WHO-EM/POL/405/E

Report on the

Twenty-seventh meeting of the Eastern Mediterranean Regional Commission for Certification of Poliomyelitis Eradication

Cairo, Egypt
26–28 March 2013

World Health Organization
Regional Office for the Eastern Mediterranean

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1. INTRODUCTION

The Eastern Mediterranean Regional Commission for Certification pf Poliomyelitis Eradication (RCC) held its 27th meeting in Cairo, Egypt during the period 26–28 March 2013. The meeting was attended by members of the RCC, chairpersons of the National Certification Committees (NCCs) and national polio eradication officers of 20 countries of the Eastern Mediterranean Region (Afghanistan, Bahrain, Djibouti, Egypt, Islamic Republic of Iran, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, Palestine, Qatar, Saudi Arabia, Somalia, Sudan, South Sudan, Syrian Arab Republic, Tunisia and Yemen). The meeting was also attended by representatives from the Centers for Disease Control and Prevention, Atlanta (CDC), Rotary International and WHO staff from headquarters, the Regional Offices for the Eastern Mediterranean and South-East Asia and country offices for Afghanistan, Pakistan and Somalia. The programme and list of participants are attached as Annexes 1 and 2, respectively.

Upon the recommendation of last year's RCC, a two-hour meeting was held between RCC members and Chairpersons of the NCC on 25 March 2013 to discuss the implementation of the general recommendations of the 26th meeting of the RCC and the use of the modified formats for annual reporting. A note for the record about this meeting is attached as Annex 3.

The RCC meeting was opened by Dr Ali Jaffer, Chair of the RCC, who welcomed the participants and acknowledged their commitments to polio eradication. He expressed concern about the prevailing security situation and political instability in some countries of the Region, which was not only affecting the quality of polio eradication efforts in these countries but also threatened to affect quality in neighbouring countries. It was hoped that the Region would see the end of polio in the very near future.

Dr Samir Ben Yahmed, Director of Programme Management, welcomed participants on behalf of Dr Ala Alwan, WHO Regional Director for the Eastern Mediterranean and delivered a message from him. In his message, Dr Alwan referred specifically to the emergencies facing the Region which were affecting public health programmes including polio eradication and emphasized the need for comprehensive solutions and coordinated efforts between neighbouring countries. He highlighted various efforts and initiatives being made by the Region to address chronic problems as well as new challenges.

2. REGIONAL OVERVIEW OF POLIO ERADICATION

Dr Tahir Mir, WHO Regional Office for the Eastern Mediterranean

In the Eastern Mediterranean Region, 19 countries have been polio free for more than five years, two countries (Sudan and South Sudan) were re-infected in 2008 and have been polio free since 2009 (i.e. less than 5 years) and two countries

(Afghanistan and Pakistan) are polio endemic. Circulating vaccine derived polioviruses (cVDPVs) are the emerging challenge for the Region.

In response to a 2012 World Health Assembly resolution (WHA65.5) on intensification of the global poliomyelitis eradication initiative, the Regional Office together with partners moved into an emergency modus operandi to build the technical capacity of polio endemic countries (Afghanistan and Pakistan), high risk countries (Somalia and Yemen) and other priority countries (South Sudan, Syrian Arab Republic, Egypt and Djibouti). During the Fifty-ninth Session of the WHO Regional Committee for the Eastern Mediterranean, Member States pledged to "unite for a polio-free Eastern Mediterranean Region" through concerted efforts to solve key political, societal, security and financial challenges to the eradication of polio. An consultation was held with Islamic scholars in Cairo to explore ways to demonstrate solidarity and responsibility among Islamic communities to finish polio in the remaining three Muslim countries. In Afghanistan and Pakistan, the Head of State has appointed a focal point and constituted a task force to oversee the national efforts to eradicate poliomyelitis.

Pakistan after remaining in a continued outbreak situation from 2008 to 2011, showed significant progress in 2012 with 70% decrease in polio cases as compared to 2011. The last wild poliovirus type 3 isolated from an AFP case was reported from Khyber in April 2012 and there is also no isolation of P3 from environmental samples. In 2012, 16 cVDPVs were reported, the majority from Killabdulla and Pishin districts of Baluchistan, bordering with the southern region of Afghanistan. In 2013, 5 polio cases have been reported to date, as compared to 15 during the same time period in 2012, and 2 cVDPVs. There are three poliovirus reservoir areas in the country: Gadap in Karachi: Khyber in the federally Administered Tribal Areas (FATA); and Quetta block (Quetta, Pishin and Killabdulla in Baluchistan). Despite the gains made in two out of the three reservoirs, the situation remains fragile in all the three reservoirs.

The Government of Pakistan and partners have developed an emergency action plan for 2013 based on the lessons learnt, identifying areas for strengthening and strategies for achieving maximum gains during the low season. A series of security incidents targeting workers of the poliomyelitis eradication programme, and the suspension of OPV immunization activities since June 2012 in two agencies of FATA, are threatening to impede further progress. Federal and provincial elections in 2013 could also divert attention from the eradication programme.

The Government of Afghanistan launched a national emergency action plan for polio eradication, focused on ownership, oversight and accountability. On the advice of the Independent Monitoring Board (IMB), an independent mission reviewed the programme and recommended to emphasize a district focus, along with communication, enhancing technical support and strengthening monitoring mechanisms. 37 polio cases were reported in 2012 compared to 80 in 2011. There are

11 cVDPVs of type 2 reported from the southern region. The last wild poliovirus of type 3 was in April 2010.

As of March 2013, only one polio case was reported to date. Two cVDPVs were reported from Nadeali district of Helmand. The Technical Advisory Group for Afghanistan has noted the strong and sustained political commitment and has linked the success with: oversight and accountability by the government at all levels; full involvement of district as well as provincial governors; and implementation of new operational and communication initiatives. Weak management and insecurity continue to complicate full strategy implementation in the low performing districts of the southern region. The window of opportunity needs to be seized during the low transmission time, as significant uncertainties lie beyond with national elections and withdrawal of the ISAF in 2014.

In Afghanistan, there are four important epidemiological risks: continued poliovirus circulation in south; outbreaks in the eastern region (Kunar) and south-eastern region (Khost and Paktiya); response to cVDPV2; and preventing poliovirus circulation in rest of country. Success depends on the progress in two provinces: Kandahar and Helmand.

In Egypt, NSL1 was isolated from sewage samples collected in December 2012 from two areas of (Al Haggana and Al Salam) of Greater Cairo. Genetic sequencing results show that these viruses are related to one in Sindh, Pakistan. Follow-up samples collected are negative and no case of paralytic polio is reported among children. The Government of Egypt and the GPEI partners immediately launched an urgent response (frequency of sampling increased, initiated contacts sampling). supplementary immunization activities were conducted in February (Al Haggana and Al Salam), March (Greater Cairo) and planning is now under way for an April national immunization day campaign (NID).

In 2012, the regional poliovirus laboratory network processed nearly 27 000 specimens from AFP cases, contacts and healthy children. 94% of specimens had culture results within 14 days, and 99% had intratypic differentiation (ITD) results within 7 days of positive virus culture. In Afghanistan and Pakistan, wild poliovirus genetic clusters of type 1 have been reduced from 16 in 2010 to 2 in 2013. A single wild poliovirus 3 cluster was last detected in April 2012.

In Yemen, cVDPV of type 2 and 3 are indicative of the large population immunity gap resulted from chronic low routine immunization and lack of high-quality supplementary immunization activities. Rapid outbreak assessment was conducted to determine the quality and sensitivity of surveillance. In response to cVDPV outbreak, Yemen conducted NIDs, in January and June 2012, and January 2013 in addition to case response and adding OPV with measles campaigns. Supplementary immunization activities are planned in April and May 2013 in six governorates. An action plan was developed to prioritize the activities as per

recommendations of the Horn of Africa Technical Advisory Group and outbreak assessment.

In Somalia, around 0.8 million target children in South–Central Somalia are not reachable to vaccinate since 2010 resulting in VDPVs circulating in this zone. Some areas have recently become accessible. The country team has developed a 6-month emergency action plan for South–Central Somalia. This includes conducting three vaccination rounds in existing accessible areas and four rounds in newly accessible areas. All opportunities are being used to reach children in inaccessible areas. From December 2012 to January 2013, at least one round was conducted in 22 newly accessible districts and twice in 8 districts. AFP surveillance is being strengthened through the introduction of community surveillance in South–Central Somalia. An international AFP surveillance review was completed in March 2013.

In summary, interrupting transmission in Afghanistan and Pakistan remains the top priority in the Region. By maximizing the benefit of low transmission and fully implementing the emergency approach, maintaining high population immunity and maintaining certification standard AFP surveillance, it is hoped to see the end of circulation in the two countries. In polio free countries, and in countries affected by insecurity and recent political instability, the main directions would be to undertake preventive campaigns and maintain highly sensitive AFP surveillance systems to ensure capability to early detect importation. The risk assessment model would be an excellent tool for subnational risk assessment. Optimizing PEI/EPI collaboration to improve the routine immunization coverage and strengthening coordination and collaboration with other WHO offices, particularly for the Horn of Africa, will be priorities.

3. GLOBAL UPDATE OF POLIO ERADICATION

Dr Rudolf Tangermann, WHO headquarters

In February 2012 WHO removed India officially from the list of polio-endemic countries, after one year had passed since the last wild poliovirus confirmed case had been reported in January 2011. As well the overall polio situation globally at this time looks better than in any year previously.

Continued transmission in the three remaining endemic countries (Afghanistan, Pakistan and Nigeria) and transmission following importation into several other previously polio-free countries led the World Health Assembly in May 2012to declare polio eradication a global public health emergency. The main partners in the Global Polio Eradication Initiative (GPEI), as a matter of urgency and in close collaboration with governments of the affected countries, put in place global and national emergency action plans to address the remaining obstacles in interrupting transmission. These plans include the establishment of improved high-level political oversight, involvement of other government sectors, a rapid increase of technical human resources in affected countries, and, where appropriate, an extensive revision

of field operations, particularly in Nigeria, where lessons learned in India in implementing high quality NIDs were used to improve supplementary immunization field operations.

As a result, the number of cases and extent of transmission decreased significantly between 2011 and 2012. Also, the continued use of bivalent (type 1 + 3) OPV led to a major reduction in the extent of wild poliovirus type 3 transmission to few remaining areas of north-west Nigeria and only one remaining focus in north-west Pakistan. As of end-March 2013, no wild poliovirus 3 has been reported anywhere in Asia for almost 1 year and from Nigeria for more than 4 months.

However, in addition to wild poliovirus, the relative burden of paralytic polio cases caused by circulating vaccine-derived poliovirus (cVDPV) has increased; cVDPV transmission is persisting in northern Nigeria, Chad, Somalia and possibly Kenya, and in southern Afghanistan and adjacent areas of Baluchistan in Pakistan.

In November 2012 the Independent Monitoring Board for Global Polio Eradication (IMB) recommended that the International Health Regulation Expert Review Committee urgently issue a standing recommendation by May 2013 that would introduce pre-travel vaccination or vaccination checks for all travellers from the last three endemic countries (Afghanistan, Pakistan and Nigeria) until national transmission is stopped. No country should allow a citizen from any endemic polio country to cross their border without a valid vaccination certificate.

Since the tragic murder of 9 field polio workers, most of them women, in 3 provinces of Pakistan at the end of 2012, followed by the killings of polio vaccinators in northern Nigeria in February 2013, serious security concerns have emerged as a key obstacle to further improving the quality of polio supplementary immunization activities in critical remaining endemic areas. The programme has already reacted to this challenge by forming new security committees, putting in place operational adjustments, and particularly by garnering the support of concerned community groups and of Islamic leaders in the affected countries.

Lastly, a new 2013 to 2018 Global Polio Eradication and Endgame Strategic Plan has been developed, with the overall objective of eradicating and containing all wild, vaccine-related and Sabin polioviruses. In this context, preparations are being made for the sequential withdraw or cessation of oral poliovaccine strains, starting with OPV2 withdrawal by replacing tOPV with bOPV for routine immunization; depending on achieving a number of key prerequisites, globally synchronized OPV2 cessation may already occur during the first quarter of 2016.

In order to mitigate the risks associated with stopping the use of type 2 OPV, the GPEI is preparing to make sufficient affordable inactivated poliovaccine (IPV) available to allow all OPV-using countries to introduce at least one dose of IPV into routine immunization programmes half a year before OPV2 cessation.

4. INTERREGIONAL COORDINATION

4.1 Update on polio eradication in the WHO European Region

Professor David Salisbury, Chairperson of the European Regional Certification Commission

The last outbreak of polio in the WHO European Region was in 2010, originating in Tajikistan and spreading to Russian Federation, Turkmenistan and Kazakhstan and involving close to 500 cases. Following rapid and widespread interventions, the outbreak was halted within six months. No further wild virus cases have been reported.

The Regional Certification Commission for Europe continues to meet annually to review the national update reports from the fifty three countries. The region is divided into epidemiological and geographic blocks and reviewed on the basis of surveillance, vaccination, laboratory services, containment and importation preparedness. For surveillance, some countries continue with “classic” AFP surveillance, some countries are undertaking enterovirus surveillance and others are undertaking environmental surveillance (or combination of these). Surveillance indicators appear stable. Countries in the western part of the region are using just IPV, central European countries are using OPV/IPV schedules and countries in the east of the region continue to use OPV. As well as scrutinizing the importation preparedness plans, the RCC has been encouraging countries to test their plans through table top or other exercises. The RCC continues to undertake risk assessments and in 2012 identified the following countries as high risk: Uzbekistan, Ukraine, Georgia, Turkey (south-east only), Russian Federation (North Caucasus), Greece, Romania and Bosnia and Herzegovina.

4.2 Update on polio eradication in the South-East Asia Region

Dr Patrick O’Connor, WHO Regional Office for South-East Asia

The last wild poliovirus case detected in India was on 13 January 2011 more than 24 months ago – this is the longest polio-free period in the South-East Asia Region. The only other country with recent wild poliovirus cases was Nepal, with two separate importations from India in 2010 – there have been no polio cases detected for more than 30 months. The nine other countries in the region have remained polio-free for more than 5 years. However, all countries in the region remain susceptible to importations as long as there is globally wild poliovirus. The region is firmly on track for polio-free certification in February 2014, three years after the last reported cases in the region.

In 2013, the South-East Asia Region is focusing additional efforts and resources towards polio-free certification and phase-1 laboratory containment activities. Members from the Regional Certification Commission and WHO-Secretariat will be

visiting each country to review all certification documentation and advocate with the respective ministries of health for continue support of polio eradication activities.

Success and lessons learned in building a highly sensitive surveillance network for polio have been expanded to include strengthening surveillance for other vaccine-preventable diseases and monitoring routine immunization activities. Strategies adopted to stop polio transmission in India represent a multi-pronged approach. Eradication challenges have been approached systematically with specific programmes: the 107 high-risk block initiative in historically polio endemic areas of western Uttar Pradesh and central Bihar has focused on rapid improvement in sanitation, availability of clean water, hygiene and prevention/control of diarrhoea; migrant populations that have played an important role in sustaining and spreading polio have been targeted for surveillance and immunization activities; and the introduction of bivalent oral polio vaccine (bOPV) has provided an additional tool for epidemiologically based supplementary immunization activities.

5. UPDATE ON THE STATUS OF VACCINE DERIVED POLIOVIRUS (VDPV) IN THE EASTERN MEDITERRANEAN REGION

Dr Humayun Asghar, WHO Regional Office for the Eastern Mediterranean

Vaccine-derived polioviruses continue to be detected in the Region. They are gaining relatively more importance as causes of paralysis as the number of cases due to wild polioviruses decreases, and they have serious implications for polio eradication efforts. The three types of VDPVs continued to be detected in the Region.

Immune deficient VDVPs (iVDPVs) have been detected in 8 countries among immunodeficient children. Through the ongoing VDPV surveillance pilot project 2011–2012 in Egypt, 3 iVDPV (one each of the 3 types) were detected.

The cVDPVs causing outbreaks of paralytic cases continued to be reported. An outbreak started in September – October 2012 in the bordering districts of Helmand and Kandahar in Afghanistan and Killabdulla of Baluchistan, Pakistan, resulting so far in 17 cases in Pakistan and 12 in Afghanistan. In this shared reservoir more than one lineage of the virus was isolated. The persistent circulation in these areas for more than six months relates to poor performance of immunization and inaccessibility problems. It threatens to spread to other low performing districts.

In Somalia, the cVDPVcases detected in 2012 and 2013 were reported from the South–Central Somalia and an importation related to Somalia cVDPVs was reported from Kenya.

In Yemen an outbreak of cVDPV was reported in Saada in which both cVDPV2 and cVDPV3 were detected, denoting low immunity.

The ambiguous VDPVs (aVDPVs) detected during 2012 were from sewage water samples in Egypt.

As regards wild poliovirus importations, two wild poliovirus type 1 closely related to strains circulating in Northern Sindh, Pakistan, were isolated from two sewage collection sites in Cairo, Egypt. This represents a serious threat for potential spread. The immunization response of Egyptian authorities was initiated rapidly and covering a very large population.

6. DISCUSSION OF THE REPORTS

The RCC received reports from all countries of the Region. The National Certification Committee chairpersons and responsible officers for polio eradication from Iraq and United Arab Emirates were not able to attend the meeting. The RCC decided to review their reports and send its comments to the chairperson of the NCCs.

6.1 Annual updates

6.1.1 Bahrain, Islamic Republic of Iran, Jordan, Kuwait, Lebanon, Oman, Palestine, Qatar, Saudi Arabia, Sudan, South Sudan and United Arab Emirates

The RCC commended the NCCs for their attention to ensure full implementation of the polio eradication strategies and for their validation of documents presented to them by the national programme. The NCC efforts and the comprehensiveness, accuracy and completeness of the reports and the clear presentations made gave the RCC confidence that these countries continued to be polio free during 2012.

A few comments were made on each of the reports, which need amendments to ensure that the record is updated.

The RCC, therefore, decided to provisionally accept the reports and relay the comments to the chairpersons of the NCC. Formal acceptance will be made upon receipt of the amended reports taking into consideration the comments of the RCC.

6.1.2 Countries facing political instability and security problems (Egypt, Iraq, Libya and Syrian Arab Republic)

The RCC expressed concern that the prevailing security situation in these countries is affecting the quality of polio eradication efforts. These effects have been of a varying degree in these countries.

The RCC acknowledged the efforts being made by the national authorities to limit these impacts and to maintain polio-free status.

The RCC advised the NCCs to assess the impacts of the security situation on the various elements of the polio eradication programme and indicate them in the annual updates together with actions taken to mitigate their impacts.

The RCC, having reviewed the annual updates of these four countries and the comments of the NCCs, agreed with the NCC conclusions that the countries remained polio free during 2012.

The RCC, therefore, provisionally accepted the reports and will relay its comments to the NCC chairpersons. Final acceptance will be made upon receipt of the amended reports taking into consideration RCC comments.

6.1.3 Djibouti

The RCC acknowledged the frank statements made by the chairperson of the NCC about the challenges and shortcomings of both the AFP surveillance and immunization activities which are also clearly reflected in the report. It is also concluded in the report that the surveillance in Djibouti is not sensitive enough to timely detect importation or VDPV emergence. The above, together with risk assessment made by the Regional Office, signify that Djibouti is at high risk of polio following importation. As a result, the RCC was not confident that Djibouti remained polio free in 2012.

The RCC supported the recommendations made by the NCC to the Ministry of Health and called on them to continue their efforts to achieve an effective surveillance and immunization both routine and supplemental. The RCC reaffirmed its request to WHO to help the Ministry of Health strengthen the technical capabilities of the programme and together with other partners ensure the urgent needs of the polio eradication programme.

In order to ensure better comprehensive annual updates, the RCC made several comments on the 2012 report that will be relayed to the NCC chairperson to take into consideration in updating 2012 report and in future reports.

6.1.4 Morocco

The RCC noted with concern that the NCC did not give the necessary attention to its comments on 2011 report as indicated by repeating the same weaknesses in 2012 report. The RCC was also concerned that apparently the NCC efforts were limited to holding two joint meetings of EPI, surveillance and laboratory staff.

The data presented during the meeting and those included in the report fall short of convincing the RCC that the standard of the ongoing activities is capable of maintaining the polio-free status of Morocco. As well, it is not able to early detect importations or deal with them.

The RCC noted with satisfaction that H.E. the Minister of Health is committed to polio eradication. This strong commitment should be utilized by both the NCC and WHO to push for the revitalization of the national polio eradication programme

particularly the surveillance aspects in order to reach the standard required for certification of polio eradication.

In order to achieve better annual updates, the RCC made several comments on the 2012 report that will be relayed to the NCC chairperson to take into consideration in updating 2012 report and in future reports.

6.1.5 Tunisia

The RCC noted with concern that some of the issues raised for several years have not been addressed, particularly the need to increase the number of reporting sites for AFP to be at least one in every district.

The RCC noted that there are many indicators denoting weakness in surveillance, particularly in some provinces, and called on the NCC to ensure that the national programme fully implements the 2010 surveillance review recommendations.

The RCC expressed the hope that its concerns about surveillance will be addressed by the national polio eradication programme and that the NCC follows up closely to ensure that the various surveillance elements reach to the standards needed for certification of polio eradication.

The RCC made several comments on the update that will be relayed to the chairperson of the NCC to update 2012 report and note them in future reports.

6.2 Final national documentation for regional certification

6.2.1 Somalia

The RCC noted with satisfaction that the polio eradication programme in Somalia has been continuously invigorated with new ideas and initiatives, the last of which is the emergency plan for the first six months of 2013 which is meant to switch the programme back into emergency mode.

The RCC noted that the NCC has not been established yet and expressed the hope that this would be composed very soon.

The RCC noted that the presentation made during the meeting included more information than did the report and advised that the additional information also be incorporated in the report.

Although there is some indication that some of the pool of unvaccinated children is now accessible, the RCC remains very concerned about grave consequences should the wild virus be introduced into this unvaccinated population. It was noted that polio partners believe that Somalia is polio free.

Recognizing the significant value of the data that should appear in the final national document, the RCC did not accept the document submitted as it did not comprehensively and accurately cover all items expected to be included in the final national document. It requested the NCC chairperson to review the document using available data at the national level and if needed seek WHO assistance in obtaining more data. The RCC will review the final national document during its meeting next year.

6.2.2 Yemen

The RCC reiterated its previous comment on the value of this document and the need to be comprehensive and accurately cover all aspects of polio eradication in the country.

The RCC noted that the updated document submitted this year is much better than last year, yet it is still missing some important information. It called on the NCC to complete the document and to ask the Regional Office to provide them with missing information available with WHO, such as the number of cases of poliomyelitis since 1988 including those clinically diagnosed.

Comments on the missing information and those requiring revision will be communicated to the NCC chairperson.

The RCC feels that when this document is updated, the NCC should be requested to begin submitting annual updates.

6.3 Provisional national documentation for certification

Afghanistan and Pakistan submitted provisional national documentation to the RCC. The RCC acknowledged the very frank and comprehensive presentation and in-depth analysis of the epidemiological situation. It recommended to both Afghanistan and Pakistan programmes to continuously update their national documentation until the time comes to submit the basic document. Until this time the NCCs are requested to submit to the RCC a summary of the developments in the previous year.

6.3.1 Afghanistan

The RCC commended the continued government commitment as reflected in the endorsement of the national emergency action plan and called for its full implementation. The RCC emphasized the vulnerability of the programme, particularly in the south where the wild poliovirus continues to circulate and the prevailing security situation and management issues are not permitting full implementation of the eradication strategies.

6.3.2 Pakistan

The RCC shared the concern of the NCC about suspension of independent monitoring of the supplementary immunization activities and expressed the hope that it will be resumed soon.

The RCC, while continuing to be satisfied with the performance of the polio laboratory, advised it to expedite the longstanding pending activity of containment in the country.

7. OTHER MATTERS

The RCC expressed concern that the prevailing security situation and political instability in a number of countries in the Region, resulting in inaccessibility of some areas, disturbance in the health services delivery, population movement, shortage of resources, is affecting the quality of polio eradication efforts in these countries and threatens to affect the quality in neighbouring countries who are receiving refugees from affected countries. The RCC recommended to the Regional Director to hold an urgent meeting for the Syrian Arab Republic, Lebanon and Jordan to assess the situation and discuss ways to address it including the necessary preparedness for any emergency that may happen due to importation of wild viruses.

The RCC expressed agreement with the recent IMB recommendation on pre-travel vaccination against polio and polio vaccination for travellers from endemic countries. The RCC requested the Regional Director to raise this issue with Member States in advance of the WHA.

The RCC noted the delay between taking environmental samples and obtaining final results reaching several months hence affecting timely response particularly to importations and appearance of cVDPV. The RCC was pleased to note that the Regional Office has initiated adequate measures to address in the delay of transportation and finalization of laboratory results of environment samples.

The RCC was concerned about the increasing number of cVDPV, denotes weak performance of routine immunization and low quality supplementary immunization activities in the affected area, and emphasized that urgent action should be taken similar to that following reporting of a wild polio virus.

Date and venue of next meeting

The next meeting is scheduled to take place on 21–24 April 2014.

Regarding the venue for the next meeting, the RCC noting the concern of some of the participants about obtaining an entry visa for Egypt suggested holding the next meeting in one of the following venues.

- Beirut, Lebanon
- Muscat, Oman
- Dubai, United Arab Emirates

Additional meeting for RCC members

The WHO secretariat is considering holding a meeting with RCC members, possibly in September 2013, to review and agree on issues related to annual report formats and development of a checklist to facilitate to the monitoring of country reports by NCC chairpersons as well as matters related to the way forward for the eventual regional certification of polio eradication.

Annex 1

PROGRAMME

Tuesday, 26 March 2013

08:00–08:30	Registration
08:30–08:45	Opening session Introductory Remarks, Dr A. Jaffer, RCC Chairperson Message from Dr Ala Alwan, Regional Director, WHO/EMRO Adoption of Agenda
08:45–09:05	Implementation of the recommendations of the 26th RCC meeting
09:05–09:20	Regional overview of polio eradication Global update of polio eradication
09:20–10:30	Discussion
10:30–11:30	Interregional Coordination EURO SEARO Discussion
11:30–14:00	Presentation and discussion of annual update reports of Djibouti, Morocco and Lebanon
14:00–15:45	Presentation and discussion of annual update reports of South Sudan, Sudan and Libya
15:45–17:15	Presentation and discussion of annual update reports of the Saudi Arabia, Kuwait and United Arab Emirates
17:15–18:15	Private meeting of the RCC

Wednesday, 27 March 2013

08:00–08:30	Status of VDPVs in the Region and WPV1 importation to Egypt
08:30–10:30	Presentation and discussion of the annual update reports of Qatar, Oman and Bahrain
10:30–14:00	Presentation and discussion of annual update reports of the Jordan, Syrian Arab Republic, Egypt, Islamic Republic of Iran and Iraq
14:00–15:00	Presentation and discussion of annual update reports of Palestine and Tunisia
15:00–16:00	Presentation and discussion of final national documentation for regional certification of Somalia
16:00–17:00	Private meeting of the RCC

Thursday, 28 March 2013

08:00–08:45	Presentation and discussion of final national documentation for regional certification of Yemen
08:45–10:15	Presentation and discussion of provisional national document of Afghanistan
10:15–11:15	Presentation and discussion of provisional national document of Pakistan
11:15–12:15	Private meeting of the RCC
12:15–13:15	Closing session and concluding remarks

Annex 2

LIST OF PARTICIPANTS

Members of the Eastern Mediterranean Regional Certification Commission

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Mrs Wallaa Elmoawen, Senior Administrative Assistant, Poliomyelitis Eradication Programme, WHO/EMRO

Annex 3

NOTE FOR THE RECORD

MEETING OF THE EM REGIONAL COMMISSION FOR CERTIFICATION (RCC) OF POLIOMYELITIS ERADICATION AND CHAIRPERSONS OF THE NATIONAL CERTIFICATION COMMITTEES (NCC)

Cairo, Egypt, 25 March 2013

Upon last year's RCC recommendations a two hours meeting was held with the chairpersons of the NCC on 25 March 2013 to discuss with them the implementation of the general recommendations of the 26th meeting of the RCC and the feedback on the modified formats for annual reporting which were made upon the request of the RCC and NCC Chairs.

The RCC noted with satisfaction the modifications made in the formats of the various reports which have ensured modifications and clarifying ambiguities. It however, noted the need for a few further modifications to ensure clarity and requested the secretariat to affect these changes. The RCC reiterated its recommendation for the translation of these reporting documents into Arabic and French while re-emphasizing that reports continue to be submitted in English.

The RCC noted that some country reports are still not strictly following the given guidelines and requested the NCC chairpersons to comply with RCC recommendations in their future reports. In this regard the NCC chairpersons suggested developing a checklist to facilitate comprehensive monitoring of completion of reports as well appropriate functioning of the NCC (as per terms of reference). The secretariat will develop a monitoring tool and share with RCC members for their comments and endorsement, and NCCs will start implementing for 2013 reports.

The RCC noted that one of the reasons for incomplete and sometimes inaccurate responses to some of the items in the formats is due to change in the NCC membership without proper briefing on previous activities related to national polio eradication programme. The RCC reiterated its recommendation that each NCC ensures having a full record of their activities since their establishment and appreciated WHO secretariat readiness to provide NCCs with any relevant background materials and record of past activities. A specific request was made to provide NCC chairpersons with the criteria for accreditation of laboratories carrying out polio work.

Concerning the functionality of the NCC, the RCC reiterated that the NCC is an independent voluntary body nominated by the highest national authority to have an oversight on all polio related activities in the country. So any constraint faced by them

in the implementation of their terms of reference, should be referred to these national authorities to ensure a solution. The RCC further emphasized that once the NCCs accept the responsibility they should be prepared to give the adequate time and put efforts to fulfil their terms of reference and facilitate pro-actively the polio eradication activities.

The RCC support the request of NCCs that WHO staff and experts, during polio eradication visits and missions to Member States, should involve the NCC. The NCC chairpersons/members request that some of the RCC members may join these visits whenever is appropriate.

The NCC chairpersons/members expressed their satisfaction about holding this pre-RCC meeting and requested that in future its duration be extended to half a day.

RCC members expressed their willingness to visit countries where polio eradication efforts need to be boosted.

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