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Report on the

Thirtieth meeting of the
Eastern Mediterranean
Regional Commission for
Certification of Poliomyelitis
Eradication

Amman, Jordan
4–6 April 2016



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 thirtieth meeting in Amman, Jordan on 4–6 April 2016. The meeting was attended by members of the RCC, chairpersons of the national certification committees or their representatives, and national polio eradication officers of 17 countries of the Region (Afghanistan, Bahrain, Egypt, Islamic Republic of Iran, Iraq, Jordan, Kuwait, Lebanon, Oman, Pakistan, Palestine, Qatar, Saudi Arabia, Sudan, Tunisia, United Arab Emirates and Yemen). The meeting was also attended by representatives from Rotary International, U.S. Centers for Disease Control and Prevention (CDC) and World Health Organization (WHO) staff from WHO headquarters, the regional offices for Africa and South-East Asia, and country offices for Afghanistan, Jordan, Pakistan and Somalia. The meeting programme and list of participants are attached as Annexes 1 and 2, respectively.

The meeting was opened by Dr Yagob Al Mazrou, Chairman of the RCC, who welcomed the participants and thanked the Government of Jordan and specifically His Excellency Dr Ali Hyasat, Minister of Health of Jordan, for hosting the meeting and providing excellent support.

Mr Christopher Maher, Manager, Poliomyelitis Eradication Programme and Emergency Support, WHO Regional Office for the Eastern Mediterranean, welcomed the participants and delivered a message from Dr Ala Alwan, WHO Regional Director for the Eastern Mediterranean. In his message, the Regional Director referred to the challenges facing polio eradication in the Region, particularly the transmission in Afghanistan and Pakistan, noting that 2015 saw more than 80% reduction in the case load in the two remaining endemic countries compared to 2014. He referred to the success achieved in controlling the outbreaks in the Horn of Africa (in Ethiopia, Kenya and Somalia) and in the Middle East (in Iraq and the Syrian Arab Republic).

Dr Alwan referred to the phased withdrawal of oral polio vaccine (OPV), starting with the type 2 component of OPV, which was due to have started by April 2016. Member States were being persuaded, and had been provided support, to implement the plans for the introduction of at least one dose of inactivated polio vaccine (IPV) and to replace trivalent OPV (tOPV) with bivalent OPV (bOPV) in their routine immunization programmes. The global shortage in supplies of IPV is a challenge, and Dr Alwan urged partners to address this urgently.

The Regional Director indicated that all WHO Member States endorsed resolution WHA68.3 at the World Health Assembly in 2015, which urged full implementation of the Polio Eradication and Endgame Strategic Plan 2013–2018 and the third Global Action Plan (GAPIII) in order to minimize poliovirus facility-associated risk by destroying, transferring or containing poliovirus materials. In order to meet these requirements, WHO conducted two intercountry meetings of the national containment coordinators in the Region, and a GAPIII training workshop during 2015, to resolve any outstanding issues to meet the containment targets. He was pleased to indicate that the Phase I containment goals have been achieved in 21 countries, all of which have confirmed destruction and no retention of

poliovirus type 2 materials in their facilities. One facility has been designated as the poliovirus-essential facility in the Eastern Mediterranean Region to serve critical international functions including production of Sabin-IPV and monovalent OPV vaccines. This is the Razi Vaccine and Serum Research Institute in the Islamic Republic of Iran.

Dr Basheer Al Qaseer, Director of Primary Health Care Administration, delivered the message of His Excellency the Minister of Health, in which he welcomed participants and thanked WHO for choosing Jordan to host the meeting at this critical stage of the polio eradication programme. He reaffirmed the commitment of the Government of Jordan to support polio eradication efforts both globally and regionally. His Excellency indicated that the goal of polio eradication can be achieved in the Region through support and continuous coordination of countries, specifically during the current time period, to protect polio-free countries from any importation.

2. OVERVIEW OF POLIO ERADICATION IN THE REGION

2.1 Regional overview

Mr Christopher Maher, WHO Regional Office for the Eastern Mediterranean

In 2015 there were fewer polio cases in fewer places than ever before: 74 cases in the two remaining polio-endemic countries (Pakistan had 54 cases in 23 districts, and Afghanistan had 20 cases in 15 districts). The case load in both countries was reduced by 80% in 2015 compared to 2014 (54 versus 306 in Pakistan, and 20 versus 28 in Afghanistan). The remaining reservoirs for wild poliovirus (WPV) are the Khyber-Peshawar-Nangarhar and Quetta-Greater Kandahar corridors, linking Pakistan with Afghanistan, and Karachi in Pakistan. In the last 4 months, only 13 confirmed WPV cases have been reported from both countries. This represents the best opportunity to stop transmission in the history of polio eradication.

The multicounty outbreaks in the Middle East and Horn of Africa have been closed: the last case in the Middle East was from Iraq in April 2014 and the last case in the Horn of Africa was from Somalia in August 2014. However, the risk of importation or emergence of vaccine-derived polioviruses (VDPVs) remains high due to the ongoing circulation of WPV in a few endemic foci in Afghanistan and Pakistan, complex emergencies in the Region and large numbers of internally displaced persons and refugees (20 million and 9 million, respectively). Systems for basic immunization services are struggling in conflict-affected countries and there is high population movement within polio-endemic countries.

With the declaration on 20 September 2015 that WPV type 2 (WPV2) has been eradicated, the Strategic Advisory Group of Experts on immunization confirmed that withdrawal of OPV2 should occur between 17 April and 1 May 2016. Implementation of Phase I of GAPIII is on track, and all laboratories in the Region have either destroyed or transferred WPV2/VDPV2 materials, except the Islamic Republic of Iran where Al Razi Vaccine and Serum Research Institute has been designated as a poliovirus-essential facility.

Work on the polio legacy, also referred to as transition planning the fourth strategic objective, has accelerated in the past 6 months in the Region. Four priority countries (namely Pakistan, Afghanistan, Somalia and Sudan) have been identified for transition planning to ensure that investments made in the polio eradication programme contribute to future health goals, through a programme of work that systematically documents and transitions the Global Polio Eradication Initiative's knowledge, lessons learned and assets.

The key priorities for the Region in 2016 are: (i) to stop WPV transmission in Pakistan and Afghanistan; (ii) consolidate improving immunization services in outbreak-affected countries (Iraq, Somalia and the Syrian Arab Republic); (iii) and to enhance preparedness and response plans in all countries of the Region.

2.2 Implementation of the Twenty-ninth RCC meeting recommendations

Dr Humayun Asghar, WHO Regional Office for the Eastern Mediterranean

Participants were informed on the status of implementation of the twenty-ninth RCC meeting recommendations. All recommendations had been successfully implemented, and the RCC was satisfied with the implementation report.

3. GLOBAL UPDATE ON POLIO ERADICATION

Dr Rudolf Tangermann, WHO headquarters

Strong progress continues to be made towards each of the four objectives of the Polio Eradication and Endgame Strategic Plan 2013–2018 (the Endgame Plan). With only Afghanistan and Pakistan remaining endemic for poliomyelitis, WPV transmission is at the lowest levels in history with the fewest-ever reported cases from the fewest-ever affected countries.

On 20 September 2015, the Global Commission for the Certification of Poliomyelitis Eradication declared global eradication of WVP2. WVP3 has not been detected globally since November 2012.

In Nigeria, no case due to WPV1 has occurred since 24 July 2014; as a result, Nigeria was officially removed from the list of endemic countries on 25 September 2015. The most recent wild-type poliovirus on the African continent was detected in Somalia in August 2014.

As of April 2016, all WPV outbreaks in non-endemic countries have been interrupted; no WPV has been found since August 2014 outside of Afghanistan and Pakistan.

The declaration of international spread of WPV as a Public Health Emergency of International Concern and the temporary recommendations promulgated under the International Health Regulations (2005) remain in effect. In September 2015, the Polio Oversight Board of the Global Polio Eradication Initiative reviewed progress and

concluded that WPV transmission is more likely to be interrupted in 2016 than in 2015. This delay shifts the predicted date for certification of global polio eradication to 2019 and increases the cost of completing polio eradication by US\$ 1500 million.

In October 2015, WHO's Strategic Advisory Group of Experts on immunization confirmed its recommendation that the withdrawal of OPVs containing the type 2 component should occur during the period 17 April to 1 May 2016 in all countries that are using tOPV through a globally-synchronized replacement of this vaccine by bOPV; all countries using OPV exclusively should introduce at least one dose of IPV into the routine programme.

By 1 April 2016, 162 (or 84%) of WHO Member States had introduced IPV (either exclusively, or in combination with OPV). Due to a continued shortage of IPV, another 25 countries have formally committed to introduce IPV in 2016, and 7 countries will only introduce IPV in 2017. By 1 April, bOPV had been approved for use in routine immunization in 141 of 144 countries, with approval immediately expected in the 3 countries where this approval is still pending.

The Strategic Advisory Group of Experts Working Group on polio, at their most recent consultation, noted that in view of the upcoming switch from tOPV to bOPV, it was imperative that all WHO Member States followed the requirement, under the International Health Regulations (2005), to immediately report to WHO any WPV or VDPV type 2 isolates, from any source (polio cases, healthy people or the environment). It was equally important that this requirement to immediately report was extended to type 2 Sabin viruses, after the switch.

Lastly, preparations have begun to plan for the "polio transition" in 16 priority countries globally, to assure that the assets created through polio eradication are maintained. Transition plans (or polio legacy plans) should have been drafted by the end of 2016 in all "legacy priority" countries and in all countries where at least 12 months have passed without a polio case.

In summary, main achievements by end-March 2016 include the unprecedented progress made against WPV, even though WPV1 cases and WPV1-positive environmental surveillance specimens indicate continued widespread transmission. Also, all persistent circulating VDPV type 2 (cVDPV2) transmission (for more than 6 months) has been interrupted; however, cVDPV2 cases were still detected relatively recently in Guinea and possibly in the Democratic Republic of the Congo. Preparations for the tOPV to bOPV switch in April 2016 are on track and the switch will be implemented according to plan.

During 2016, the focus of the Global Polio Eradication Initiative will be on further improving the quality of supplementary immunization activities, in order to reach the previously unreached children in remaining reservoirs of Afghanistan and Pakistan. In the context of the switch, all countries should continue to track, detect and enhance capacity to rapidly respond to VDPV2. This will include strengthening surveillance for

polioviruses, especially AFP surveillance, in all countries with AFP systems, and expanding environmental surveillance to include more countries, as per the existing environmental surveillance expansion plans.

4. INTERREGIONAL COORDINATION

4.1 Update on polio eradication in the WHO African Region

Dr Koffi Kouadio Isidore, WHO Regional Office for Africa

Remarkable progress has been made in the African Region in each of the four objectives of the Polio Eradication and Endgame Strategic Plan 2013–2018.

Objective 1. The number of WPV cases has been significantly reduced from 657 cases in 2010 to 17 in 2014, with the last case reported on 24 July 2014 in Nigeria (20 months ago). No WPV cases were reported in 2015 or, to date, in 2016. Environmental surveillance has been established in selected countries (Angola, Cameroon, Chad, Kenya, Madagascar, Niger and Nigeria) to supplement AFP surveillance. In 2015, one cVDPV was isolated (onset: 4 March 2015) from Nigeria, but no WPV cases have been reported from the environment.

Objective 2. WHO Regional Office for Africa and partners UNICEF are currently supporting and closely monitoring the good progress made by countries in their preparation towards successful switch from tOPV to bOPV (planned for 17 April to 1 May 2016), through regular conference calls, subregional trainings and staff deployment. The switch status is delayed only in Angola due to the fact that all stakeholders are fully involved in responding to a large yellow fever outbreak in the country. IPV has been introduced in the routine immunization system in only 25 countries of the Region before the switch period due to the global shortage of IPV production. The remaining 22 countries plan to introduce IPV after the switch.

Objective 3. Phase I of GAPIII containment activities is being completed in the Region. All countries have documented and submitted their report, but Guinea and South Africa are still pending statements of destruction of WPV materials and potentially infectious materials. The Africa Regional Commission for the Certification of Poliomyelitis has accepted the complete documentation of 33 countries.

Objective 4. Documentation of polio eradication initiative best practices has been conducted in 8 countries (Angola, Chad, Cote d'Ivoire, Democratic Republic of Congo, Ethiopia, Nigeria, Tanzania and Togo). Polio-funded staff have supported other public health emergencies in the Region, including staff deployment for Ebola virus disease outbreak preparedness and response. In 2015, the African Region nominated members to the global Polio Legacy Management Group. The African Region Polio Legacy Working Group was established in June 2015 and all WHO heads of country offices were oriented on legacy planning in November 2015. In regards to all these experiences, WHO

Regional Office for Africa conducted a writing exercise workshop on polio eradication initiative best practices in strengthening other public health programmes in October 2015.

Despite these important achievements, there are some challenges remaining for the polio eradication initiative in the Africa Region including: (i) gap in population immunity in many countries with low OPV3 coverage in routine immunization (less than 80%) and important proportion of non-polio AFP cases remaining with less than 3 doses. Furthermore, many countries reported a proportion of non-polio AFP cases with zero doses above 10% in 2014–2015; (ii) existing cVDPVs in some countries. The Region is currently responding to the most recent cases reported in Guinea and Madagascar; (iii) AFP surveillance performance is suboptimal in many countries, especially at subnational level. The most important surveillance challenge is the low stool adequacy performance recorded in the majority of countries, with setbacks in adequate stool surveillance performance in Ebola-affected countries (Guinea, Liberia and Sierra Leone); (iv) suboptimal quality of supplementary immunization activities, with missing cases more than 5% in many countries; (v) insecurity challenges and population movement; (vi) challenges of polio eradication activities in Ebola-affected countries; (vii) weak infrastructure and logistic challenges to deliver quality immunization services; (viii) decline in current momentum and commitment before regional certification; (ix) inadequate human resources and weak health systems to sustain the gains and progress in polio eradication.

Taking these challenges into account, the key priorities for 2016–2017 in regard to the four objectives of the Polio Eradication and Endgame Strategic Plan are as follows.

Objective 1: (i) achieve and maintain interruption of WPV transmission; (ii) improve surveillance and quality of supplementary immunization activities in localized poor-performing areas, Ebola-affected countries and areas with insecurity and massive population movements; (iii) expand environmental surveillance as per the plan; (iv) interrupt current cVDPV outbreaks in Guinea and Madagascar.

Objective 2: (i) close immunity gap and support countries for a successful switch from tOPV to bOPV; (ii) support IPV introduction in the remaining 22 countries.

Objective 3: (i) ensure timely phased containment of polioviruses, VDPVs and vaccine viruses; (ii) support countries documentation of polio-free status towards certification.

Objective 4: (i) provide technical support to assist with polio legacy planning in priority countries; (ii) ensure proper documentation of polio legacy and best practices for other health programmes.

4.2 Update on polio eradication in the WHO European Region

Professor David Salisbury, Chairman, European Regional Certification Commission

At its 2015 meeting, the European Regional Commission for the Certification of Poliomyelitis Eradication concluded that the Region remains free of WPV transmission.

However, the Commission continued to have grave concerns about the circumstances in Ukraine where previous deficiencies in the polio immunization programme had been exacerbated by the ongoing conflict in the country. Following its risk assessment of all countries in the Region, the Commission identified Bosnia and Herzegovina, Romania and Ukraine as being at high risk of ongoing poliovirus transmission were an importation to occur.

In August 2015, the WHO Regional Office for Europe was alerted to two virologically linked cVDPV2 cases in Ukraine. Following a protracted period of discussion over vaccine supplies and type of vaccine to be used, three rounds of national immunization were undertaken with the final round expanded to include children up to 10 years of age. No further cVDPV cases have been found.

Surveillance in the Region continues on a mixed basis with AFP, environmental and enterovirus surveillance being undertaken: there have been no significant changes in the quality of the surveillance indicators nor in the levels of immunization coverage. Those countries that currently use tOPV are all expected to switch to bOPV in April 2016.

Progress continues to be made in GAPIII containment activities with identification of poliovirus-essential facilities and national committees, and the number of laboratories where poliovirus specimens are held (especially containing type 2 viruses) is being progressively reduced.

The Region continues to advance its experiences with polio outbreak simulation exercises at national, regional and interregional levels.

The Commission noted with concern the very large numbers of refugees and migrants coming into the European Region especially from conflict-affected countries, whose vaccine status may not be known and who were not engaging with those providing public health and immunization services.

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

Dr Sigrun Roesel, WHO Regional Office for South-East Asia

At its eighth meeting in September 2015, the South-East Asia Regional Commission for the Certification of Poliomyelitis Eradication concluded that the WPV-free status of the Region had been maintained. Terms of reference of the Commission and national certification committees were updated after Regional Certification. Some national certification committees are also to serve as measles elimination verification committees and are monitoring preparations for the switch from tOPV to bOPV.

VDPVs reported in 2014–2015 from two countries (India and Myanmar) have been fully investigated and comprehensive response measures undertaken. Maintaining quality AFP surveillance indicators in all countries poses challenges during the post-certification period. The performance of the polio laboratory network has been maintained to a high

standard, with challenges in one laboratory. Polio supplementary immunization activities and catch-up routine immunization are conducted in countries with suboptimal routine OPV3 coverage.

Activities in preparation for the withdrawal of OPV2 are progressing well. National switch plans have been developed by all countries in the Region and IPV has been introduced in 10 out of 11 countries (Indonesia to introduce by July 2016). Updated outbreak response plans are under development, with priority in tier 1 and 2 countries (deadline of March 2016). Timely implementation of laboratory containment requirements poses a major challenge.

WPV2/VDPV2 materials are currently kept in India, where the Ministry of Health and Family Welfare has identified a designated poliovirus-essential facility and established a national laboratory containment assessment board to support the national containment taskforce. Another poliovirus-essential facility is expected in Indonesia in line with polio vaccine production requirements. Countries are updating national surveys to meet Sabin2/OPV2 laboratory containment requirements under GAPIII.

5. POLIOVIRUS CONTAINMENT: PROGRESS WITH GAPIII IMPLEMENTATION

Dr Nicoletta Previsani, WHO Regional Office for the Eastern Mediterranean

In September 2015, the Global Commission for the Certification of Poliomyelitis Eradication declared WPV2 an eradicated agent. Clearly, WPV2/VDPV2 as well as the related OPV2/Sabin2 viruses are not yet gone forever, but are still available in a number of facilities (including polio vaccine manufacturing plants and research facilities) for some very critical reasons. One such reason is that IPV and Sabin-inactivated polio vaccine (s-IPV) are necessary assets to the eradication programme, which need to be continuously produced and supplied for global use.

In May 2015, the Sixty-eighth World Health Assembly endorsed resolution WHA68.3 on poliomyelitis, and with it, GAPIII on containment. All 194 Member States thus committed to ensuring appropriate poliovirus containment, starting with poliovirus type 2.

While the ultimate goal of poliovirus containment is the prevention of inadvertent or malicious release of poliovirus from facilities and subsequent transmission to people, preparations towards containment of poliovirus type 2 is organized in different phases.

The currently ongoing Phase I aims at reducing the number of facilities holding poliovirus type 2 worldwide. Countries have been requested to identify and destroy unneeded WPV2 materials by end-2015 and OPV2/Sabin2 materials by August 2016. At the same time, countries are also requested to designate poliovirus-essential facilities that plan to retain essential type 2 polioviruses.

Phase II aims at reducing risk in the remaining facilities. Countries and facilities have a shared responsibility in ensuring appropriate containment: facilities are expected to implement the containment requirements described in GAPIII to ensure no poliovirus type 2 is accidentally or maliciously released, and have full responsibility to manage and control risks associated with the facilities themselves. Hosting countries, on the other hand, are expected to ensure appropriate levels of population immunity and sanitary conditions (sewage treatment) in areas where poliovirus-essential facilities are located.

Progress on completion of the first part of Phase I, addressing WPV2 and VDPV2, was discussed. As of early April, 18 countries reported hosting 51 designated poliovirus-essential facilities globally.

GAPIII implementation activities to support countries include expanded communications and advocacy with, and active engagement of, stakeholders including non-polio laboratory networks, as well as the establishment of a formal containment advisory group to guide the identification and categorization of potentially infectious materials to support the completion of Phase I for Sabin2.

The implementation of Phase II is expected to require a significant amount of time. The new GAPIII containment certification scheme proposes robust, transparent and equitable mechanisms to be applied for containment certification across sectors and geographies, and time-limited certification options including a certificate of participation for poliovirus-essential facilities formally engaging in the containment certification process, and an interim certificate of containment for facilities that may not yet be able to fully comply with GAPIII requirements but need to continue with valuable/critical activities, e.g. vaccine production, while working towards a full certificate of containment.

WHO is providing technical support to countries to implement Phase II, including regional GAPIII implementation and certification trainings for national containment authorities and poliovirus-essential facilities, and the development of a pool of GAPIII containment auditors to support national containment certification efforts.

Next steps include the completion of Phase I for OPV2/Sabin2 materials by end-July 2016, the finalization of the containment certification scheme after consideration of public comments, and the continuous engagement of countries and stakeholders in the implementation of appropriate containment and containment certification efforts.

6. UPDATE ON GAPIII CONTAINMENT ACTIVITIES IN THE EASTERN MEDITERRANEAN REGION

Dr Humayun Asghar, WHO Regional Office for the Eastern Mediterranean

In 2015 and the first quarter of 2016, there was significant progress in efforts to contain poliovirus type 2, in line with the WHO GAPIII to minimize poliovirus facility-associated risk after type-specific eradication of WPVs and sequential cessation of OPV

use. To help achieve this target, two meetings and one workshop on containment of poliovirus and potential infectious materials were held.

As of April 2016, 21 countries in the Region reported they had no WPV2 or VDPV2; only Razi Vaccine and Serum Research Institute in Islamic Republic of Iran will retain poliovirus type 2 materials in a poliovirus-essential facility. All the countries that destroyed VDPV2 materials documented the destruction process; only Pakistan did not destroy VDPV2 materials, which were shifted to National Institute for Biological Standards and Control, United Kingdom for research purposes. A dashboard has been developed to monitor the progress of the GAPIII Phase I containment activities. All countries in the Region were asked to produce a report for which a format was circulated. Libya and Pakistan have not submitted the full report due to delays in documentation of completion of the survey and inventory process. It was noted that lack of support from ministries of health, especially lack of resource allocation, is the main factor delaying the completion of containment activities. In most countries there is no or only partial legislation for laboratory registration and non-availability of a list of laboratories at the national level.

7. DISCUSSION OF THE REPORTS

7.1 Reports from Djibouti, Libya and Syrian Arab Republic

Three countries, namely Djibouti, Libya and the Syrian Arab Republic, submitted their annual update reports and basic national documentation for review by the RCC but, due to visa issues, the country delegations were unable to attend the meeting. The RCC discussed these reports during private meetings.

7.1.1 Syrian Arab Republic: basic national documentation for certification

The RCC acknowledged the receipt of the national documentation from the Syrian Arab Republic and acknowledges also the major efforts that have been made to improve and sustain high-quality surveillance and immunization activities, despite the present difficult situation. The RCC has also taken note of the findings of the Middle East outbreak review completed in October 2015, which took into account epidemiological and supplementary immunization data from all available sources, and which came to the conclusion that the Middle East outbreak had been stopped.

In subsequent reports to the RCC, every effort should be made to ensure that all available data from whatever source are provided. WHO should assist the Ministry of Health to collect and collate data and assist in finalizing the basic documentation report. WHO should also provide any additional relevant information to the RCC.

7.1.2 Libya: annual update 2015

The RCC noted that the report was missing detailed information about polio eradication activities from some parts of the country and more efforts were required to fill

the information gaps. Reported high routine coverage, high non-polio AFP rate (2.6 per 100 000) and Guillain-Barré syndrome rate should be verified.

The report was provisionally accepted by the RCC and comments will be transmitted to the chair of the national committee. Formal acceptance will be made after amendments are added to the report.

7.1.3 Djibouti: revised annual update 2012 and compiled annual update for 2013, 2014 and 2015

The RCC commended the efforts of WHO and national authorities to complete the 2015 report and also in completing the backlogged reports from 2012, 2013 and 2014. The RCC concluded AFP surveillance performance is not at par with the certification standard indicators, and more efforts are required to improve polio eradication performance indicators. Recommendations were made to improve the functions of the national certification committee through government ownership, mobilization and prioritizing polio eradication activities.

The 2015 report is provisionally accepted by the RCC and comments will be transmitted to the chair of the national committee. Formal acceptance will be made after amendments are added to the report.

7.2 Reports from other countries

7.2.1 Somalia: basic national documentation for certification

The RCC noted the continuous presence of unimmunized children in inaccessible areas, and encouraged implementation through innovative efforts to reach these children. The RCC Chairman's letter to WHO/UNICEF, while acknowledging the difficulties facing surveillance, highlighted the need to further upgrade the quality of AFP surveillance and immunization status of children. The RCC requested the Secretariat to continue to closely monitor polio eradication activities and continue to provide necessary support for the programme.

The report is provisionally accepted and comments will be transmitted to the chair of the national committee. Formal acceptance will be made after amendments are added to the report.

7.2.2 Iraq: basic national documentation for certification

The RCC provisionally accepted the basic national documentation for certification submitted by Iraq, with minor comments on the report. These comments will be communicated to the chair of the national certification committee. The report will be amended accordingly and the revised version resent to the RCC for final acceptance.

7.2.3 Annual updates for 2015: Bahrain, Egypt, Islamic Republic of Iran, Jordan, Kuwait, Lebanon, Oman, Palestine, Qatar, Saudi Arabia, Sudan, Tunisia, United Arab Emirates and Yemen

The RCC considered the reports from the above countries satisfactory and will be sending their respective national certification committees' comments to be addressed in a revised version of the reports. The certification committees' efforts and the comprehensiveness, accuracy and completeness of the reports, and the clear presentations made, have given the RCC confidence that these countries continued to be polio free during 2015. There were a few comments 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 national certification committees. Formal acceptance will be made upon receipt of the amended reports taking into consideration the comments of the RCC.

7.2.4 Afghanistan and Pakistan: progress of annual reports

Afghanistan

The RCC noted that summary report had captured the salient points of polio eradication activities and highlighted the processes, achievements and issues faced by the programme. It was encouraging to note that the programme is addressing challenges, but inaccessibility and security remain a challenge that may need coordination and collaboration at all levels of operational activities with Pakistan. The polio eradication programme may continue to use innovative methods/approaches to meet these challenges. The RCC urges national authorities to expedite follow up of the pending laboratory survey and complete Phase I of GAPIII.

Pakistan

The RCC was pleased to note higher level political commitment, and desired that all provinces and districts show commitment equal to that at the higher level. The RCC noted the decline in the number of cases in 2016, as compared to the same period for 2014 and 2015. However, WPV circulation in reservoir districts and isolation of WPV from environmental samples remains a threat for polio eradication in Pakistan. The RCC encourages the programme in Pakistan to continue efforts to address these issues efficiently and effectively to achieve the polio eradication target.

The RCC showed its dissatisfaction on the progress made in Phase I of GAPIII activities, and urged the completion of Phase I as per Pakistan's national plan of action for poliovirus containment.

8. OTHER MATTERS

The RCC noted the progress made in both Afghanistan and Pakistan in polio eradication and encouraged the polio eradication programmes in the two countries to continue high-quality AFP surveillance and immunization activities to achieve the target of polio eradication in 2016.

The RCC encouraged member countries to carry out the simulation exercises and document the process, outcome, lessons learnt and recommendations made as a result of this exercise.

The RCC expressed concern that the prevailing security situation in countries in conflict (Iraq, Libya, Syrian Arab Republic and Yemen) may affect polio outbreak response and the quality of polio eradication efforts.

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

The RCC noted with concern that some of the presentations by chairs of national certification committees were too long and included unnecessary details. It was suggested that the country presentations be restricted to 10–15 slides and presented in 15 minutes. They should highlight the most important and critical issues related to polio eradication.

The RCC showed its deep concern that Morocco did not submit its annual update for the year 2015 on time, despite several reminders sent by the Secretariat to the national certification committee in Morocco. It is also noted that surveillance indicators for 2015 (non-polio AFP rate 0.8, adequacy of stool collection 58%) and as of March 2016 (non-polio AFP rate 0.6, adequacy of stool collection 60%) are still alarming and do not meet certification standards.

The RCC notes that the conclusions of the outbreak response assessment for the Middle East and Horn of Africa, held in October 2015, show that both outbreaks have been stopped. These conclusions were based on thorough review of the epidemiological evidence presented by the affected countries and the results of field assessment missions in several Middle East and Horn of Africa countries. It was concluded that due to the time lapse since the last WPV case, improved population immunity due to multiple high-quality campaigns and enhanced AFP surveillance sensitivity in the Middle East and Horn of Africa regions, the outbreaks have been successfully interrupted. However, the risk of importation remains high due to pockets of persistently missed children because of inaccessibility in conflict-affected adjacent areas in Iraq, Somalia, the Syrian Arab Republic and Yemen.

The role of the Horn of Africa Technical Advisory Group was appreciated in cross-border coordination between the WHO regional offices for Africa and the Eastern Mediterranean, and should be continued in order to share epidemiological data and experience.

The Eastern Mediterranean RCC decided to hold its next meeting during the period 18–20 April 2017 in Casablanca, Morocco.

Annex 1**PROGRAMME****Monday, 4 April 2016**

08:00–08:30	Registration	
08:30–09:00	Opening session	
	<ul style="list-style-type: none"> • Introductory remarks • Message from the Regional Director • Welcoming remarks by H.E. Minister of Health • Adoption of agenda 	<p><i>Dr Y Al Mazrou, EM/RCC Chairman</i> <i>Mr C Maher, WHO/EMRO</i></p>
09:00–09:25	Regional overview	<i>Mr C Maher, WHO/EMRO</i>
	Implementation of the 29th RCC meeting	<i>Dr H Asghar, WHO/EMRO</i>
	Recommendations	
09:25–09:45	Global update of polio eradication outcomes/recommendations	<i>Dr R Tangermann, WHO/HQ</i>
09:45–10:15	Interregional coordination	
	<ul style="list-style-type: none"> • AFR 	<i>Dr K Kouadio, WHO/AFRO</i>
10:15–10:45	<ul style="list-style-type: none"> • EUR 	<i>Professor D Salisbury, EUR/RCC</i>
10:45–11:45	<ul style="list-style-type: none"> • SEAR <p>Discussion</p>	<i>Dr S Roesel, WHO/SEARO</i>
11:45–12:45	Basic national documentation for certification, Somalia	
12:45–14:45	Annual update reports of Jordan and Bahrain	
14:45–16:00	Annual update reports of United Arab Emirates, Qatar and Oman	
16:00–17:00	Annual update report of Lebanon	
17:00–17:30	Private meeting of EM/RCC	

Tuesday, 5 April 2016

08:30–09:00	Poliovirus containment: progress with GAPIII implementation	<i>Dr N Previsani, WHO/HQ</i>
09:00–09:15	Update on EMR GAP III containment activities	<i>Dr H Asghar, WHO/EMRO</i>
09:15–11:15	Annual update reports of Egypt and Islamic Republic of Iran	
11:15–12:15	Basic national documentation for certification, Iraq	
12:15–14:15	Annual update report of Kuwait	
14:15–16:30	Annual update reports of Palestine, Saudi Arabia and Sudan	
16:30–17:30	Private meeting of EM/RCC	

Wednesday, 6 April 2016

- 08:30–09:30 Annual update reports of Tunisia and Yemen
- 09:30–11:00 Annual progress report of Afghanistan
- 11:00–11:30 Annual progress report of Pakistan
- 12:00–14:30 Private meeting of EM/RCC
- 14:30–15:00 Closing session and concluding remarks

Annex 2

LIST OF PARTICIPANTS

Members of the Eastern Mediterranean Regional Certification Commission

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