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Report on the

Thirty-first meeting of the Eastern Mediterranean Regional Commission for Certification of Poliomyelitis Eradication

Casablanca, Morocco
16–18 May 2017



World Health
Organization

Regional Office for the Eastern Mediterranean

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1. INTRODUCTION

The Eastern Mediterranean Regional Certification Commission (RCC) for poliomyelitis eradication held its 31st meeting in Casablanca, Morocco on 16–18 May 2017. The meeting was attended by members of the RCC, chairpersons of the national certification committees (NCCs) or their representatives and national polio eradication officers of 16 countries of the Region. The meeting was also attended by representatives from Rotary International, the Centers for Disease Control and Prevention and WHO staff from WHO headquarters, Regional Office for Africa and offices in Afghanistan, Pakistan and Somalia. The meeting was opened by Dr Yagob Al Mazrou, Chair of the RCC, who welcomed the participants and thanked the Government of Morocco, and specifically His Excellency Dr El Houssaine Louardi, Minister of Health, for hosting the meeting and providing excellent support. The programme and list of participants are attached as Annexes 1 and 2.

Dr Mahmoud M. Fikri, WHO Regional Director for the Eastern Mediterranean, welcomed the participants and thanked them for their commitment and sustained efforts to achieve the target of eradicating polio in the Region. As this was the first RCC meeting for Dr Fikri to attend since he took over the office of the Regional Director, he assured the participants that polio eradication is one of his highest priorities and that he is fully committed to achieving the polio eradication target in 2017. Despite the challenges of access and complex security situations in some Member States, he indicated that we are closer than ever to eradicating poliomyelitis and stopping the transmission of poliovirus.

Dr Fikri congratulated all Member States for successfully implementing the switch from the trivalent to the bivalent form of oral polio vaccine in routine immunization and campaigns, noting that this was achieved through close coordination between ministries of health, WHO, UNICEF and partners.

For more than three years, no cases of polio due to wild poliovirus or circulating vaccine-derived poliovirus have been reported in the Middle East; the last case due to wild poliovirus in Somalia was reported on 11 August 2014. In 2016, both remaining endemic countries in the Region, Afghanistan and Pakistan, have shown a marked reduction in poliomyelitis cases, together with a decline in genetic diversity and geographical restriction of cases. However, continued detection of wild polioviruses during the current low season for transmission in the few remaining reservoir districts of both countries is a concern to the polio eradication programme. The regional polio eradication programme is working closely with both endemic countries and supporting the focused implementation of their national emergency action plans. The national programmes in both countries are working closely and synergizing their activities. In addition, actions are being taken to further intensify efforts in the remaining reservoir areas, including the implementation of a robust migrant and mobile population strategy and ongoing advocacy to ensure strong political commitment to sustain the momentum necessary to complete the work.

In 2015 all WHO Member States endorsed a World Health Assembly resolution to implement the Polio Eradication and Endgame Strategic Plan 2013–2018 and the third Global Action Plan in order to minimize poliovirus facility-associated risk by destroying,

transferring or containing poliovirus materials. The Phase 1a containment goals have been achieved in 22 countries, all of which have confirmed destruction and no retention of poliovirus type 2 materials in their facilities. Phase 1b is in progress, awaiting a WHO guidance paper for completion. Two laboratories, one in the Islamic Republic of Iran and one in Pakistan, have opted to become poliovirus essential facilities (PEFs) to serve critical international functions, including production of Sabin-inactivated poliovirus (IPV) and monovalent oral poliovirus (OPV) vaccines and Sabin-like type 2 PEF for testing human sera for poliovirus antibody.

Professor Abderrahmane Maaroufi, Public Health Director, delivered a message from the Minister of Health. He reaffirmed the commitment of the government of Morocco to support polio eradication efforts globally and regionally. The goal of eradicating polio from the Region can be achieved through the support of the countries and continuous coordination, especially during the current period to prevent any importation into polio-free countries.

2. OVERVIEW OF POLIO ERADICATION IN THE REGION

2.1 Regional overview

Mr Christopher Maher, Manager, Polio Eradication Programme, WHO/EMRO

An overview of the epidemiology of poliomyelitis in the countries of the WHO Eastern Mediterranean Region reflected significant improvement in reduction of disease incidence in the two remaining polio-endemic countries in the Region, Pakistan and Afghanistan. A total of five polio cases had been reported, two from Pakistan and three from Afghanistan. The technical advisory group for both countries observed that progress was in right direction and their strategic priorities under the National Emergency Action Plans were endorsed. Risks to polio eradication include failing to stop transmission in Afghanistan and Pakistan in the coming low season; moving of polio into conflict-affected countries, especially the six “at risk” countries; failing to effectively manage the programme and resources; inadequate resources to fund/support eradication activities; and inability to sustain political will in the Region. The six “at-risk” countries are Iraq, Libya, Somalia, Sudan, Syrian Arab Republic and Yemen. Regional polio eradication plan was shared. Support to the technical advisory group will continue besides conducting periodic risk assessment and desk/field reviews, resource mobilization, accelerating transition planning and developing a detailed plan and timeline for certification activities.

In conclusion, all indicators reflect weakening transmission (lowest transmission ever, disrupted seasonality and decreasing genetic diversity). At risk countries have maintained polio-case free status despite the complex security situation. Risks remain for wild poliovirus type 1 (WPV1) persistence in few discrete areas of Pakistan and Afghanistan and development of circulating vaccine-derived polioviruses (cVDPVs) in conflict-affected areas. There are strong, competent, effective programmes in endemic countries, following appropriate plans.

2.2 Implementation of the 30th RCC meeting recommendations

Dr Humayun Asghar, Polio Coordinator and Regional Certification Focal Point, WHO Eastern Mediterranean Region

The meeting was informed on the status of the 30th RCC meeting recommendations. All recommendations were successfully implemented.

3. GLOBAL UPDATE OF POLIO ERADICATION

3.1 Outcomes/recommendations

Dr Rudolf Tangermann, Medical Officer, HQ/SAC Surveillance, Data and Certification, WHO/HQ

Strong progress continues to be made since the World Health Assembly called for the worldwide eradication of poliomyelitis in 1988. At the time, poliomyelitis was endemic in more than 125 countries around the world and more than 350 000 cases were reported. Today, transmission of wild poliovirus is at its lowest level ever, with endemic transmission occurring in parts of only three countries – (in order of burden of disease) Pakistan, Afghanistan and Nigeria. In 2016, 37 cases of polio (WPV1) were reported worldwide. In 2017, only five WPV1 polio cases have been reported (as of mid-May 2017). Only WPV1 continues to be detected WPV2 was officially declared eradicated in 2015 and no case of paralytic poliomyelitis due to WPV3 has been detected anywhere since November 2012.

The risks and consequences of failure, by contrast, are significant: an epidemic-prone disease, polio will spread again beyond its current borders, and, within 10 years, upwards of 200 000 new cases will again be reported around the world every year. Progress is fragile; this was underscored in August 2016 with the confirmation of four new cases of paralytic poliomyelitis due to WPV1 in Borno State, north-eastern Nigeria, the first reported in the country and in the African Region since July 2014. These risks underscore the urgent need for the rapid and sustainable achievement of a polio-free world, recalling resolution WHA68.3 (2015), in which the World Health Assembly urged Member States to fully finance and implement the Polio Eradication and Endgame Strategic Plan. To more effectively help guide and oversee progress towards interrupting poliovirus transmission, the remit of the Independent Monitoring Board is currently being adjusted to focus even more strongly on achieving the success of this critical objective of the Strategic Plan.

The declaration in 2014 of the international spread of wild poliovirus as a public health emergency of international concern (PHEIC) and the Temporary Recommendations promulgated under the International Health Regulations (IHR 2005) remain in effect. National polio emergency action plans continue to be implemented in all countries affected by circulation of either wild poliovirus or vaccine-derived polioviruses, and all countries currently affected by circulation of either type of virus have declared such events to be national public health emergencies.

Between 17 April and 1 May 2016, all 155 countries and territories that were still using trivalent oral polio vaccine (tOPV) successfully switched to the bivalent oral polio vaccine (bOPV) through a globally-synchronized replacement. It was the first step in the phased removal of oral polio vaccines, which will culminate with the cessation of use of all OPVs following global certification of eradication of all wild poliovirus types. Since the declaration of the eradication of WPV2 in September 2015, Member States have been completing efforts to identify facilities holding type 2 polioviruses (wild, vaccine-derived or Sabin), destroy unneeded materials or appropriately contain needed materials in poliovirus-essential facilities.

In 2016, acceleration of transition planning continued in order to ensure effective advances in human resources planning at all levels of WHO to reduce the number of polio-funded staff and associated financial liabilities; to understand the consequences of the loss of polio-funded staff and infrastructure on other WHO programme areas, and WHO country offices; and to help identify opportunities to mainstream or integrate polio functions into other programmes areas or national health system, where feasible.

In late 2015 and early 2016, countries affected by outbreaks of cVDPV2 intensified their responses to ensure that circulation of these viruses was stopped before the globally-synchronized switch from tOPV vaccine to bOPV in early 2016. In 2016, one case of poliomyelitis due to cVDPV2 was reported in Sokoto state, Nigeria. A separate occurrence of cVDPV2 was confirmed in Borno state, from an environmental sample (collected in March 2016) and stool specimens (collected in August 2016) from a healthy contact of one of the cases of polio due to WPV1 (see above), during strengthened surveillance activities in the area. Genetic sequencing of this strain indicates it has been circulating for almost four years in the area and was last detected in northern Nigeria in November 2014.

With the lack of access in many areas and the inability to conduct high-quality vaccination and surveillance in key areas of Borno State, the strain has likely circulated undetected in this inaccessible population. Multicountry response plans, including improvement of the quality of surveillance at the subnational level such as the in pivotal Lake Chad region of Chad, continue to be implemented. The Director-General of WHO authorized the release of monovalent OPV2 (mOPV2) from the global stockpile for use in supplementary immunization activities responding to the cVDPV2 outbreak. Lao People's Democratic Republic was affected by a cVDPV1 outbreak but no case has been reported from that country since 11 January 2016. However, gaps in the quality of subnational surveillance persist in key areas where previously circulation of vaccine-derived polioviruses had been confirmed, including parts of Guinea.

The Global Polio Eradication Initiative is actively monitoring the presence of vaccine-derived poliovirus type 2, from any source. Detection of such strains in the first 6 to 12 months after the switch from tOPV to bOPV was expected, given that children who had previously received trivalent oral polio vaccine will continue to excrete the type 2 strain originally contained in the trivalent vaccine for a limited period of time. Each detection of a type 2 vaccine-derived virus from any source results in the immediate activation at global,

regional and country levels of a newly-established incident management system, with the aim of conducting a thorough risk assessment associated with the isolated strain and implementing, if appropriate and necessary, an outbreak response, including the accessing of the global stockpile of mOPV2, which was released from the global stockpile for implementation of response activities in the countries of the Lake Chad region (Cameroon, Chad, Niger and Nigeria), as well as Mozambique and Pakistan.

4. POLIOVIRUS CONTAINMENT

4.1 Progress with Global Action Plan III implementation

Ms Liliane Dalila Boualam, Technical Officer, HQ/CNT Containment, WHO/HQ

Ms Liliane Boualam presented an overview of the current status of the global containment situation, highlighting progress, identified risks and current programme focus. Participants were given an update of the current progress towards Global Action Plan III (GAP III) phases I and 2 implementation. The challenges and risks identified assorted by mitigation measures were as well presented and discussed during the opened questions session.

The updated containment oversight structure, with its newly established groups such as the Containment Advisory Group (CAG) and Global the Certification Commission Containment Working Group (GCC-CWG), was presented with detailed roles and interactions with national authorities for containment.

The countries in the Region have completed Phase Ia (WPV2/VDPV2) inventories and one country (Islamic Republic of Iran) has expressed their intention to designate at least one PEF. Countries were requested to initiate their Phase Ib (Sabin 2 and potentially infectious type 2 material) inventories during the November 2016 regional/national certification committee meeting waiting for the global guidance on how to handle potentially infectious materials, especially in non-polio laboratories. Another country (Pakistan) is considering nominating a PEF (national laboratory). So far, neither of these two countries have nominated any national authority for containment.

The risk posed by the completion of containment certification as opposed to certification of eradication was emphasized, especially if the current low reporting trend persists. Although 30 countries and 79 PEFs have reported their intention to move towards the certification process (Phase II), the national capacity for auditing is being re-enforced in 25/30 countries through WHO technical support, and 17/30 national authorities for containment being designated, no certification process applications have yet been received.

National compliance to criteria related to the establishment of PEFs, nomination of national authorities for containment and compliance with safeguards (OPV coverage and routine availability of IPV) were emphasized, and the need for initiating the certification process (i.e. submitting the certification of participation application) was strongly recommended.

In conclusion, countries were strongly encouraged to initiate their certification process as soon as possible by designating their national authorities for containment, and making an application for certification of participation considering compliance with other GAP III criteria (safeguards). Additionally, a review of the data quality from the previous inventory was recommended and using the on-going Phase Ib inventories for validation of data quality (scope of laboratories checked) should be considered.

5. INTERREGIONAL COORDINATION

5.1 Update on polio eradication in the WHO African Region

Dr Mbaye Salla, Medical Officer, AF/PEP Polio Eradication Programme, WHO/AFRO

The African Region made good progress in reducing the number of wild poliovirus cases, from 657 cases in 2010 to only 17 cases in 2014, with the onset of the last case on 24 July 2014. Unfortunately four WPV1 cases were reported in Borno state, Nigeria, in security-compromised areas from July to August 2016. The WPV1 outbreak in Lake Chad Basin has been declared a public health emergency by all five countries of the Basin (Cameroon, Central African Republic, Chad, Niger and Nigeria). A new coordinator for the Lake Chad Basin has been appointed for Phase 2 to support countries in the implementation of recommendations of the Abuja assessment meeting and the high level Global Polio Eradication Initiative meeting, the implementation of activities in accordance with the National Emergency Action Plan for *Polio* and to strengthen surveillance. Vaccine derived poliovirus type 2 cases have been reported in 2016 and 2017 in areas where mOPV2 has been used.

Acute flaccid paralysis (AFP) surveillance indicators improved from 2015 to 2016 and in the last 6 months with gaps at sub-national level for stool adequacy, including areas with insecurity and inaccessibility. Efforts to close the gaps include expansion of environmental surveillance, training and sensitization, tracking cases from camps for internally displaced persons, sweep and collection of samples from healthy children, use of Auto-Visual AFP Detection and Reporting (AVADAR) and other technologies and the Brazzaville initiative.

The risks include the increase in WPV1 transmission, subnational gaps in surveillance, insecurity, low population immunity, population movements and financial gaps. Strategies to address the risks include prioritized joint technical support for the Global Polio Eradication Initiative, supporting programme reviews e.g. external reviews in weak performing countries, implementation of the environmental surveillance expansion plan for the WHO African Region, Brazzaville initiative Phase 2 countries, training on new standard operating procedures in responding to polio events and outbreaks, use of AVADAR and other new technologies, prudent transition planning and ramping down versus remaining risks and institutionalization of the accountability framework.

At its last meeting in November 2016, the Africa Regional Certification Commission (ARCC) discussed the current epidemiology and concern in the Lake Chad Basin, surveillance performance indicators in security-compromised areas and progress on containment GAP III. The Commission reviewed and accepted documentation from Algeria and Cape Verde, and

recommended high level advocacy visits in priority countries, including Equatorial Guinea. The next ARCC meeting will therefore be held in Equatorial Guinea on 19–23 June 2017 to review the documentation from Ethiopia and progress in Nigeria, Guinea, Liberia and Sierra Leone.

5.2 Update on polio eradication in the WHO European Region

Professor David Salisbury, Chairman, Global Certification Commission

The WHO European Region RCC continues to work on a risk based approach; in 2016, Bosnia-Herzegovina, Romania and Ukraine were scored as ‘high risk’ based on estimates of population immunity, quality of surveillance, preparedness to respond to poliovirus transmission, and containment. The activities of these countries in response to the RCC recommendations of 2016 will be scrutinised carefully at the upcoming RCC meeting. Special attention was paid by the RCC to the services that are being provided to migrants and refugees by European recipient countries, notably Greece, Germany and Italy. Whilst containment activities continue with the European Region expected to have the highest number of PEFs of all regions, it is of concern that there has been a recent failure of containment of wPV2 in an IPV manufacturing facility in the Netherlands. Follow-up activities show that the two infected individuals are no longer excreting poliovirus and environmental samples are negative. National, regional and interregional polio simulation exercises continue to be undertaken.

5.3 Update on polio eradication in the WHO South East Asia Region

Dr Supamit Chunsuttiwat, Chair, South East Asia Regional Certification Commission

Outline

As the WHO South-East Asia Region (SEAR) has been certified polio-free since 2014, the region is undergoing implementation of polio endgame strategies. The progress in six major programme areas of the polio endgame covers:

- recent epidemiology of polioviruses and actions to maintain polio free status.
- sensitivity of surveillance
- population immunity against polioviruses
- poliovirus laboratory containment
- outbreak response preparedness
- transition planning.

Wild polio virus

Regarding the epidemiology of poliovirus, no WPV has been reported in the South-East Asia region since the last case in January 2011. Since the regional certification in March 2014, the RCC has been meeting annually. The next meeting will be in November 2017 in Myanmar. In the meantime, NCCs for polio eradication submit annual progress reports using a new format with conclusions on the levels of immunity, surveillance sensitivity, bio-risk management and outbreak preparedness.

Vaccine-derived poliovirus, 2015–2017

Some VDPVs have been detected since 2015: VDPV type 2 was found in AFP cases in India and Myanmar before the OPV switch. The virus was also isolated from sewage samples in India, both before and after the OPV switch.

In a special study, not from the environmental surveillance in India, VDPV type 3 was isolated from an asymptomatic immune-deficient individual. His stool samples tested positive for VDPV type 3, with 41–76 nucleotide changes; but the samples tested negative after August 2016. There was no virus circulation.

India: vaccine-derived poliovirus, 2015–2016

In more detail, during 2015–2016 VDPV2 was detected in three AFP cases in three states in India. There was no evidence of circulation nor of genetic linkages. Two of these cases were immune-deficient and one was of ambiguous classification. Appropriate investigation and response were conducted.

Additionally, VDPV2 was found in 17 sewage samples in seven states, with no evidence of circulation. Of these, four VDPVs were isolated after the OPV switch in Hyderabad, Delhi and Kolkata. They were analysed and graded as low risk. Adequate response was made.

Myanmar: vaccine-derived poliovirus, 2015

In Myanmar, genetically linked VDPV type 2 was detected in stool specimens of two AFP cases, whose onset dates of paralysis were in April and October 2015. The outbreak was confirmed in early December. Both cases were from the same township, Maungdaw in Rakhine State. The nucleotide study suggested that the virus had been circulating for more than one year in the area which has low vaccine coverage.

Five rounds of immunization campaign were implemented from December 2015 to April 2016 to contain the VDVP outbreaks. The immunization response met global guidelines and standards. In the response, a national health emergency was declared, and an intensive immunization campaign was conducted with the involvement of political, administrative and religious leadership as well as nongovernmental organizations, with support from WHO, UNICEF and international nongovernmental organizations, and with effective cross-border and cross-regional collaboration.

To verify the effectiveness of the response, two rounds of outbreak response assessment were conducted, which came up with favourable conclusions. The first assessment, right after the last immunization round, concluded that cVDPV2 transmission might have been interrupted; however uncertainty remained due to gaps in surveillance. The second assessment 6 months later indicated that improvements in AFP surveillance in Rakhine State were sufficient to reasonably conclude that cVDPV2 transmission had ceased.

India: vaccine-derived poliovirus, 2017

Recently, a single type 2 VDPV was detected in environmental sample in Delhi; the virus had 11 nucleotide divergence. An intensive investigation was immediately launched. Risk assessment reflected low–medium contextual risk of further transmission, and low risk for international spread.

While no monovalent OPV2 response is warranted, the advisory group recommended enhancing environmental surveillance sampling; strengthening routine immunization with fractional dose IPV; ensuring outbreak response readiness; and completing virologic assessment.

Surveillance for poliovirus detection

Conventional AFP surveillance is being maintained in all SEAR countries, with environmental surveillance conducted in four countries as a supplementary measure. Sensitivity of AFP surveillance seems adequate in most countries, with challenges in some, especially Indonesia with its population living on thousands of islands.

Common challenges include timely investigation, shipment of samples and timely classification of cases in smaller countries. Laboratory performance meets global standards, while in the Democratic People's Republic of Korea and Indonesia, challenges in regard to laboratories are being addressed.

Non-polio acute flaccid paralysis, 2013–2017

Among 11 member countries in the South-East Asia Region, one half are reporting non-polio AFP rates above 2 per 100 000, while the remaining half are struggling to meet the required target. The key challenge is how to maintain enthusiasm and attention to AFP surveillance among health care workers as well as policy-makers, while they are also attending to many other tasks. Equally challenging is adequate stool specimen collection. Again, only one half of the countries meet the target of 80%. As complacency tends to creep in, the national programmes struggle to maintain performance.

Environmental surveillance

Environmental surveillance is being conducted in four countries. India was the first to start in 2001; now it is in place in eight states. This was followed by Bangladesh and Indonesia in 2015 and Thailand last year; Myanmar and Nepal will join this year, 2017. The expansion of environmental surveillance, to which countries and to which sites in the country, is driven by risk analysis.

Routine OPV3 coverage and polio supplementary immunization activities

Immunization coverage must be maintained to minimize the risk of WPV spreading following importation and the emergence of cVDPV. Routine OPV3 coverage over 90% has been maintained in seven countries, and supplementary immunization activities have been maintained in countries with areas of low coverage. For this year, 2017, supplementary immunization activities are planned to be conducted in four countries: India, Indonesia, Myanmar and Nepal.

Switch from tOPV to bOPV and introduction of IPV

All countries completed the OPV switch in April 2016 and IPV has been introduced in all countries, although Indonesia started a little late due to supply issue. In response to the global IPV supply shortage, IPV supply has been prioritized to countries with higher risk of VDPV emergence; this includes India, Indonesia, Myanmar and Timor Leste. Bangladesh, India, Nepal and Sri Lanka adopted the use of fractional dose IPV.

After the switch, Sabin-like type 2 poliovirus was detected in the environmental surveillance in India. Nucleotide studies suggested the recent introduction of Sabin type 2 virus.

Response to Sabin-like type 2 isolation post-switch in India

Consequent to the detection of Sabin-like type 2 virus, a thorough investigation was conducted to see if the virus came from the unwarranted use of trivalent OPV or from other causes. The investigation included the immediate search of all cold chain points, visits to all AFP reporting sites in the area involved, mapping and search of all private stocks and vaccine distributors and a street-by-street physical check of all small private clinics or health facilities.

Following the search, 50 tOPV vials were found in small private sector practitioners in Hyderabad and Ahmedabad; these tOPV vials had been purchased and delivered before the switch. No type 2 vaccine was found in a visit to the OPV manufacturer.

Polio laboratory containment

By the end of 2015, six of 11 countries were no longer storing infectious and potentially infectious materials for type 2 virus. India and Indonesia have nominated PEFs and they have established national advisory committees, the NACs, for this purpose. Myanmar has destroyed VDPV2 materials from the 2015 outbreak. Bangladesh and Thailand will soon complete in-depth checks for potentially infectious poliovirus type 2 materials from international research collaborations.

Meetings and training sessions were organized in the region to build containment capacity under GAP III. Countries are conducting a re-survey for Sabin type 2 materials.

Based on the NCC for Poliomyelitis Eradication report; Bhutan, Democratic People's Republic of Korea, Maldives and Timor Leste have completed Phase 1b containment, and Myanmar will complete it soon.

Outbreak response preparedness

Outbreak response plans have been updated in Bhutan, India, Indonesia, Myanmar, Nepal and Sri Lanka; the plans of the remaining countries will be updated this year. The Regional Office will conduct a standardized review of the national outbreak response plan, simulation exercise on the plan has been urged by the RCC. India and Myanmar successfully implemented outbreak response following detection of VDPV2 in 2015 and 2016, and the operation met international outbreak response standards.

Transition planning

As funding for polio eradication is waning, five SEAR countries with Global Polio Eradication Initiative (GPEI)-funded polio assets will be affected. India will be most impacted as the country obtains 80% of the funding provided to the region. Therefore, transition plans are being developed to ensure maintenance and mainstreaming of essential functions. Transition planning is making good progress in India, while planning has started in Bangladesh, Myanmar, Nepal and Indonesia.

Summary

In summary, WPV-free status in SEAR has been maintained for over six years. VDPVs have been detected in two countries and the incidents were properly investigated and responded to.

Immunization coverage and AFP surveillance are being maintained, with challenges at national level in some countries and at subnational level in others. All SEAR countries have completed the OPV switch and have introduced IPV, while challenges from the global IPV supply problems are being coped with.

Outbreak response plans are being updated and aligned to new standard operating procedures, while transition planning is ongoing in five countries.

6. UPDATE ON GAP III CONTAINMENT ACTIVITIES IN THE REGION

Dr Humayun Asghar, Polio Coordinator and Regional Certification Focal Point, WHO/EMRO

All Member States in the Region have submitted the Phase 1a report and many of the countries are awaiting the WHO guidance paper for the completion of Phase 1b to finally achieve the full implementation of GAP III Phase 1. However, Afghanistan, Bahrain, Saudi Arabia and United Arab Emirates have already completed Phase 1b. In 2016, two meetings were held to update and facilitate the GAP III activities: the regional polio staff meeting to

discuss regional progress on containment (Amman, Jordan, 31 December 2015–01 February 2016) and the regional meeting of NCC chairs and national containment coordinators (Amman, Jordan, 29–30 November 2016).

Islamic Republic of Iran has designated Razi Vaccine Production Facility as a PEF is and also preparing a new facility for Sabin-IPV production, which should also be designated as a PEF. Pakistan has shown interest in designating the National Institute of Health polio laboratory as a Sabin-like type 2 PEF, however, as yet, the Ministry of Health has not sent an official letter. Neither Islamic Republic of Iran nor Pakistan has constituted an NAC. In all countries which are hosting NACs, WHO is providing training to auditors on the GAP III containment certification scheme and Islamic Republic of Iran and Pakistan have been asked to send in their nominations for auditors to be trained.

7. DISCUSSION OF THE REPORTS

7.1 Submitted reports

Djibouti, Iraq, Libya and Yemen have submitted their annual update reports and Syrian Arab Republic submitted its basic national documentation for review by the RCC, but owing to visa issues they were unable to attend the meeting and the RCC decided to discuss these reports during private meetings.

Syrian Arab Republic basic national documentation for certification

The RCC acknowledges the receipt of the national documentation from 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 expressed its concern regarding the declining OPV3 coverage and consequent low population immunity in four conflict-affected governorates, Deir-el-Zor, Idleb, Hasaka and Raqqa.

The RCC accepts the national documentation from Syrian Arab Republic provisionally and awaits the response of the NCC on comments by the RCC.

In subsequent reports to the RCC, every effort should be made to ensure that all available data from whatever source is provided. WHO should assist the Ministry of Health to collect and collate data and assist in finalizing Syrian Arab Republic's certification reports. WHO should also provide any additional relevant information to the RCC.

Djibouti annual update 2016

A new NCC chair and committee has been nominated and briefed about the process of national certification documentation by a technical officer from WHO.

The RCC expressed its concern about poor AFP surveillance and immunization activity performance. This makes Djibouti vulnerable to poliovirus importation, the emergence of cVDPVs and failure of early detection of wild polioviruses or cVDPV transmission.

The Regional Director will write to the Minister of Health to bring the situation to his attention and to offer support in resolving the problem.

Iraq, Libya and Yemen annual updates 2016

Certification reports from Iraq, Libya and Yemen were accepted provisionally. Formal approval will be accorded on receipt of amended reports incorporating responses to the comments of the RCC, which will be relayed to each country's NCC chair.

7.2 Discussed reports

The certification reports from Bahrain, Egypt, Islamic Republic of Iran, Jordan, Kuwait, Lebanon, Morocco, Oman, Palestine, Qatar, Saudi Arabia, Somalia, Sudan, Tunisia and United Arab Emirates were discussed and accepted provisionally. Formal approval will be accorded on receipt of amended reports incorporating responses to comments of the RCC, which will be relayed to each country's NCC chair. Annual progress reports from Pakistan and Afghanistan were reviewed, as well.

Egypt annual update 2016

The RCC noted with concern the low routine OPV3 coverage for Cairo Governorate (68%). This is of concern since it would indicate a large number of children susceptible to polio infection. In view of the performance of the Egypt's immunization programme elsewhere in the country, the RCC urges the programme to utilize the other sources of coverage data, such as OPV history of reported AFP cases, to counter-check and corroborate the accuracy of the reported low coverage in Cairo.

Islamic Republic of Iran annual update 2016

The RCC noted the report from the Islamic Republic of Iran and comments will be shared with the NCC. The Eastern Mediterranean Region Certification Secretariat will follow up with the Ministry of Health and the laboratory for polioviruses to ensure environmental surveillance is started.

The RCC urges the Ministry of Health and Medical Education to nominate an NAC.

Morocco annual update 2016

The RCC has concerns about surveillance sensitivity and quality, and looks forward to seeing positive impacts of the two projects mentioned by the NCC member to build

awareness and capacity of staff to report all AFP cases. Detailed comments by the reviewers will be communicated to the Morocco NCC.

Afghanistan: progress of annual reports

The RCC acknowledged the presentation of the report and the discussion during the meeting that followed. This gave the RCC a clear picture of the polio situation in Afghanistan and the strategies being adopted by the programme to achieve polio eradication in Afghanistan. The report shows improvement in the quality of services by targeting high risk groups, increasing access to previously inaccessible children, training and deployment of local staff and continuing the dialogue with local communities to allow access to populations in many of the security-challenged areas. Surveillance in general has improved at the national and regional levels. However, there is decline in a few indicators in southeast, eastern and southern regions, where there has been recent detection of wild poliovirus. This requires further strengthening of surveillance activities. The RCC drew the attention of national authorities to the low OPV3 coverage at national level (65%).

Pakistan: progress of annual reports

The RCC acknowledged the thorough and clear presentation by the NCC Chair, which gave the RCC a clear picture of the polio situation in Pakistan and the strategies being adopted by the programme to achieve polio eradication. It was noted that the country has seen significant improvement in the polio situation. However, poliovirus circulation is still occurring widely, although at reduced level. It is recommended to maintain and further improve AFP surveillance. Routine immunization must be improved, focusing on missed vaccination, and supplementary immunization activities to be intensified.

8. OTHER MATTERS

WHO Eastern Mediterranean Region Certification Secretariat should develop a regional certification activities dashboard to monitor critical activities, track implementation of RCC recommendations and provide updated information. The draft format for the dashboard should be shared with the RCC by the Secretariat.

The RCC reiterates that NCCs should schedule meetings in accordance with previous recommendations, that is, to hold at least one meeting before and after the RCC meeting(s).

Date and venue of next meeting

It was agreed by the Regional Director and the RCC Chair to hold the next meeting in Abu Dhabi, United Arab Emirates, on 17–19 April 2018.

Annex 1**PROGRAMME****Tuesday, 16 May 2017**

08:00–08:30	Registration	
08:30–09:00	Opening session	
	<ul style="list-style-type: none"> • Introductory remarks • Address by the Regional Director • Welcoming remarks by H.E. Minister of Health 	<i>Dr Y. Al Mazrou, EM/RCC Chair</i> <i>Dr M. Fikri, WHO/EMRO</i> <i>Professor Abderrahmane Maaroufi,</i> <i>Director of Public Health</i>
	<ul style="list-style-type: none"> • Adoption of agenda 	
09:00–09:30	Regional overview	<i>Mr C. Maher, WHO/EMRO</i>
	Implementation of the 30th RCC meeting recommendations	<i>Dr H. Asghar, WHO/EMRO</i>
09:30–09:45	Global update of polio eradication Outcomes/recommendations	<i>Dr R. Tangermann, WHO/HQ</i>
09:45–10:00	Poliovirus containment: progress with Global Action Plan III implementation	<i>Ms L. Boualam, WHO/HQ</i>
10:00–10:45	Discussion	
10:45–12:00	Inter-region coordination	
	<ul style="list-style-type: none"> • AFR • EUR • SEAR 	<i>Dr M. Salla, WHO/AFRO</i> <i>Prof. D. Salisbury, EUR/RCC</i> <i>Dr S. Chunsuttiwat, SEA/RCC Chair</i>
	Discussion	
12:00–14:00	Basic national documentation for certification, Syrian Arab Republic	
14:00–15:45	Annual update reports of Morocco, Bahrain and Djibouti	
15:45–16:45	Annual Update reports of Egypt and Iran	
16:45–17:30	Private meeting of EM/RCC	

Wednesday, 17 May 2017

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 Iraq, Jordan and Kuwait	
11:15–14:15	Annual update reports of Lebanon, Libya, Oman and Palestine	
14:15–16:30	Annual update reports of Qatar, Saudi Arabia, Somalia and Sudan	
16:30–17:30	Private meeting of EM/RCC	

Thursday, 18 May 2017

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

Annex II

LIST OF PARTICIPANTS

Regional Certification Commission Members of the Eastern Mediterranean

Dr Yagob Y. Al Mazrou, Chair, Secretary General, Council of Health Services
Dr Magda Rakha, Chair, Deputy for Technical Affairs, VACSERA, Holding Company for Biological Products & Vaccines
Dr Abdoulie Jack, African Regional Certification Commission
Professor Tariq Iqbal Bhutta, Professor of Paediatrics and Former Principal, Nishtar Medical College
Dr Bijan Sadrizadeh, Senior Health Advisor to the President, Iranian Academy of Medical Sciences
Dr Moncef Sidhom, Former Director Primary Health Care Department, Ministry of Health
Dr Supamit Chunsuttiwat, Chair, South-East Asia Regional Certification Commission, Senior Specialist in Preventive Medicine, Department of Disease Control, Ministry of Public Health

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OMAN

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Observers

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Dr Fayka Al-Raqam, Former National Certification Committee Chairperson

Other organizations

ROTARY International

Mrs Najoua Azouz, District Governor

Centers for Disease Control and Prevention (CDC)

Dr Derek Ehrhardt, EMRO Team Leader, Polio, Global Immunization Division

Mr Abhijeet Anand, Co-chair of EOMG Surveillance Task Team

EMPHNET

Dr Magid Al-Gunaid, Director, Public Health Programmes

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Mrs Liliane Dalila Boualam, Technical Officer, Containment

Dr Zubair Mufti, Technical Officer, Country Assessment and Support

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