

WHO-EM/POL/409/E

Report on the

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

Amman, Jordan
22–24 April 2014



World Health
Organization

Regional Office for the Eastern Mediterranean

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1. INTRODUCTION

The Eastern Mediterranean Regional Commission for Certification of Poliomyelitis Eradication (RCC) held its 28th meeting in Amman, Jordan, during the period 22–24 April 2014. 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 Region (Afghanistan, Bahrain, Egypt, Islamic Republic of Iran, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, Palestine, Qatar, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates and Yemen). The meeting was also attended by representatives from the U.S. Centers for Disease Control and Prevention (CDC), and Rotary International and by WHO staff from headquarters, the Regional Offices for Africa and the Eastern Mediterranean, and country offices for Afghanistan and Pakistan. The programme and list of participants are attached as Annexes 1 and 2, respectively.

Upon the recommendation of last year's RCC meeting, a half-day meeting was held between RCC members and Chairs of the NCCs on 21 April 2014 to discuss the implementation of the general recommendations of the 27th meeting of the RCC and the use of the modified formats for annual reporting and to present the new NCC guidelines/checklist to NCC Chairs.

The RCC meeting was opened by Dr Yagob Al Mazrou, Chairman 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 is not only affecting the quality of polio eradication efforts in these countries but also threatens to affect quality in neighbouring countries. The Chairman expressed the hope that the Region would see the end of polio in the very near future.

Mr Christopher Maher, Manager Poliomyelitis Eradication Programme and Emergency Support, WHO Regional Office for the Eastern Mediterranean, delivered a message on behalf of Dr Ala Alwan WHO Regional Director for the Eastern Mediterranean. In his message, Dr Alwan referred specifically to the emergencies facing the Region which were affecting public health programmes including polio eradication. He expressed deep concern over the outbreak of poliomyelitis in Somalia, Syrian Arab Republic, the evidence of renewed poliovirus circulation in Egypt and occupied Palestinian territory identified through environmental surveillance and the uncontrolled poliovirus transmission in parts of Pakistan. He emphasized the need for comprehensive solutions and coordinated efforts between neighbouring countries and referred to various efforts and initiatives being made by the Regional Office to address chronic problems as well as new challenges.

Dr Ahmed Katitat, Director Hospitals Management, Ministry of Health, Jordan, delivered a message on behalf of H.E. Dr Aly Nahla Hyasat, Minister of Health in which he referred to the priority given by the Government of Jordan to polio

eradication not only nationally, but also regionally and globally. He noted that Jordan has a strong national surveillance system that was capable of early detection of any importation and appropriately addressing it. In addition, the government continued extending support to eradication efforts in close collaboration with WHO and UNICEF.

2. OVERVIEW OF POLIO ERADICATION IN THE REGION

2.1 Status of polio eradication in the Region: challenges to interrupting transmission and the response

Mr Christopher Maher, WHO Regional Office for the Eastern Mediterranean

With regard to polio endemic countries, Pakistan reported 93 polio cases in 2013 as compared to 58 in 2012. In 2014, it reported 50 cases to date (6 on the same date in 2013). 85% of the cases are from FATA. In Pakistan more than 500 000 children are inaccessible for vaccination in North and South Waziristan (ban on vaccination) and Khyber Agency (military operations) of FATA and Peshawar (attacks/intimidation) of KP. In 2014, more than 90% of polio cases are from KP/FATA.

Afghanistan reported 14 polio cases in 2013 as compared to 37 in 2012. In 2014, reported 4 cases to date (2 at the same date in 2013). All cases in 2014 are from the eastern region. Kandahar and Helmand indicators show progress with significant reduction in percentage of zero dose and inaccessible children while the situation in Kunar is still of concern with increase in zero dose cases and no change in inaccessibility (approximately 20 000 children inaccessible).

Somalia reported 194 cases in 2013 and in 2014 zero cases reported to date. Latest case date of onset is 20 December 2013 from Puntland and latest case in the Horn of Africa outbreak, 5 January 2014 in Ethiopia. Ethiopia reported 10 cases in 2013–2014, latest onset 5 January 2014 and all cases in Warder Zone, Somali region. Kenya reported 14 cases in 2013, latest onset July 2013.

In the Middle East outbreak, 35 cases were reported in 2013, all in Syria and in 2014, 2 cases were reported to date (from Syria on 21 January from Hama, and Iraq on 10 February) and the rate of new cases declining. The Iraq virus was related to virus isolated in December 2013 in north-eastern Syria.

In response to the polio situation in the Eastern Mediterranean Region and to prevent further international spread of polio, the Regional Committee for the Eastern Mediterranean in its 60th session adopted a resolution declaring polio an emergency for Member States of the Region, and committing to intensified efforts to stop transmission. Member States showed deep concern over the outbreaks in the Horn of Africa and Middle East and poliovirus spread into Egypt and the occupied Palestinian territory, and reemphasized the importance of stopping ongoing endemic circulation in Pakistan and Afghanistan.

The Government of Pakistan initiated its response addressing the ban on polio vaccination in North and South Waziristan including incorporating polio in government and TTP negotiation, military ensuring security at transit vaccination points, improving the security of vaccination teams, changing strategy in Peshawar and Karachi to one-day campaigns (12 one-day campaigns conducted in Peshawar and 8 in Karachi), with 3 one-day campaigns conducted in districts adjoining Peshawar and no security incidents in Peshawar or Karachi during these campaigns. Advocating for increased ownership is visible with commitment by the provincial government in KP, an advocacy mission by the WHO Director-General and Regional Director, and engagement of religious scholars through the global and national Islamic advisory groups.

The Government of Afghanistan took action to improve quality and access in the southern region, negotiation of access round by round, transit point vaccination, placement of permanent polio teams and district EPI management teams and continued working on improving accessibility in the eastern region by local negotiation, transit point vaccination and placement of teams and other approaches as in the southern region.

Based on the risk assessment and epidemiology, the programme identified four zones by priority to respond to the Horn of Africa outbreak and there is encouraging impact of Phase I plan on transmission. Phase II response plan implementation is in progress to stop the transmission.

For the Middle East outbreak, Phase I response (October 2013–April 2014) was developed together with UNICEF and other partners with the three priority zones of intervention defined: Syrian Arab Republic, Iraq, Turkey, Lebanon, Jordan and remaining neighbouring countries. Currently both outbreaks are being assessed and the action plan for the next phase will be developed in the light of recommendations.

Other key actions include the establishment of the global Islamic Advisory Group (first meeting in Jeddah) and reaching out to religious leaders and Islamic institutions to support polio eradication. Coordination was enhanced between WHO regions and with partners by appointment of overall coordinator for the Horn of Africa outbreak. A consultation was organized to exchange experience in increasing access to and demand for immunization in areas with insecurity and/or other complex circumstances. Joint outbreak teams for Horn of Africa and Middle East were formulated and are engaged in concerted and coordinated efforts to solve the very specific political, societal and security challenges in the Region.

In summary, polio in the Region remains a significant problem and a serious risk. Immunizing children in situations of conflict and restricted access is key to finally eradicating polio and requires the full engagement of government, relevant international bodies, religious leaders and humanitarian actors. Full national ownership in endemic and infected countries, and holding of local authorities fully

accountable for the quality of activities, is essential. In order to minimize the risks of international spread all countries are required to enhance surveillance, immunization activities and review policy on immunization for travellers in light of new recommendations. For the withdrawal of the type 2 component of the oral polio vaccine (OPV) by 2016, WHO will be working closely with countries to establish plans for the introduction of at least one dose of inactivated polio vaccine (IPV) into their routine immunization programmes in 2015.

2.2 Implementation of the recommendations of the 27th RCC meeting

Dr Tahir Mir, WHO Regional Office for the Eastern Mediterranean

Regarding modifications to the report format, the country report format has been revised to further clarify and translation in Arabic and French has been completed and was shared with the NCC in December 2013.

At the request of NCC Chairs, a checklist to facilitate comprehensive monitoring of completion of country reports was developed and shared with the RCC in November 2013. The secretariat developed the monitoring tool and it was presented to the NCC Chairs during their pre-RCC meeting on 21 April 2014 and also endorsed by the RCC. For the quality and accuracy of reports, the RCC members need to be updated of any changes in NCCs. The WHO secretariat provided NCC records of past activities upon the request of Lebanon and Morocco. The secretariat also shared criteria for accreditation of laboratories with NCCs in April 2013

Involvement of NCC by WHO staff and experts, during visits and missions to Member States, was not fully implemented. However, the RCC members joined these visits whenever appropriate.

During the last meeting, the RCC expressed concern about the spread of poliovirus and requested the Regional Director to hold a consultation on the situation in Syria. In response, a side meeting was organized during the Regional Committee with the participation of the Regional Director and WHO Representatives from these countries. The Regional Committee declared an emergency in all the Member States. To continue this consultation with the Member States, a pre-World Health Assembly meeting is planned to discuss the polio situation in the Region.

The RCC also requested the Regional Director to review polio vaccination for travellers from endemic countries and raise this issue with Member States in advance of the World Health Assembly. In this regard, WHO recommendations on vaccination for travellers from endemic/infected countries have been reviewed by the polio working group of the Strategic Advisory Group of Experts on Immunization to prevent further spread of polio.

3. GLOBAL UPDATE ON POLIO ERADICATION

Dr Rudolf Tangermann, WHO headquarters

3.1 Global Polio Eradication Initiative strategic plan, objective 1: poliovirus detection and interruption

The reported number of cases of disease due to wild poliovirus in 2013 increased by 82% compared to 2012 (405 cases compared with 223 cases), with eight countries reporting cases of poliomyelitis compared to five in 2012. This increase was driven by an increase in cases in Pakistan and disease outbreaks due to new international spread of polioviruses from Nigeria into the Horn of Africa (194 cases in Somalia, 14 in Kenya, 9 in Ethiopia) and from Pakistan into the Middle East (38 cases, reported from all sources, in the Syrian Arab Republic). Wild poliovirus of Pakistani origin was also detected in environmental samples collected in Israel and the occupied Palestinian territory. Four cases due to an imported poliovirus were detected in Cameroon.

Cases increased by 60% in Pakistan (to 93) compared with 2012. In Nigeria and Afghanistan, cases declined by 57% and 62% respectively. Of note, of Nigeria's 53 cases, only six were reported between September and December 2013 (that is, in the "high season" for poliovirus transmission). Of Pakistan's 93 cases, 60 were reported between September and December, 48 of which were from the Federally Administered Tribal Areas and Khyber Pakhtunkhwa province.

For the first time in history, in 2013 all cases of poliomyelitis caused by a wild virus were due to a single serotype, type 1; the most recent case due to wild poliovirus type 3 occurred on 10 November 2012 in Nigeria. A total of 63 cases due to circulating vaccine-derived poliovirus type 2 occurred in seven countries, heavily concentrated in Pakistan and the border area of Cameroon, Chad, Niger and Nigeria.

Insecurity, targeted attacks on health workers and/or a ban by local authorities on polio immunization resulted in a deterioration in access in the Federally Administered Tribal Areas and Khyber Pakhtunkhwa province of Pakistan and the state of Borno in Nigeria. Chronically poor implementation of activities remained a critical challenge in other priority areas, most notably in the state of Kano, Nigeria, and Balochistan province, Pakistan. In poliovirus-affected areas of Pakistan and Nigeria an estimated combined total of 530 000 children remained inaccessible for vaccination; in the reinfected area of south-central Somalia more than 500 000 children were inaccessible for polio vaccination.

The risk of further international spread remains high, particularly in central Africa, the Middle East and the Horn of Africa. Consequently, the Regional Committee of the Eastern Mediterranean at its sixtieth session in October 2013 declared polio transmission an emergency for all Member States of the Region. Following the deliberations of the Executive Board at its 134th session, the Director-General convened the polio working group of the Strategic Advisory Group of

Experts on Immunization (Geneva, 5–6 February 2014) to update WHO's vaccination recommendations for travellers from polio-infected countries. The convening of an Emergency Committee under the International Health Regulations (2005) is planned in advance of the Sixty-seventh World Health Assembly in order to advise the Director-General on measures to limit the international spread of wild poliovirus.

3.2 Global Polio Eradication Initiative strategic plan, objective 3: containment and certification

The draft global action plan to minimize poliovirus facility-associated risk after eradication of wild poliovirus and cessation of routine oral polio vaccine use is being updated to align activities with the strategy and timelines of the Endgame Plan. The updated plan will be available for public consultation later this year. Operationally, the immediate priority for containment is to ensure that phase 1 activities are completed by 2015. These include establishment of an inventory of all facilities holding infectious and/or potentially-infectious wild poliovirus materials and the implementation of measures to ensure the safe handling of all residual wild polioviruses, especially serotype 2. At the end of 2013, all Member States had completed phase 1 activities with the exception of two countries in the Eastern Mediterranean Region and 37 countries in the African Region.

On 27 February 2014, the South-East Asia Region was certified as free of indigenous wild poliovirus. The Global Commission for the Certification of the Eradication of Poliomyelitis will review data from all six WHO regions in late 2014 or early 2015 to determine whether there is sufficient evidence to conclude formally that wild poliovirus type 2 has been eradicated globally.

3.3 Major risks and programme priorities for 2014

The major risks to eradication are: the bans on immunization campaigns in the North Waziristan agency in Pakistan and parts of southern and central Somalia; the continued targeting of vaccinators in Khyber Pakhtunkhwa province in Pakistan; ongoing military operations in Khyber Agency (within the Federally Administered Tribal Areas) of Pakistan; insecurity in the eastern region, Afghanistan, and Borno state, Nigeria; active conflict in the Syrian Arab Republic; and gaps in programme performance in Kano state, Nigeria. These risks are compounded by gaps in polio surveillance and the continued threat of new international spread of wild poliovirus.

Management of these risks requires full national ownership of the eradication programme in all infected countries, with deep engagement of all relevant line ministries and departments, and the holding of local authorities fully accountable for the quality of activities, particularly in accessible areas such as Kano state. Accessing and vaccinating children in insecure and conflict-affected areas will in addition require the full engagement of relevant international bodies, religious leaders and humanitarian actors to implement area-specific plans, generate greater community

demand and participation, and adapt eradication approaches in line with local contexts. In order to minimize the risks and consequences of international spread of poliovirus, Member States are urged to enhance surveillance and immunization activities and implement fully recommendations for immunization of travellers.

In order to be prepared for the withdrawal of the type 2 component of oral polio vaccine by 2016, Member States are encouraged to establish plans for the introduction of at least one dose of the inactivated poliovirus vaccine into their routine immunization programmes. Recognizing the complex financing arrangements and tight supply timelines for introduction of this vaccine globally, it is recommended that countries endemic and at high risk of re-emergence of polio develop by mid-2014 a plan for inactivated polio vaccine introduction, and all countries develop such plans by the end of 2014.

4. INTERREGIONAL COORDINATION

4.1 Update on polio eradication in the WHO African Region

Dr Mbaye Salla, WHO Regional Office for Africa

The African and Eastern Mediterranean regions share several borders. The Horn of Africa comprises 10 countries (6 in the African and 4 in the Eastern Mediterranean region). Several importations occurred in this epidemiological block from 2004 to 2013. The current polio outbreak in Horn of Africa involves Ethiopia, Kenya and Somalia and accounts for 49% of wild poliovirus type 1 cases globally the last 12 months.

There is a good progress in the African Region with a decline of the number of wild poliovirus 1 cases from 350 cases in 2011 (67% of cases from re-established transmission countries) to 128 cases in 2012 (95% of cases from endemic country) and 80 cases in 2013 (78% of cases from endemic country). In 2014, 4 countries reported wild poliovirus 1 cases: Cameroon (3 cases), Equatorial Guinea (3 cases), Ethiopia (1 case) and Nigeria (1 case), with date of onset of the latest case in Equatorial Guinea on 19 February 2014.

AFP surveillance indicators have been met by several countries at subnational level but gaps persist in outbreak countries and countries with security compromised areas. A total of 25 countries submitted complete documentation with 25 of them accepted by the African Regional Certification Commission (ARCC).

Coordination mechanisms have been put in place between the two regions:

- Horn of Africa Technical Advisory Group (TAG) to accelerate and complete interruption of polio transmission in the epidemiological block with joint Horn of Africa risk assessment, joint supplementary immunization activity plans and

synchronized campaigns, and a common follow up of implementation of TAG recommendations.

- A Horn of Africa Polio coordinator has been appointed by both WHO Regional Directors with an office set up in Nairobi, Kenya
- A joint full membership is designated by each RCC to the other's RCC.

The coordination areas are many, including technical aspects of polio eradication, environmental surveillance, Kenya polio laboratory serving Eastern Mediterranean countries, communication and information sharing between countries for cross-border AFP notification and investigation, cross-border meetings, technical assistance and conduct of joint high level meetings.

The priority actions for 2014 are to interrupt wild poliovirus 1 transmission in the Horn of Africa and other outbreak countries in the African Region, enhance AFP surveillance, complete containment phase 1 activities and further strengthen the very good coordination and collaboration between regions.

4.2 Update on polio eradication in the WHO European Region

Professor David Salisbury, Chairman, European Regional Certification Commission

The European Regional Certification Commission last met in June 2013. At that time, there had been no reported cases of paralytic poliomyelitis in the region in the preceding year. The Commission noted that overall surveillance and programme performance remained the same with some gaps in annual update reports and some deficiencies in quality of surveillance in some countries. The European RCC undertook a risk assessment for transmission of polio in the event of an importation and identified Ukraine, Georgia and Bosnia and Herzegovina as being at high risk. Following the European RCC meeting it was reported that Israel had detected positive samples for wild poliovirus type 1 from environmental sampling sites in the south of the country. Since that time, further positive samples have been detected especially from the south but also more widely across the country. Stool surveys of children under nine years have detected positive samples but there has been no case of paralytic poliomyelitis despite the continued detection of wild poliovirus 1 in sewage samples. Israel has undertaken a first national round of bivalent OPV vaccination plus a second round in the south of the country. It has also adjusted its immunization schedule, which for the last nine years had been IPV only, to include two doses of bOPV for all children.

4.3 Update on polio eradication in the WHO South-East Asia Region

Dr Supamit Chunsuttiwat, Chairman, South-East Asia Regional Certification Commission

The South-East Asia Region is home to quarter of world's population, and about 70% of this population lives in India. In 1988, the South-East Asia Region reported over 25 000 paralytic polio cases, which was 70% of the global polio case burden at

that time. Twenty-five years later, by 2013 the South-East Asia Region had made tremendous progress in polio eradication, remaining polio free since the reported last wild polio case from India on 13 January 2011.

Among 11 member countries, Bhutan was the first country to see the last wild polio case in 1986. Then in the course of polio eradication, other countries followed on, one by one. Until January 2011, India reported its last case from West Bengal state, after several years of tremendous efforts of the STOP polio campaign across the vast country. However, during 2005 to 2010, 4 countries experienced importation of wild poliovirus that caused local outbreaks. The outbreaks in Bangladesh, Myanmar and Nepal were relatively smaller than the large outbreak in Indonesia, with 351 cases reported. These outbreaks were finally contained.

For surveillance, all countries in the South-East Asia Region have established AFP surveillance since 1997. The AFP surveillance system in five countries is strengthened by WHO supported personnel. Environmental surveillance has been conducted only in India since 2001.

The regional laboratory network was established in 1993. This includes 16 national polio laboratories, 2 regional reference laboratories and a global specialized laboratory. This laboratory network handles more than 120 000 specimens annually. The laboratories are annually accredited by WHO.

From review of AFP surveillance, zero reporting is made from over 32 000 reporting sites. 95% of AFP cases are investigated within 48 hours of notification. 87% of stool specimens reached the laboratory within 72 hours. 97% of stool specimens' primary result was available within 14 days.

All countries have submitted 2013 annual updates of the national documentation, the national plan for polio outbreak preparedness plan, and the national report on phase 1 containment. For the containment report, Bangladesh, Nepal and Myanmar submitted updated reports of the phase 1 containment after a re-survey in 2013.

For the whole region, almost 87 000 laboratories have been surveyed and enlisted. Over 80% of these laboratories are in India. By now these laboratories have destroyed the stools specimens after the intended testing. Only one laboratory in India is carrying wild virus infectious materials and potential infectious materials that will be destroyed in due course according to containment guideline.

Countries are recommended to conduct risk assessment at national and subnational levels. At the national level, 4 countries assessed themselves in 2013 as being at high risk: India, Bangladesh, Myanmar, Indonesia and Timor Leste. Risk assessment criteria include immunization coverage or susceptibility status, surveillance performance as well as the result of population or programme evaluation.

By these criteria, Thailand and Nepal were classified to be at medium risk, while the remaining 5 countries were considered at low risk.

However, if only immunization coverage and surveillance performance are used as criteria in the risk assessment at subnational level, the picture turns out differently. India, Bangladesh and most of Thailand are classified to be at low risk. Only part of Myanmar, Nepal and Indonesia, and the whole of Timor Leste are at high risk. The RCC has recommended that all countries continue to conduct regular risk assessment to the subnational level.

The countries that have been identified as high risk areas have implemented strategies of intensification of routine immunization. Supplementary immunization activities were conducted in 5 priority countries (Bangladesh, India, Myanmar, Nepal and Thailand) and all countries achieved more than 90% coverage of immunization. Polio vaccination is given at the entry and exit points along the borders of Bangladesh, Bhutan, India, Myanmar, Nepal, Thailand and Pakistan. In addition, India has introduced polio vaccination for travellers to and from polio infected countries.

Based on the evidence submitted by the National Certification Committees, the South-East Asia Regional Commission concluded on 27 March 2014 that wild poliovirus transmission has been interrupted in all 11 Member States of the region. However, in view of the continued risk of virus importation from an infected area or a country, the RCC and NCCs must continue their functions and remain active until global certification, in order to assist countries to remain polio free, to maintain effective preparedness for importation and to sustain polio-free status of the region.

5. GLOBAL POLIOVIRUS CONTAINMENT STATUS AND FUTURE PLANS

Dr Nicoletta Previsani, WHO Regional Office for the Eastern Mediterranean

The draft policy document on containment of polioviruses *GAPIII* was developed in 2009. In light of the new Endgame Plan Strategy that advises to switch trivalent OPV to bOPV and introduce IPV to eliminate persistent circulating vaccine-derived polioviruses (cVDPV2s), *GAPIII* needs to be revised.

In terms of containment, the 3 poliovirus types may be addressed separately. Containment requirements and implementation timelines for wild poliovirus and Sabin strains will be based on thorough risk assessment considering the need for global access to IPV and justified accordingly.

The finalized *GAPIII* intends to provide containment recommendations that aim at ensuring risks arising from poliovirus-holding facilities including production of IPV vaccines for global use are identified, adequately managed and appropriately controlled.

Countries are encouraged to update and complete the inventory of wild poliovirus-holding facilities and consider plans to destroy or contain such assets. In the post-eradication phase, the containment of remaining polioviruses will be a key issue to maintain polio-free status.

6. DISCUSSION OF THE REPORTS

6.1 Report on the polio epidemic in the Syrian Arab Republic

The RCC was briefed about the epidemic of wild poliovirus cases which started in July 2013 and noted that as of today the last reported case was in January 2014. The RCC acknowledged the efforts made by the national authorities and all polio partners in addressing the situation. It calls on all concerned to maintain their support to ensure that no wild poliovirus continues to circulate in Syria. Depending on further developments, the RCC will decide when it will request the NCC Syria to resume sending reports to the RCC.

The RCC was pleased to note that all the annual updates reports submitted have met the minimum requirements for being accepted by the RCC, denoting efforts made by the national programmes and the NCCs. There were however differences in the degree of accuracy and completeness of the presented reports as well as in the degree of risk for possible spread following importation.

6.2 Annual updates

6.2.1 Bahrain, Egypt, Islamic Republic of Iran, Iraq, Jordan, Kuwait, Libya, Oman, Palestine, Qatar, Saudi Arabia, Sudan, United Arab Emirates and Yemen

The RCC commended the NCCs and national polio eradication programme for their comprehensive reports and for their efforts to ensure accuracy and completeness of the data in the report which together with their presentation gave the RCC confidence that these countries continued to be polio free during 2013.

Some comments were made on each of the reports which need amendments.

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 RCC comments.

6.2.2 Lebanon

The RCC acknowledged the excellent and frank presentation made by the NCC Chair reflecting achievements and concerns facing maintenance of some of the polio eradication activities together with the serious risk of possible wild poliovirus importation due to the influx of hundreds of thousands of Syrian refugees and gaps in

polio eradication programme implementation. Several recommendations were made to address the situations which are endorsed by the RCC.

The RCC decided to provisionally accept the report and relay its comments to the chairman of NCC. Formal acceptance will be made upon receipt of the amended report taking into consideration RCC comments.

6.2.3 Tunisia

The RCC noted that its comments on previous annual reports related to surveillance have not been adequately addressed and that some of the surveillance indicators are showing deterioration. Actions taken to address the situation were noted and it is hoped that these measures will have a positive impact on surveillance.

The RCC decided to provisionally accept the report and relay its comments to the chairman of NCC. Formal acceptance will be made upon receipt of the amended report taking into consideration RCC comments.

6.2.4 Morocco

The RCC noted with satisfaction, government commitment to polio eradication which has been behind the revitalization of some of the programme activities. It is noted the recent surveillance review and look forward to full implementation of its recommendations in order to improve surveillance to reach the required standard.

The RCC decided to provisionally accept the report and relay its comments to the chairman of NCC. Formal acceptance will be made upon receipt of the amended report taking into consideration RCC comments.

6.2.5 South Sudan

As South Sudan was still a Member State of the Eastern Mediterranean Region during 2013, the RCC reviewed its annual report and will send comments to the African RCC (ARCC).

7. OTHER MATTERS

The RCC is concerned that Djibouti, which is at very high risk of wild poliovirus importation, has not submitted an annual report for 2013, particularly as their report to the previous meeting of the RCC denoted serious shortcomings in both surveillance and immunization activities. The RCC reiterates its request to WHO to help the Ministry of Health to strengthen the national polio eradication programme capabilities and ensure their urgent needs.

The RCC looks forward to receiving a report from Djibouti during its next meeting.

The RCC requested the secretariat to arrange to screen the NCC reports for missing information prior to the RCC meeting and request the NCCs to complete them before sending them to RCC members. This will help RCC members to focus their assessments of country reports on the standard of implementation of the basic strategies of polio eradication and on main issues that can have impacts on the national programme and give the RCC confidence of being polio free.

The RCC reiterated its concern about the hundreds of children falling ill with paralysis due to traumatic neuritis and calls on the NCCs to continue their efforts with national authorities to address these mostly preventable paralyses.

The RCC requested the secretariat to provide information on the proportion of AFP cases identified through routine surveillance and those through active surveillance.

The RCC requested that reviewers receive with the country annual update the previous year's report to enable RCC members (reviewers) to compare data on the country situation.

The RCC suggest holding its next meeting during the period 14 to 16 April 2015 in one of the following venues: Muscat, Oman; Cairo, Egypt; or Dubai, United Arab Emirates.

Annex 1

PROGRAMME

Tuesday, 22 April 2014

- 08:00–08:30 Registration
- 08:30–09:00 Opening session
Introductory remarks/Dr Y. Al Mazrou, EM/RCC Chairman
Message from the WHO Regional Director for the Eastern Mediterranean
Welcoming remarks by H.E. the Minister of Health
Adoption of agenda
- 09:00–09:25 Regional overview and implementation of the recommendations of the 27th RCC meeting/Mr C. Maher, WHO/EMRO and Dr T. Mir, WHO/EMRO
- 09:25–09:45 Global update on polio eradication/Dr R. Tangermann, WHO/HQ
Outcomes/recommendations
- 09:45–10:45 Discussion
- 10:45–11:50 Interregional coordination
African Region/Dr M. Salla, WHO/AFRO
European Region/Prof. D. Salisbury, EUR-RCC
South-East Asia Region/Dr S. Chunsuttiwat, SEA-RCCPE
Discussion
- 11:50–12:30 Syria outbreak, response, challenges and lessons learned
- 12:30–14:30 Annual update reports of Jordan and Bahrain
- 14:30–16:45 Annual update reports of Egypt, Islamic Republic of Iran, Iraq and Kuwait
- 16:45–17:45 Private meeting of EM/RCC

Wednesday, 23 April 2014

- 08:30–09:00 Global poliovirus containment status and future plans/Dr N. Previsani, WHO/HQ
- 09:00–11:00 Annual update reports of Lebanon, Libya and Morocco
- 11:00–14:30 Annual update reports of Oman, Qatar and Palestine
- 14:30–16:45 Annual update reports of Saudi Arabia, Sudan, South Sudan and Tunisia
- 16:45–17:45 Private meeting of EM/RCC

Thursday, 24 April 2014

- 08:30–10:30 Annual update reports of the United Arab Emirates and Yemen
- 10:30–11:30 Annual progress report of Afghanistan
- 11:30–12:30 Annual progress report of Pakistan
- 12:30–14:30 Private meeting of the EM/RCC
- 14:30–15:30 Closing session and concluding remarks

Annex 2

LIST OF PARTICIPANTS

Members of the Regional Certification Commission

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