: I don't know.

MCNAB: But about what decade?

OBLAPENKO: I think it was early years when polio was growing everywhere.

MCNAB: Funny. Public health contraband.

OBLAPENKO: That's right. Professor Drozdov was having very nice photographs in his office. It was a queue, dramatical queue of mothers in Japan, in Tokyo. It was a demonstration: this queue went down to the government building, demanding that government buy OPV vaccine, because polio came down to Japan, and there were a lot of kids who [could] catch polio.

MCNAB: Yes. Wow. On the program then, so you have all of these meetings; there's been lots going on. At the same time, you still have you and one secretary, and you and some support from the national governments. But what was the turning point for you to get more money into polio? I guess Operation MECACAR [Eastern Mediterranean, Caucasus, Central Asian Republics] came into play. We talked about it the other day. But for this interview, can we talk about that a bit more and how you turned minds over to great Operation MECACAR?

OBLAPENKO: I think you're perfectly right. It was Operation MECACAR. I don't remember. It happened maybe a little bit before, but apparently, [it happened] with Operation MECACAR. I think what happened [was] partners saw enthusiasm at the Ankara [Turkey] meeting [October 20-22, 1999], the first MECACAR coordination meeting. They saw how people are willing to cooperate and would like to do it and promise that they will do whatever is necessary in order to achieve the reduction of poliomyelitis, because during that time, it was the first [priority] task—if I can say—or first goal. That's number one.

Number two, it was the IICC [Interagency Immunization Coordinating Committee] created. I told you that in Amsterdam in November, something like that, 1994, it was the first meeting of coordination. This is the Interagency Immunization Coordinating Committee. That's it. What happened after that? We started conducting MECACAR, and already in 1995, reduction of polio was observed, but one year—still, epidemiologically, it's nothing because it's one year. It might be [that] something has happened which [does] not depend upon your intervention. **[00:54:51]**

Early 1996, when—still, this is a reduction of poliomyelitis [that] was observed—and when we considered that it is time to already start moving towards implementation of surveillance, I think that during that time, the CDC provided certain operational funds to me, number one.

Number two, it [was], maybe luckily, that Steve [Steven G. F.] Wassilak [MD] had finished his coordination activities and study of acellular pertussis vaccine, which was conducted in Europe. Steve was in charge of that study. Steve was moved from Rome [Italy] to Copenhagen, and it

was very helpful, of course, because previously, I was alone—not alone, but having a rather small team. But with regards to professional level, yes, I was alone.

Number three, it was the [Global Laboratory Network, GPLN] laboratory coordinator Galina [Y.] Lipskaya [PhD] who appeared and [selections] were conducted [for the position]. I don't remember who paid for her position. I believe WHO, but maybe it was via CDC. Also, money maybe was given to Geneva, because the laboratory network was necessary to have in more regions.

But before that, it was, I think, another very interesting event. It was Dr. Walter [R.] Dowdle [PhD] who came down to draw the plan of action for the laboratory network. I told you Saturday how we were discussing it, and it was not easy to explain countries, but when we finally received agreement from many countries, that they would follow WHO recommendations—so Walter came, and Walter was helping.

Practically, he prepared the plan of action for the laboratory network as a first draft. I remember [it was] very interesting when I asked Walter once how he liked Copenhagen. He told [me], "You know, George, Copenhagen is a very strange city. You go to any side and wind will blow in your face." It's not related to polio, but just—

MCNAB: We talked about it the other day. Just for the record for this interview, George and I did speak the other day about Operation MECACAR in much more detail. I think we can refer to those questions and answers, as well, for this history. Can you explain maybe more briefly how

you had the idea for Operation MECACAR and how that germ was planted, I guess, based on this idea of importations?

OBLAPENKO: Yes, I think the main idea, as I can see it from now—or even [as] I thought about it before that—it was my knowledge, which I received from the meeting in Guatemala from a presentation which was made by Dr. Olen [M.] Kew [PhD], that outbreaks, which we were having in Europe, recently—I mean during that time, recently; it's during 1990. Maybe even before [that] a little bit, we were having every year an average [of] between two hundred and three hundred cases of poliomyelitis in many countries that [depended] upon importation of wild poliovirus from India, Pakistan, and Afghanistan.

I learned about that, and then I did not pay attention to that, if I can say [so]. Only after three years, three years later [May 1995], when Dr. Nicholas Ward informed us about the plans of WHO to conduct a polio event at the World Health Day of seventh of April [1995]. I was sitting with my friend, Dr. Rafi [G.] Aslanian [MD], and we were waiting to enter the room of experts, which during that time, the meeting was at CDC, I believe. **[01:00:12]**

We discussed what we can do and how we can organize this one, just to exchange our views. Then, I saw that it might be a good time, and I had to propose a coordination activity with Rafi, because otherwise, I [would] be behind development, and I [would] be all the time fighting importation which [would] come down to my territory, instead of cleaning my territory with the support of Rafi in his territory. Then I [would] be polio-free, because the public health level of

infrastructure in Europe was definitely much higher. Rafi, after brief discussion, agreed that we [would] try to join our efforts in coordination.

During that time, we're talking only about national immunization days. But later on, we moved down, so we coordinated our mopping up activities. We coordinated our work in high-risk territories of countries.

That's it. That's how MECACAR started, and that's how it was developing, because coordinated activities related to surveillance—it's not easy. It should be going based on national public health infrastructure, based on national tradition and so on and so on. But mass vaccination definitely was very helpful, I believe, and until now, I'm sure that the MECACAR is a key of our success in [eliminating] polio, in cleaning the European region from polio.

MCNAB: With MECACAR it was coordination across European borders and across borders with EMRO [Eastern Mediterranean Regional Office of the WHO] with several countries. What was the scale of it? How many children were being vaccinated at the same time?

OBLAPENKO: Oh. I think MECACAR, if I can—battery change?

MCNAB: We're just doing another synchronization with the backup mike. If we look at the scale of MECACAR, how many children were being vaccinated? What was the scale and scope of this huge effort?

OBLAPENKO: Christine, it's difficult to say, because MECACAR, as I told you, it was just an umbrella [at] the beginning. Later on, we called it like "MECACAR Plus," when Russia decided in 1996 to join MECACAR. It was quite a bit [later]. Later on, we requested Ukraine to join MECACAR. Then, at a certain moment, for one year at least, it was Romania, Bulgaria, Bosnia and Herzegovina. That's why it was in fluctuation if I can say [so]. But apparently, I believe that it's in our book, and when we started it, it was fifty-five million [children being vaccinated]. It went up, but I don't remember [final] figures. Maybe [it] was up to seventy [million]or seventy-five [million].

MCNAB: You used your money from Rotary International to start it.

OBLAPENKO: Right. Rotary was providing support for vaccine and for social mobilization and a little bit for the cold chain, because the cold chain is a very important part of Operation MECACAR. Previously, it was not existing at all. I did not mention that—not in parallel, because it was independent activities. I know at least in Russia that they conducted many technical briefings or meetings for health staff [on] how to deal with the cold chain and how to keep it, how to preserve it, because previously, vaccine was only in a refrigerator. That's right, it was kept— **[01:05:09]**

But going out for mass vaccination using a car or going on your own, nobody pays attention to such a kind of—it was, if I can say [so], during briefings, it was mentioned that you have to keep [protect the] potency of vaccine. But what does it mean to keep the potency of vaccine for field workers? Just words. You have to explain to him what to do. I think it was done.

MCNAB: The field workers had to use their ingenuity in a way at the local levels to ensure the cold chain wasn't broken. What were some examples of the things you saw, and how did they work?

OBLAPENKO: How I can say? It's difficult to explain, because it is not like something that is a story. I can recall now, I can see just in my eyes, how we conducted mass vaccination in Turkey in Diyarbakir Province [Turkey]. This senior nurse was going around and shouting, just calling people to come out of their household and to get vaccine, because she was having—"This is a cold box," and she put it in a site in shadow [in the shade]. It was a hot day, and she was providing vaccination on the spot. It was a small queue, but she received very quickly support from one volunteer, and they were doing pretty good. You have to see it. Nothing to tell from my point of view is very special, but people were willing to—how I can say [it]—adjust to make something comfortable for kids. Mothers were coming out with small kids, with kids who were five years, who were obliged to get vaccine. But what to tell? What's the story?

MCNAB: There was a story, and you told it the other day, but I think this audience will appreciate it, as well—of the man you came across in a very remote area.

OBLAPENKO: On horse, yes. But it might be unique. I saw it in Kazakhstan in the borderland with China. This might be a unique story, indeed, because it was the first round of MECACAR. We were not having during that time cold boxes, or maybe [there were] not enough. But it was a really very remote area. Anyhow, this person was able to manage with bucket of ice, where he kept vaccine while he was going to the village and then returning back to the health center.

MCNAB: He said something to you that was quite memorable.

OBLAPENKO: That's how it ended, but yes.

MCNAB: What did he say? What did he say?

OBLAPENKO: Christine, he said that it's a great day, because, "You know, doctor, today eighteen countries of our region and our neighbors join efforts to vaccinate kids and to protect them from poliomyelitis, and it will come one day—then [there] will be no polio anymore, globally, and so I'm working for this, so I feel great. "Because I asked him, "How do you feel sitting on a horse, having bucket of ice? How do you feel instead of sitting down in your health center and [seeing] patients in a warm place?" **[01:10:10]**

He explained to me, "One day it will come, and I feel great, really." I also felt great. I also felt great.

MCNAB: Yes, because that showed that all of the work you'd been doing and that the countries had been doing was paying off, wasn't it? That the message was getting through to the lowest level.

OBLAPENKO: Right.

MCNAB: Yes. I'm just taking a picture of you now, too, because the light just got very nice. That's nice. Thank you.

Operation MECACAR is going well; you're seeing the cases are coming down. AFP surveillance is improving. The laboratory network is improving. Then, in 1996, all of a sudden there's a new outbreak in Albania. At a time, too, when there were challenges in the Balkans. Can you talk about that and the impact that had on the operation?

OBLAPENKO: I think it's very strange to say, but it strengthened Operation [MECACAR], because during that time, already many countries started to feel that polio [had] declined, had pretty much declined, so it was not like before.

Suddenly, we were too nervous, because really the outbreak in Albania was very dramatic event. They got vaccine; they vaccinated, and suddenly it was clear that that vaccine does not work. It was necessary in a very short time to organize [and replace] the supply of Albania with new vaccine, and UNICEF was so kind and so nicely worked that they managed to bring vaccine. I did not mention [this] last time, but I went into Albania for the meeting before the first round of NIDs [national immunization days] and explained to them why it is necessary and explained to them why it's happening in Albania.

There were many nongovernmental organizations like Médecins sans Frontières [MSF, Doctors Without Borders], then Red Cross, then other organizations. Each organization definitely was having their own interest. Some of them were not agreed [supportive] with polio, because it

changed their plan or made them postpone [their missions], because you have to, after vaccination, at least for one or two months, not to use other vaccines. It's usual for immunization.

They [the NGOs] started to say that, "We're not going to take part, and we would like to do that and that." I said—and then the local national public health authority repeated very strongly—that, "You are working in Albania not just for yourself, but for the people of Albania. Now, the great danger for people of Albania, it is to get polio. We're going to stop it with OPV vaccination. If you're not going to do it, then what? You have to be not there. You may come later when you think that time will come for you to return. But in one week's time, when vaccine will be here—and if you're here and your health staff [are here] and we need hands to do vaccination, then better to do it."

It worked. I think that discussion with regards to what was around this OPV virus and vaccine virus and wild virus, Steve [Wassilak] can better tell, because he was part of the discussions. It's really—I felt during that time, particularly—very nice that Steve joined us.

Because it was an outbreak in Albania, it was necessary to do certain preparatory work. He [was] in Ukraine and in Russia, and I was not able to cover all these matters. **[01:15:13]**

I requested Steve to go to Albania because Donato Greco [MD] was already requested and agreed to do it, and [R.] Bruce [Aylward, MD, MPH] was flying to Albania. I thought it [would] be just good for Steve to start. It was done, and Steve was happy.

MCNAB: It was an interesting case, as well, wasn't it? Unusual.

OBLAPENKO: It is. It is a very unusual case. It is, I think, a great experience he gained. We all gained from that experience. It was importation. Later on, when I was in Serbia and in the Kosovo region, I saw one case of polio which was an importation from Albania, but it's only one case. We were able to do vaccination in time, also, and the virus did not spread too [broadly].

We were really very much worried about Greece [Roma] population, because the vaccination program in Greece was—how can say [it]—not well structured. It's good health system, but it was certain—how I can say [it]—disorganized, up to a certain extent. We were worried. That's why we also requested Greece to run special rounds in particular areas where gypsies were.

MCNAB: Yes, with the gypsy—or Roma—population, we saw in Europe how there are missed children, and how there's some populations that are—I don't know if you can say—neglected. But what's your take on that? Because it was often the Roma or gypsy populations who were affected by these outbreaks. What did we learn from that that also informed the program in other countries?

OBLAPENKO: I think it is definitely from country to country, because in some countries like in Hungary, gypsies, yes, they're living separately, but they're well covered by national health services or immunization services, let's say. I'm not sure about other ones, but about immunization, yes.

It happened in Slovakia. It happened in Poland also. But anyhow, we were very worried that during that importation it might be—how I can say [it]—certain spots, certain small territories, like remote areas you have, where sometimes [vaccination is] difficult to approach. That's why we paid special attention during these periods [to] try to control importations from Albania. It worked.

But with regards to other territories, I can recall Armenia, where I told you there is a political party of gypsies and they work in parliament. Also, in Bulgaria, it was more or less a simple situation. It's different. There are big settlements of gypsies. It's like, I don't know, they put houses very close to each other. Sometimes they constructed houses, as I understood, without having enough access to the water supply. I think the hygiene, that's problem which affected [Roma] communities in many such areas. They do not pay attention to this one, because you know that the special type of living is different, and that's maybe the reason. I don't know. **[01:20:07]**

MCNAB: I guess, too, you talked about how you did work to define these high-risk areas which would be linked to some of those populations and that also really helped to finish polio in Europe.

OBLAPENKO: It's a difficult question, because we were working on the criteria for high-risk areas for many, many years, and even when we left in 2012, the last meeting in Copenhagen which I was taking part, we were having special discussion with CDC. I believe, also, somebody from EMRO participated in this discussion. Because the criteria, I believe, might be different

from one region to another. This will be sensitive, yes. For our case, we were focusing on the level of routine immunization coverage as the most important criterion.

Then we tried to assess two, if I can say [it], major points: risk of importation, which is very difficult to assess, and finally, we decided not to use that one. The second one, what we decided to assess and were trying to assess, it's the level of surveillance, because if you are ready to detect virus—poliovirus, I mean—very fast, then it means you have good surveillance, and then it means that the risk is not an importation risk; the risk of your territory is not high, because you'll be able to detect [the virus] pretty fast and it will work. It will switch on to bring you to control measures, which [you] follow very quickly. Try to coordinate these—or not coordinate but try to link—these issues.

We started sometimes with water supply or whatever, but then we also deleted that criterion and went down only with regards to all criteria related to quality surveillance. It's truthful samples. Do you have it [your surveillance at a] high level, or it is just forgotten about? You detect an AFP case and then [have you] forgotten about this one? Then, how is the laboratory is working? How fast is the laboratory able to give you feedback about what was isolated or not isolated? Because it is important.

Now, WHO developed pretty strong criteria for the time of [getting a] response from laboratory to health staff. I think that this criterion, finally, we considered the most important.

MCNAB: Yes, and with the development of criteria and I guess the development of standards—Are we changing batteries? No, we're doing something—from one of the meetings that the commission was hard on the Netherlands, or Great Britain: "No, we need more proof. We need you to give the age differential and the sequencing." It was interesting just to see that rich countries didn't get off easy in a way, that there was a need to level the playing field, no matter if you were Uzbekistan or Kyrgyzstan, or if you were Great Britain. Thought that was interesting.

We're syncing up again, just had a pause to fix the lighting, and we're starting up again with George Oblapenko. **[01:25:08]**

[INTERRUPTION]

OBLAPENKO: Certification.

MCNAB: Yes, these plans of action for certification. It was a lot of work to create the plans, review the plans, but also for countries to come to a level I suppose that was the same across a very diverse region.

OBLAPENKO: For certification, we worked pretty hard with Bruce [Aylward], because Bruce was, during that time, gaining experience of preparing a national document or a draft for a national document. This was very important and very helpful. But we were facing a problem, because it's necessary to certify—for the commission [to certify]—fifty-three countries. How [will you] work? That's why what I proposed—and after discussing with Bruce we agreed—that

we [would] try to divide countries into certain sub-regional zones: countries with similar public health infrastructure—or not infrastructure, but yes, we can say infrastructure—and with long histories [of being] polio free can be grouped as one. Then, countries recently having polio, like MECACAR countries, should be another group, because the commission also will [need] maybe more time—if necessary—to work with these countries. The commission may request to visit these countries, because it's already clear from previous experience. For example, you mentioned the UK [United Kingdom] or Nordic countries. Also, [there] was recent importation into Norway. Sometimes I can recall that.

But anyhow, it's quite a different situation from the beginning. That's way how we started. We made a few groups. We proposed to the commission that it would be a way, how they would work. If they preferred something different, [fine]. But the commission agreed with us.

Then we gathered. I believe it was 1998, the meeting with all polio-free countries, because previously we did not inform [them]. No, we informed them, definitely, but it was very superficial information. We were sending these letters [about] what we were going [to do] with polio and whatever but knowing how busy the national EPI managers [were], we realized that they might be not interested to read these documents at all.

We made few very technical presentations. Number one, we explained what documents we expected them [the countries] to prepare for the commission. That document, which Bruce developed as a national basic information for the commission, this was a very important issue. That's number one.

Number two, we discussed surveillance. Some countries, as you mentioned, were saying, "Oh, we're polio-free. There is no virus," la, la, la, "[why do] you need more? What do you need more? It's not necessary. We can write down that there is no poliomyelitis since 1960 and that's it."

The commission was not [in agreement] with this, also, because knowing—as with [what] we started our discussion today, even—knowing that polio might spread very fast, and if surveillance was not good, then it [would] not detected until the first case would appear. But who knows when [the first case will be detected]? We also know from experience [in] the Netherlands that if you did not see poliomyelitis for a long time, you may miss it and say that it is Guillain-Barré, or whatever. **[01:30:01]**

Finally, countries accepted our demand [as the regional certification commission]. We also proposed, as I already mentioned, that optional supplementary surveillance might be considered as a surveillance. Environmental. It means to study sewage water virologically, but with special [treatment] plants and in special territories, which might be considered as high risk, in the Netherlands.

That was accepted. Countries were free to see what they were going to do. The majority of countries, apparently, they started to work on AFP surveillance, to do it better. I mean the detection of paralytic cases was already there. We know, for example, in Belgium there are plenty of pediatricians, so kids [with AFP] will be detected pretty [early]. But [the problem was] that doctors did not consider that it was necessary to send the [stool] samples [to a polio lab for

testing] or to inform somebody from the public health sector to come and to collect stool samples. That was the point, because I think I already mentioned that coordination is very important, even in surveillance.

To link these two pieces, it was important, and countries [had] done it differently. In certain countries, it was the public health staff who were coming and collecting this one [the stool samples]. In certain [countries], it was immunization services [collecting samples], if it existed. That's how it started to move.

The first meeting of the certification commission with [polio-free] countries—which were a long time polio-free, keeping this—that [meeting] was, I think, in 1999. By that time, we requested [that a few countries make] like a pilot study to work with that document of basic information and to bring whatever they felt was important for the commission to learn about their surveillance. That's how we started, and it was OK. The commission accepted this one.

With regards to visits, as far as I can recall, no one [single polio-free country] was visited by commission members, with the exception maybe of Spain, because it was a certain moment [of] recent importation. That's it. But for MECACAR countries, it was Turkey, visited. Tajikistan was not; Uzbekistan was visited. Then Kazakhstan was visited; Russia was visited. That's how the commission was working.

MCNAB: Yes. It was hard work.

OBLAPENKO: Yes, it was hard work, and what I was trying to do, because we discussed with Sir Joseph [Smith], who was the chairperson, what to do and how and what he would like the commission to do. I was proposing usually a few options in advance. We were preparing such a meeting a couple months sometimes or a few months, let's say, because sometimes he read it fast and then he responded [with] what his vision [was] and what he would like me to do, but sometimes he consulted other members of the commission: what they think about that or that topic which we're going to discuss. It was useful. Usually, the commission was well prepared in advance, and sometimes we gathered the commission before the meeting, and it was a day of free reading, if I can say [so]. **[01:35:00]**

Because to read even ten documents or five documents, it's not easy. Moreover, what Sir Joe [Joseph Smith] proposed was that two members of the commission would be nominated specially to read, carefully, the report and [would] be keeping special attention to the report. It does not mean that eight members [of the] commission will not read and only two will read. No, everybody was obliged to read all documents, but two members were receiving the task to read it carefully and to give their comments.

MCNAB: Yes, that's enormous. Were you comparing notes, also, with WPRO [Western Pacific Regional Office of the WHO], where they were also undergoing, I'm assuming, a similar process? A little bit earlier. But did you learn from each other?

OBLAPENKO: No, I didn't. I did not learn. We sometimes briefly discussed with Dr. Julian [B.] Bilous. But not too much. With regards to certification, no, we did not pay attention [to WPRO] during that time. We discussed more surveillance, mass vaccination.

MCNAB: How did you feel when you felt confident that Melik Minas, that young boy in Turkey, was the last case after one year, probably? What was going through your mind at that time?

OBLAPENKO: How I can say [it]? It was a good feeling, because we learned finally that we were coming to the happy end. Of course, it was a little bit [more delayed] than I estimated we could do it. But it was another story. But finally, we realized that it's done, and we practically came down to open the door to a polio-free world, to a polio-free Europe. It was good feeling. We discussed it with the team—I mean, our polio team—and we agreed that [there] should be a special press release on this topic. But that's it.

MCNAB: Yes, and then two years later, you were sitting [and] having the meeting with the commission. I read one interview you did with WHO where you talked about the night before, that you talked with the commission, that there was agreement that you'd go ahead. What was that night like? Do you remember the night before the ceremony?

OBLAPENKO: Night before the ceremony.

MCNAB: Was it the night before the ceremony? The night before the final meeting of the commission to decide to agree.

OBLAPENKO: It was an entire day. It was a long day, because our publication press release was ’99. In June 2002, yes. It was this. We invited a few countries to bring their reports to the commission. This was a long day because the commission was careful. [One] report was from Georgia. because there was a recent importation into Georgia. [One] report was from Bulgaria, also because of importation. [One] report was from Russia, because Russia is a huge country, and it was the Caucasian territories—Chechnya, which was affected by war, as you know—and the commission would like to be sure that it was good: vaccinated, well protected.

[One] report was, I believe, from the Netherlands, because—no, from Belgium, because Belgium, also—

It’s suddenly strange, but Belgium during the last stage was, for us, a very problematic country. I don’t know why. That’s why we decided to organize a meeting in 2001 in Belgium, later in the year, that the commission [would] be able to come down to the Ministry of Health to discuss and express to the Ministry what they were thinking about polio eradication. I don’t remember who from the commission [was] told. We like to hear at the meeting of the European Union that Europe did not receive the certificate because of Belgium. It was like that. Definitely, they were very much committed, promised to do whatever necessary, and they have done it. **[01:40:31]**

It was long day. Finally, I think around 5:00 or 6:00, we went down, and the commission started discussing general things about—still, exchanges is one.

Then Sir Joe said that we're going tomorrow to say something to countries. What will be our decision? The commission said the decision should be or will be positive. Sir Joe said, "That, I understand, but let's go around the table to see. Maybe somebody has a certain disagreement. Let's talk openly, because it's a very important issue." I made a short brief intervention, saying that I recall how in 1996, when we presented [for] the first time to the commission documents and plans and saying that [the time will] come when the commission will sign the certificate, they said, "We? We're going to certify that Europe is free of polio? It's not you?" I said, "No, we're going through this process in order to bring Europe to a polio-free situation, but [it is] you who is going to certify, because it's quite an independent body. It will be your responsibility."

Now, it's time. [Laughs] They went around and Sir Joe was asking—I don't remember who was next to him. I know that Walter was at another end of the table. He asked, "What do you think?" He said, "I trust George." [Laughs] They went around and they said, "Yes, no problem, no problem." What they discussed, what we're going to write down, but we [had] discussed already the certificate a few times—because they are scientists, and they [wanted] to be very specific [about] what to say, what to certify. They said, "We cannot certify that [in] Europe, the wild poliovirus does not circulate, because it may; we just did not catch it. But what we can say [is] that endemic wild poliovirus is not in Europe anymore." They were sure about that. We accepted this one. You can see on the certificate how they expressed and how they signed [it].

This was a very good day indeed, or evening. Then Donato said, "We have to do something to celebrate it, because tomorrow it will be a rather busy day." Not far from us was a very good restaurant named Riviera. We proposed that we may go and have a dinner. Everybody was

supportive, and it was five minutes to walk, only. We went, and Donato after all said that I approve this restaurant as a good Italian.

MCNAB: You had a celebration that night, and then another celebration the next day. You'd also said that you didn't sleep much that night, or you felt like you had probably lots of excitement and nerves and everything going into such a monumental occasion.

OBLAPENKO: Yes.

MCNAB: What do you remember from that? **[01:45:00]**

OBLAPENKO: Good music. It was very good music, indeed, because when we were preparing, we made it at the Carlsberg Glyptotek, in a big hall. I think we have it on our poster photograph, 2002 Europe polio-free. This is photograph from stone which at the Glyptotek when it is doorkeeper, it means the priest with polio. We decided to use it as a symbol for the invitation.

MCNAB: The certification process and the criteria developed for that also helped inform future certification, didn't it, of regions and how you could define, like you said, the language about what was being certified? Which has evolved a little bit over time as we face circulating vaccine-derived virus, etc. But I think the experience you made with Europe helped define how regions could be defined as polio-free.

OBLAPENKO: It is right. We were having very good relations, as I told you, with the regional certification commission. It was no misunderstanding, if I can say [so]. It was a little bit in the beginning when people were still not familiar with what to do, or how. But step by step, we tried to help them to solve their—not problem, but questions. Because for example, they thought we didn't know much about surveillance, so we organized a special meeting with our technical advisory group, and it was focusing on existing surveillance for communicable disease in Europe: how it goes, who reports what, where, how we analyze. This one, that's number one.

Second point was, as I already mentioned to you, after the Holland story, we discussed matters about environmental surveillance, how we can use it. Can we use it, generally? Because if the commission would not accept it, then [let's] just forget about this one. The commission accepted it as an alternative method [of surveillance], as optional. Such a kind of thing we discussed technically with the commission. Mark [A.] Pallansch [went] a couple of times, presenting. I think at one point we were thinking about using surveillance for enteroviruses, what we can learn from this one. After all, Mark Pallansch says nothing. We can not do [enterovirus surveillance], but there's nothing we can use from enterovirus surveillance for certification. It's too still vague and still not clear what does it mean.

All these technical methods, finally, we were bringing forward if the commission wanted to learn more about something, and that's why we arrived at the end with more or less similar vision.

[INTERRUPTION]

MCNAB: I think we're on the fourth tape now after another pause to change the battery. This is syncing up the next part of the interview with Dr. George Oblapenko. Thank you, George, for your patience with this.

I wanted to talk about partners a bit. You mentioned there's the main polio partners and then there's partners like MSF or Red Cross. What more would you want to say about them? Because they sometimes maybe are overlooked a little bit, because they do specific work in specific countries often. How much did they help during the MECACAR time? **[01:50:07]**

OBLAPENKO: It was a help. I cannot say how much, because it was different from one country to another, and we didn't try to compare or to count it a certain way. These partners which you mentioned which were members of the interagency immunization coordinating committee, they're key partners, if I can say [so]. But in addition to that, many countries were receiving support from Red Cross, for example. There were Red Cross volunteers which were taking part in national immunization days. They were very active, I can say, and countries accepted this one. But I cannot count it, because we never asked. It's maybe our fault, but we never asked countries to precisely describe what partners they received.

Then I told you about local volunteers. Sometimes there were local volunteers which a country was receiving from a national organization—and we don't know even names, but it was a time when the number of volunteers was growing, particularly in newly independent states. That's what I can say with regards to [that]. Then we received support for selected countries, from the Swedish government, for example, from SIDA [Swedish International Development Authority].

I was talking to one of my friends who was working in DANIDA [Danish International Development Agency], Danish interagency, and was asking him, let's say, to investigate possibilities to get certain support. But he thought that DANIDA [was] not interested in that, because DANIDA was more busy with something in Africa. That's it.

That's what I can say about partners in addition to key—what? Five, or? I don't know. I didn't count to CDC, UNICEF, Rotary. Red Cross we can count, definitely, as a good partner because many countries—in Ukraine, I believe also, Red Cross was involved at local activities.

MCNAB: Yes, as you say, they're not always recorded, or the reports don't always capture how much effort they've put in, but they're often there.

OBLAPENKO: Yes, exactly.

MCNAB: You talked about Steve Wassilak a bit. How about Galina Lipskaya? What was her influence? How did she influence the laboratory work?

OBLAPENKO: It's also a difficult question, because the laboratory network and this laboratory sensitivity and quality of laboratory work, it's very specific matters. I'm not a virologist, so I [relied] on Galina, because I learn very fast that she is well qualified person, very high-level quality. That's why we were having—weekly, practically, or sometimes twice a week—our operational meetings. Galina just reported to me general figures, what was required to know about the laboratory, certain problems. I know that a few times, Galina was trying to initiate

production of serum in a Moscow institution. I think it did not happen until now because she was very interested to do it, and with support maybe from Harrie van der Avoort, because it's a very specific and very difficult, if I can say, task. **[01:55:27]**

MCNAB: Very specialized.

OBLAPENKO: Very specialized, yes. But that's it. Very technical, very professional, and as we know from the final stage of our certification, very reliable person. High quality, that's what I can say.

MCNAB: Yes, and you, Steve, and she made a good team.

OBLAPENKO: Yes. What I did not mention, we were having more than that. I mean that me, Steve, Galina, it was like a key team, because then we started to grow a little bit. When we started to develop surveillance and when the WHO regional office learned about that, they decided to use our reporting AFP cases system as a tool to develop more automatic surveillance. We received more support, and there were a few people coming to help us, and it was technical staff and one epidemiologist from France. Francois [phonetic] his name was. I don't remember his family name.

Then particularly having support, it is a person with whom I started to work in 1993, I believe. It's Johanna Kehler [PhD]. I already mentioned this name but did not talk too much about Johanna. She was technical. No, administrative assistant. She was an administrative assistant of

mine. In difficult times when it was necessary to go to organize meetings and it was necessary to have administrative work, she was very, how I can say [it]—she demonstrated very good character and quality of work.

Can you imagine, for example, a meeting which has to be organized in Tashkent, [Uzbekistan]? There is no bank cooperation between any banks in Tashkent, because there is no bank system for transfer of money. Johanna was able to bring cash of $1,000 in order to pay participants on the spot, because they were coming sometimes without practically any money, any funds. That's not an easy job. She was responsible [for monitoring] our budget line, because finally we were receiving quite good support from different angles and at different times. It was necessary to learn when we received [funds], in order to use these funds, start already and whatever that was. Then she was monitoring our work and places' requests for giving more support for supplementary staff, which we called—I don't know, I think that's "floater," [that] they're called. Johanna was talking to floaters. At the final stage, I was coming or Steve was coming to assess a few candidates and to decide which will be taken by us. But that, also, she was doing. It's a lot of office work, if I can say [so]. **[02:00:06]**

MCNAB: Yes, the behind-the-scenes work that doesn't get noticed all the time.

OBLAPENKO: Yes.

MCNAB: We talked about this a little bit the other day, George, and you thought about this one some more. But your own personal style of how you work with people, how you coordinate, what do you think you brought to the effort that made it work so well?

OBLAPENKO: I think that I already mentioned this one, that we were trying to be well understood [through strong communication and planning]: what we will be doing next and when [one] matter was coming to the next, it's just not to say that yes, now we'll start AFP, but also to give more information and technical information and certain, if I can say [so], administrative information—when, what, who, as I told you just now, about collecting samples from cases of paralyzed children.

It was necessary [for] countries to demonstrate that there are a few options, and each country will decide what and how [plans] will be [carried out]. I remember our discussion in Turkey, for example, with regards to who will bring samples from regions—I mean the Turkish provinces—down to the Ankara laboratory, because there were immunization services. There were public health services already in place. Who will be responsible? Definitely, it's not a pediatrician. How will it be organized? All these matter. That's what we just mentioned. We didn't discuss from the beginning [of this interview], but we mentioned what will be the main topics for our discussion.

I believe that our planning—and when planning was already in the operational stage, we were [setting] exact dates when we were going to check it, what they're going to report to us. It was very helpful, because I started, I told you—maybe [I did] not tell [you]. I started my activities when there was no reporting on polio [cases] as a separate—[polio cases were reported as part

of] communicable disease. Some reports were coming to us, some not. But weekly reporting does not exist or did not exist during that time.

I started demanding [that polio cases be reported], and it was good that in early May [1995], it was the first meeting of the regional national EPI managers, when I presented myself and explained that [there would] be polio eradication program [activities] in the region. I told [EPI national managers] what we [were] going to do and requested [of] them, as a first step, to send weekly reports on polio cases. Or if [there was no] polio, just to say "zero polio," that's it. So-called zero reporting, we were fighting for. That's how it started. Then I prepared a special reporting list and all these methods, and it started to move.

Then, already in late 1990, I believe, it was the first meeting on AFP surveillance, the very first preliminary meeting, [in] which the big countries of Europe—I mean with regards to population—were invited. We discussed how it will be possible, will it be possible, and if [it was] not possible now, what we have to do so that it will be possible in future, because it was clear that it will be done. There were [countries]: UK [United Kingdom], Russia, Uzbekistan, France, Spain. We discussed [AFP surveillance], and I was pleased to learn that generally, [they felt]—all the countries—that it [would] be possible, but it [would] require more time and more preparation. **[02:05:02]**

It means that, step by step, I was trying to be a little bit leading: to brief countries and to inform countries—maybe "brief" is not [the] proper [word], because [they were briefed] already—but to

inform countries what will be done next and what [would be] expected. When the plan of action was ready, I sent it to all countries of my region.

MCNAB: To get their feedback.

OBLAPENKO: Yes, I was receiving feedback. Not from newly independent states, I believe—maybe from Russia I received [feedback]—but from Western countries. David [M. Salisbury, C.B.] wrote me a good letter with comments. Spain, Italy. Donato is a good epidemiologist, and Donato had a lot of experience. What I learned from Donato, Donato was involved in assessment of preparatory work. I think it was SARS [severe acute respiratory syndrome], yes? At a certain moment. He was involved, and he was going [to a] few countries in order to assess how countries [had] done this.

What he was doing, very simple, he was taking the plan of action, which was prepared at a national level, and then with this plan—he was going down to the hospital, for example, or to a health office, sometimes just at a capital, and demonstrated this plan. Do you know this document? No, first time we [had seen] it. That's all work. It's very often such a kind thing that would happen. I was very much afraid that it [would] be the same with polio plans of action, because when we were preparing national immunization days, in particular—when it was certain provinces, it required additional planning, careful planning. When you have only one or two cars, how do you distribute your vaccine? How do you distribute your teams? I think it came from my experience in smallpox eradication.

MCNAB: You're saying that you were very clear, I suppose, in what countries were to do, and you were very committed to helping them solve some nitty-gritty problems, as well. It was clarity and patience, probably, and willingness to get down into some details, too, that would be challenging, maybe.

OBLAPENKO: Patience, yes.

MCNAB: Yes. We have to go through now. We've talked about the lessons from MECACAR. You said the other day that the lessons from MECACAR were probably in a way the same as the lessons for the polio experience in Europe. But do you want to go through—any top three, would you say?

OBLAPENKO: For MECACAR?

MCNAB: From your experience with EURO, overall.

OBLAPENKO: EURO. I think with regards to EURO, definitely, it will be MECACAR, because MECACAR was key to success for European eradication. Then I will pick up from yesterday's discussion, or our Saturday discussion. It [one lesson learned] will be health field staff: motivated, interested to work, understanding what they're working for, how they're important in this activity. Then it is partnerships, because without good coordination of partnerships, also we would be not able to achieve polio eradication in Europe. It's maybe not only for Europe, but for Europe, I think, particularly. **[02:10:03]**

MCNAB: Yes. Steve Cochi had a question. He wondered if you would do it again if you were asked, and secondly, if you would do anything differently.

OBLAPENKO: Nowadays, I'm not willing to do it, because I think that I do not have strength to move out of my apartment.

MCNAB: Sure. But I guess if it was playback thirty years and you knew then what you know now, would you take the job?

OBLAPENKO: Yes, I can tell that nowadays I would like to do it. I love [polio eradication work], but I can't. But if without a joke, definitely. I think that I would be pleased to do it again, because it was a great experience. It was a great experience to work and to meet a lot of people, good people, and it's encouraging. Very much encouraging. Definitely.

MCNAB: Would you do anything differently?

OBLAPENKO: That's what I'm thinking. Differently: if [I had] the same knowledge, the same way, differently, I can see only a few things: one, the time between information, which I got from Olen Kew, about importation and my reaction should be shorter. I think that I lost a lot; I lost three years. That's number one.

MCNAB: You're saying the time between [when] you saw that presentation about importations and how important they were and the time that you decided we should do Operation MECACAR.

OBLAPENKO: Yes, right. I think that I was not ready to digest it properly, if I can say like that. Then I believe that I would increase the number of countries for MECACAR from very beginning. Because I told you there were countries, Caucasian, Central Asia. I mean from the European side. I think that I did not manage to bring Russia [in]. I tried, I discussed [it] a couple of times. But Russia was not ready, and they were having just few cases of polio. Russia decided to join MECACAR only the next year. Why? You know why? Because it was importation into Chechnya.

MCNAB: Importation into where?

OBLAPENKO: Chechnya.

MCNAB: Into Chechnya, OK.

OBLAPENKO: Chechnya. I do understand that it was difficult for Russia to understand epidemiological information because Russia was in a war during that time. But maybe I did not manage to explain myself. Maybe I did not [go] up enough to brief. Because Russia was in a reorganization during that time. That's a problem.

Second country, which I missed, also—it was Ukraine, definitely, because Ukraine joined only late in 1996 after importation into Albania. Also, there were three cases in Ukraine by that time, early I mean. It was something different. Maybe it was good to not just focus on countries where cases were very recently, because I started with countries where [there had been polio cases] recently, in 1992 and 1991, where virus was imported. **[02:15:08]**

I remember how Azerbaijan called me and told [me], "George, we do have a poliovirus outbreak and we do not have funds for vaccine." I called Nick Ward and explained, and I said, "Can you do something? How I should respond?" Nick talked to Steve Cochi, and when they learned about the amount of vaccine—I don't remember now, but Azerbaijan is not big country, so it [was] not a big amount. Nick told me, "Yes, George, we will be able to provide vaccine."

I called Dr. Abbas [S.O.] Velibekov [MD] and said, "Abbas, we will get vaccine from Geneva." He was so glad, because it's kids which he saw. We came with Harry [F.] Hull [MD] and with Nick in a couple of years to conduct courses there. There were still kids, [who] were coming through rehabilitation. It's very painful.

I think that that's my point. I should have analyzed more deeply, maybe countries to involve them—not just to think about money, but to start with the epidemiological need, because it would be possible, maybe—I don't know, but it's just my thinking—it would [have been] possible if I would [have increased] the number of countries. Definitely, it [would] require more vaccine and more funds, but as I learned—one epidemiologist from the U.S. told me, "Good projects get funded." With these two additions I can respond to Steve Cochi.

MCNAB: We're resuming again after a card switch for the fifth session. You had me a little bit emotional there, George, with the Azerbaijan story. When you see the kids, that's when you remember that there's data and charts and reports and meetings, but it's the kids that move people, I guess, to act, as well.

OBLAPENKO: Yes, sure.

MCNAB: You mentioned a sign that you saw in Geneva, and we talked about it a bit the other day, but I think we missed some of it, because our battery had run out. A poster, I think. It was something, "We're stronger because we're different." Can you talk about that again, and why that stayed with you?

OBLAPENKO: I don't know where it was written now, why it was written. But I saw it, and I stopped to read it again and to think about what is the meaning of that, to understand. I understood that it's a very important statement, just for my job—because it came to my mind, my work for smallpox—and it was now a new experience [in polio eradication], but it's still the same, where if we join our efforts, then it's very important to understand that we are all different. That's why if we will join our efforts, we are, too, strong. Because we may cover different issues, different issues of our activities. We can solve very big problems all over the world if we'll join our efforts. We're all different, but we are strong, that's why we are strong. That's how I understand it. **[02:20:11]**

MCNAB: Yes. What will it mean when the world ends polio? What does it mean for the world, and for humanity in a way?

OBLAPENKO: What do you mean? I think it means everything. You mentioned yesterday that there were forty people who were killed in Pakistan, yes? There were people who were killed in Tajikistan. They were doing their job. They were doing their job because they believe that their work is very important. At the same time, somebody was not thinking about that, or maybe was not interested to do something properly, and that's why kids were not immunized in time, and that's why this territory started to be a high risk territory, and that's why, finally, virus from India or Pakistan were coming to that area. That's the meaning; this is my understanding.

MCNAB: What does it mean about humankind in a way, in terms of what we can achieve? Maybe that links a bit to the point about we're different but we're strong.

OBLAPENKO: I really don't have now a clear vision of what might be different. But remember, I can tell you, I remember that Dr. [Jo Erik] Aswal [MD], at one of our meetings, said that he joined WHO because it was announced in the newspaper that WHO was going to fight malaria, eradicate malaria. He was a young doctor, so he decided to go, and he worked for malaria eradication for a few years. But he did not achieve his goal. Of course, partially, it was not achieved because technical strategies were not properly designed, and we did not have good technical chances, if I can say [so], from a technical point of view to achieve malaria eradication. But I believe that if we [had done] something differently—then malaria [would be] stopped. That's it, yes?

Malaria eradication was stopped. There were, again, many outbreaks of malaria. But I think that if we would continue to do something in the field with malaria, because we are still having a certain achievement, then it would be better.

Nowadays, we're going to eradicate polio. I believe that another new doctor, sitting somewhere in Norway or in Russia or in Czech Republic will read it and will start to work for international health. Different countries, different cultures, different human beings, different understanding. But if it will be organized in such a way that we better will understand each other, then we may achieve more.

I remember at one of our meetings of national immunization coordinators—it's a discussion [that was] started, that WHO had not done that, did not [do] that, or we cannot do this one. Then somebody said, "Look here. We blame WHO, but what has been WHO? WHO is [us]. We are WHO. If we [did not do a] proper job, it's not WHO, it's [us]." **[02:25:06]**

I think that sometimes we do not understand clearly [that] we may not deliver in our service or what we didn't achieve and try to blame another organization, whatever. If you understand better the statement, as I told you, "We are all different, that's why we're strong," so we were lucky that we were able to join our efforts and demonstrated that we are strong in smallpox eradication. We were very lucky that we achieved and demonstrated it in polio eradication, even [though] we still continue fighting with polio in certain areas. It's because we did not do it properly in those areas. If people in Afghanistan or in Pakistan still try to kill the vaccinator, it means that they don't understand something. Something important is missed for them. It means that we're

different, yes, but we're not strong, because they [are not] doing it properly. Something like that. It's not clearly maybe my expression. But that's what I was thinking.

MCNAB: I keep saying I have one more question, but one thing I wanted to—final question. You've written and published most of, more than 150 papers. Why was it so important for you to write and publish so much? Because you were working so much in the day. This would have also taken a lot of time. You were very committed to publishing.

OBLAPENKO: I can tell you, easily answering this question. My first publications were related to outbreak investigation, because I received good training, and I worked with one very good epidemiologist. I learned that we are doing a pretty fast outbreak investigation. He was joking sometimes, "Look here, George, we can sit down in our offices and can send our methodology," which is two, three pages, "and then get it back, study, and go. Outbreak will be controlled." But it's not the case, because you have to explain people how to analyze, how to compare, and what might be good methodology. My first publications were related just to my experience from different outbreaks.

Then I worked on the efficacy of the measles vaccine, which just appeared or was implemented in health services. It was also important, because there was a lot of concern about measles vaccine: why it is necessary, what to do. I was already aware, because I had read what does it mean, measle? Not just a rash. It's a lot of pneumonia, a lot of death, encephalitis, and all these matters. **[02:30:00]**

I was going [around] in Saint Petersburg, because it was Saint Petersburg—in Leningrad, sorry, in Leningrad—in many hospitals, in many meetings, with pediatricians, I was explaining why and so on and so on. That was another, how I can say [it], wave or stone [*sic*] in publication.

Then I moved to another area, which I learned, and I was very much excited. It's geographical epidemiology. Because I understood that from an epidemiological point of view, if you will study similar territories, and if you see that in one territory there are no cases and in another it's more, and if you clearly define that it is really so, then it will be the case to understand why, and that will be like a key for us.

Finally, for high-risk territories, I arrived in that situation. It's finally high-risk territories, that's the place which we have focused [on]—which [we] have to focus [on]—because there is not enough funds in public health, generally speaking. Not only [is it] true for Russia, not only true for the UK, I believe it's also not true for Canada. But we have to focus funds somewhere to [make] our work [more effective]. That's why high-risk territories appeared in my work.

I think that, finally, it was publications on WHO activities related to polio eradication, because there are still many concerns. Many people see or do not understand what it is. If you go around, if you'll ask, "Do you know that polio does not exist?" I believe that you will receive two or three percent who know. Maybe five. Not more than ten. Why? I don't know why. Maybe we do not have enough explanation or noise about this one. I believe we do not have [enough coverage] because it was the anniversary in PAHO [Pan American Health Organization], of polio eradication in PAHO. I don't remember that it was on radio news, on TV [television] news. OK,

PAHO may be far away, but there was also not any news about this one, about the tenth anniversary or fifteenth anniversary now. Last year, it was the fifteenth anniversary of a polio-free Europe. What did I hear on the radio? Somebody was killed; somebody was put in jail, somebody was—oh, come on.

MCNAB: When there was some good news that could have been mentioned.

OBLAPENKO: Yes. It's not only related to public health. Of course, I think that it's a lot of good information which does not appear anywhere—like, we have a lot of good doctors, which sometimes I can hear [about], a lot of good physics. Now, physics disappear. When it was the atomic bomb period, it was a lot about physics [in the news]. Now it is not. What is physics [as a field] doing? I don't know what they're busy now with.

MCNAB: George, do you want to add anything else? Do you have any other points that you think we missed, or do you feel like we've covered good territory? We have eight minutes left on our tape. **[02:34:55]**

OBLAPENKO: I don't know. I don't know. I can just tell back again, saying that I'm very grateful—that that was good luck for me to join WHO and to meet a lot of good people and to work with them and to learn from them many things and to be part of the team, or teams, because there are many teams that work together—finally, which understood that [working] together for a great purpose or to solve a big problem, it's a very good satisfaction. I think that's it.

MCNAB: OK, George, thank you so much for having us into your home and for spending so much time talking about the lessons you've learned and experience you've had that you can share with everyone on polio eradication. Thank you very much.

OBLAPENKO: Thank you very much, indeed.

MCNAB: OK, I think that's a wrap for that. **[02:36:49]**

[END OF INTERVIEW]