

Report on the

**Eleventh meeting of the Eastern
Mediterranean Regional Commission for
Certification of Poliomyelitis Eradication**

Cairo, Egypt
3–5 April 2004



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Regional Office for the Eastern Mediterranean
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2004

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1. INTRODUCTION

The Eleventh Meeting of the Eastern Mediterranean Regional Commission for Certification of Poliomyelitis Eradication (RCC) was held in the WHO Regional Office for the Eastern Mediterranean (EMRO), Cairo, Egypt, from 3–5 April 2004. The meeting was attended by: members of the RCC; chairmen or representatives of the National Certification Committees (NCC); and national officers dealing with polio eradication from Bahrain, Djibouti, Egypt, Iraq, Islamic Republic of Iran, Jordan, Kuwait, Lebanon, Libyan Arab Jamahiriya, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates and Yemen. Members of the European and African Regional Commissions for Certification, staff from WHO headquarters and WHO regional offices for Africa, Eastern Mediterranean and South East Asia and representatives of the Centers for Disease Control and Prevention (USA) and of Rotary International also participated in the meeting.

Dr Ali Jaffer Mohammad Sulaiman, Chairman, RCC, opened the meeting and welcomed all the participants and thanked Dr Hussein A. Gezairy, Regional Director for the Eastern Mediterranean, for attending the meeting. Dr Sulaiman expressed confidence that now more than any time previously, the Region appeared to be on its way to certification. He noted the interest being taken by the national certification commissions (NCCs) in the Region in polio eradication and certification related work and urged them to award a high priority to the work within their existing heavy commitments. He stressed the need for the NCCs to have 3–4 meetings during the year and continue to have close interaction with the national programme and observe first hand various activities related to polio eradication. Dr Sulaiman also emphasized the importance of timely submission of reports.

Dr Gezairy in his address welcomed all the participants and thanked the members of the RCC for their continued commitment to poliomyelitis eradication in the Region. He noted the improvements in the quality national/subnational immunization day campaigns (NIDs/SNIDs) in the still endemic countries and the high level of surveillance for acute flaccid paralysis (AFP). He urged the participants to be vigilant of the ever-present danger of importation from within and outside the Region. He expressed satisfaction that the work on containment was proceeding satisfactorily and was being aligned with certification related activities at the national level. He pointed out that as certification approached, the tasks faced by the RCC and NCCs had become more onerous and called for new ways of collaboration between these two bodies.

The programme and the list of participants are given in Annexes 1 and 2 respectively.

2. PRESENT SITUATION OF POLIO ERADICATION

2.1 Global overview

Dr Ronald Sutter, WHO headquarters, presented a summary report on the global status of the poliomyelitis eradication initiative. The eradication activities have brought down the number of cases from nearly 350 000 in 125 countries in 1988 to 785 cases in only 6 countries

in 2003. The epidemiology of wild poliovirus circulation has changed, with an increased number of importations from endemic countries to those that have been polio free for some time and from endemic areas within a country to those areas that have been polio free. The Nigerian virus had been exported to 8 countries and the virus from western Uttar Pradesh in India had been exported to other states in India that had been polio free. Nearly 75% of all polio cases are now linked to just 5 provinces/states. During 2003, the response to importation had cost over US\$ 20 million.

In India, one of the priority countries, the number of cases was at the lowest level ever. Transmission was at very low levels in the previously highly endemic provinces of Uttar Pradesh and Bihar. Nationally, there is a strong motivation to finish the job. In Nigeria, progress could be rapid if NIDs were fully implemented. In September 2003 the national political leaders suspended the campaign and postponed the NIDs under pressure from local opinion leaders from the north, who accused the initiative of being a plot to depopulate northern Nigeria and to infect the population with HIV/AIDS virus etc. After high-level international advocacy and advocacy from Islamic and religious organizations, and testing of vaccine at local and international institutions, NIDs were being reinstated.

Dr Sutter pointed out that globally, gaps in surveillance for AFP still exist in some countries but are being closed. The global polio eradication initiative strategic plan for 2004–2008 outlined activities to interrupt polio transmission during 2004–2005, achieve global certification and mainstream existing long-term polio functions into mechanisms for serious pathogens and for integration of polio funded human resources and infrastructure into country focus, surveillance and control of infectious diseases and other EPI initiatives. The plan also outlined work required to develop specific products needed to facilitate safe cessation of OPV 3.

2.2 Eastern Mediterranean Region

Overview

Dr Faten Kamel, Medical Officer, Polio Unit, WHO EMRO, presented the current status of the polio eradication initiative in the Region. The number of cases of wild poliovirus reported during 2003 was 113. Of these, 8 were from Afghanistan, 1 from Egypt and 103 were from Pakistan. There was one imported case in Lebanon. In 2004, so far 9 cases (2 from Afghanistan and 7 from Pakistan) have been reported. This is the lowest ever recorded in the first three months of the year. Nineteen countries have been free of polio for three years or more. No case has been reported in Egypt since mid June 2003 and the last positive environmental sample was reported in early January 2004. The last case from Somalia was reported more than one and a half years ago. The quality of SIAs in the still endemic countries has improved considerably and is being closely monitored by independent observers including those from outside the country.

On a regional basis the surveillance indicators continue to meet certifications standards. The non-polio AFP rate per 100 000 children under the age of 15 years was 2.4 in 2003 and the annualized rate for 2004 is 2.07. With the exception of Djibouti, Bahrain and Palestine the

percentage of cases with adequate specimens has been over the 80% certification standard. Surveillance reviews have taken place in several of the endemic and recently endemic countries. A review will take place in Egypt in May 2004. Meetings of TAGs for Egypt and Pakistan have taken place since the last meeting of the RCC.

The major challenge was to stop the circulation of wild poliovirus in the three remaining endemic countries, i.e. Afghanistan, Egypt and Pakistan. In Afghanistan there was evidence of indigenous transmission in the southern and western part of the country. The constant population movement and the security situation hinder at times the implementation of surveillance and supplementary immunization activities. In Egypt the challenge was now to identify and focus on poorly performing districts. The number of positive environmental samples has dropped sharply from 16% in 2002, to 4% in 2003 and to 0.9% so far in 2004. In Pakistan, the areas of concern are in NWFP province and in Quetta, Baluchistan province where security problems and a conservative population have limited the implementation of surveillance and immunization activities. There were a high proportion of un-immunized children in these areas. District level analysis and advocacy was being carried out with improved planning and implementation of supplementary immunization.

Dr Kamel added that a regional strategic plan for the period 2004–2008 has been drawn up in consultation with other UN agencies and partners in the initiative. Its components include intensification of SIAs, enhancing surveillance, maintaining the regional polio laboratory network, proceeding with certification and strengthening routine immunization services. In countries with out any pre-existing surveillance system, the AFP surveillance system has already been found useful in reporting outbreaks of other infectious diseases. The inter-agency coordination mechanism established by the initiative is being used by other programmes/agencies like GAVI. Finally, it was pointed out that no planned activity had been cancelled or postponed due to lack of funds.

Regional polio laboratory network

Dr Humayun Asghar, Virologist, Polio Unit, WHO EMRO, briefed the meeting on the regional polio laboratory network. All the 12 laboratories participating in the eradication initiative were fully accredited during 2003. Following the looting of the NPL in Baghdad, Iraq, it has been fully equipped and refurbished and was now operational. The NPL in Oman is being strengthened to perform molecular analysis and will be accredited by the end of 2004 to perform ITD testing.

During 2003, a total of 12 068 specimens were processed in the network laboratories. Of these, 10 689 specimens came from AFP cases, 995 from their contacts and 384 specimens from 'others'. The timeliness of reporting has much improved. In 2003, the mean time from onset of paralysis to reporting of the ITD results was 43 days and in 2004 so far it is 34 days. Dr Asghar also presented data on genotyping of isolated viruses which showed that Afghanistan and Pakistan constitute a single epidemiological zone for wild poliovirus 1 circulation, with the major reservoir being in Pakistan where the circulation has become much more focal. Strong coordination continues to exist between the national staff involved in surveillance, immunization and laboratory activities.

Stress was being placed on continuous training and upgrading of skills. At the regional level, workshops on molecular ITD methods and on LABIFA were organized since the last meeting of the RCC.

2.3 European Region

Professor M. Böttiger, member of the European Regional Certification Commission (ERCC), made a presentation on the sustainability of polio-free status in the countries of the WHO European Region, which involved maintaining high population immunity, laboratory backed quality surveillance for AFP cases, making progress in laboratory containment and addressing post-certification vaccination policy issues. She referred to continued existence of a sizeable susceptible population existing in countries with moderate immunization coverage and high-risk groups like minorities, displaced persons and refugees. The region is also susceptible to importation of wild poliovirus as the AFP surveillance is incomplete in many of the western and central European countries and there was already a decrease in the non-polio AFP rate below the required level in some of the formerly endemic countries. The Regional Office for Europe is making efforts to maintain the quality of surveillance through a number of ways, including communicating through electronic means, providing updates and workshops material to field staff and providing support for laboratory supplies and for transport of specimens.

In addition, the ERCC at its next meeting later this year would be reviewing annual updates from NCCs in the region and the updated national plans of action for sustaining polio free status. Regarding progress in laboratory containment, the survey as been completed in 49 out of 53 countries and in March 2003, 96 laboratories were found to be storing wild poliovirus and/or infectious material.

2.4 African Region

Dr Sam Okiror, Medical Officer, Polio, WHO/AFRO, presented a report on the status of the polio eradication initiative in the African Region. On a regional basis the non-polio AFP rate has remained above target since 2000 and two adequate stool specimens were obtained from more than 80% of AFP cases since 2002. However, maintaining the stool integrity and quality in transit to the network of 16 accredited polio laboratories still remain problematic. Synchronized NIDs have been carried in 16 countries in west Africa, 5 in central Africa and in 4 countries in east Africa during 2001 and 2002. Dr Okiror also described the situation in Nigeria. During 2003 and so far in 2004, SIAs have been conducted mostly in the Nigeria and Niger and were extended to countries that had experienced importation and to countries considered at high risk, i.e. Angola, Democratic Republic of Congo and Ethiopia. Fifteen countries have been selected to present their national documents during 2004. The success achieved so far in the region has been possible because of the increased human resources at the national and subnational levels and the availability of transport and communication facilities.

2.5 South-East Asia Region

Dr N. K. Shah, Chairman, South East Asia Regional Commission for Certification, presented a summary overview of the polio eradication programme in the WHO South-East Asia Region. Except for India, the remaining 10 countries in the region continue to be polio free. In India, 225 cases were reported during 2003; up to end March 2004; only 6 cases have been reported. In 2003, all the countries except for Maldives reported a non-polio AFP rate among children under the age of 15 years of over 1 per 100 000 and the 80% target of collection of two specimens within 14 days of the onset of paralysis had been met in all countries except Bhutan and Maldives. A high coverage with routine immunization with OPV3 in the border districts of Bangladesh and Nepal has created an immunity barrier and has prevented importation of polio from India in these two countries despite large-scale population movement across the borders.

In India, 6 rounds of NIDs/SNIDs are planned for 2004 and it is widely anticipated that by the end of the year transmission will cease. Meanwhile the infrastructure established by the polio eradication initiative in the region is being utilized for surveillance of measles and other vaccine preventable diseases.

3. PROGRESS TOWARDS LABORATORY CONTAINMENT OF WILD POLIOVIRUS AND POTENTIAL INFECTIOUS MATERIAL

3.1 Progress at the global level

Mr Chris Wolff, WHO headquarters, briefed the participants on the global progress with containment of wild poliovirus. The second edition of the global action plan for laboratory containment of wild poliovirus, providing details of Phases 1 and 2, is now available on the polio web page (www.polioeradication.org) and will soon be available as a published document for wide dissemination in countries. Work has already started on the third edition of the action plan that will specify long-term requirements for laboratory containment of wild poliovirus and VDPVs and Sabin-strains. Mr Wolff described the status of implementation of Phase 1 involving laboratory survey and establishment of an inventory, in different WHO regions except for the Eastern Mediterranean Region (which is given below). In the European Region, all but three countries have completed the survey and the process is now under way to review the quality of the survey process. The plan is to complete Phase 1 and submission of quality assurance reports by the end of 2004. In the Region of Americas, the first meeting of 'Regional Commission for the Certification of Poliovirus Laboratory Containment and Verification of Polio-free Status' was held in March 2004. Forty-one out of 48 Member States in the region have completed the survey and 9 have established inventories. In the Western Pacific Region, a survey has been completed in all 36 Member States. In the South-East Asia Region, a survey has been completed in 9 out of 10 Member States. The process has just begun in the African Region, where national coordinators have been designated in 28 out of 46 countries and a survey has been completed in 1 Member State.

Some of the lessons learnt from the progress achieved so far included the realization of the importance of containment to polio eradication and that a comprehensive laboratory

survey and inventory process was the foundation for polio containment and that it had been effective in identifying laboratories with wild poliovirus infectious material world wide. The documentation process serves as a critical role for compiling information that will be important for subsequent phases and certification. The challenges to reaching the global completion of phase 1 were: the stalled survey process due to non-responding laboratories, changes in leadership and lack of resources; and institutionalizing the laboratory containment activities into national structures so that data and records were secured and updated at regular intervals.

3.2 Progress in the Eastern Mediterranean Region

Dr Humayun Asghar, Virologist, Polio Unit, WHO EMRO, presented a summary of the progress in Phase 1 of laboratory containment of wild poliovirus. National containment coordinators have been assigned in 18 countries and a task force has been constituted in 16 of these countries. National plans have been formulated in 19 countries. A listing of national laboratories was available in 18 countries. Phase 1 activities had been completed in 9 countries (Bahrain, Djibouti, Islamic Republic of Iran, Jordan, Lebanon, Oman, Qatar, United Arab Emirates and Saudi Arabia), 3 of which (Islamic Republic of Iran, Oman and Saudi Arabia) presented a report on documenting the quality of Phase 1 activities during the current RCC meeting. Work on Phase 1 is ongoing in another 9 countries (Egypt, Iraq, Kuwait, Libyan Arab Jamahiriya, Morocco, Sudan, Syrian Arab Republic, Tunisia and Yemen). Due to non-responses, some of these countries are experiencing difficulty in completing Phase 1 of laboratory containment activities. Work has not started as yet in Afghanistan, Pakistan, Palestine and Somalia. During the coming year, technical assistance would be provided, where necessary, to enable countries that have completed Phase 1 to submit a quality assurance report to the RCC and to countries where the survey is ongoing, to expedite its completion. In the countries still endemic for polio, efforts will be made to sensitize and assist in preparing containment plans and in starting laboratory surveys.

The RCC was assured that all the biomedical laboratories in the private sector/industry were being included in the laboratory survey. The importance of active and sustained national leadership in ensuring the completion of the survey and establishment of inventory was considered to be paramount.

3.3 Report on pilot studies of quality assurance of laboratory surveys

Of the 9 countries in the Region that completed Phase 1 of laboratory containment, 3 (Islamic Republic of Iran, Oman and Saudi Arabia) carried out quality assurance of the laboratory survey using the WHO quality assurance guidelines. The coordinators of laboratory containment from these 3 countries (respectively Dr Seyed Zahraie, Dr Sueliman Al-Bussaidy and Professor Talal Bakir) presented a summary of their findings.

Some of the common factors that contributed to the successful completion of Phase 1 in the three countries were: high level political support; utilization of existing legislation covering laboratories; competent and sustained leadership; wide dissemination of the national plan and sensitization of concerned personnel; involvement of laboratories belonging to

different sectors; easy intergovernmental communications; delegation of responsibility (to medical sciences universities in Iran and to the regional polio coordinators in Saudi Arabia) to an appropriate operational level; and the absence of funding constraints.

The RCC expressed satisfaction with the quality assurance reports submitted and recommended that the remaining countries that have completed Phase 1 activities should be advised to submit these reports as soon as possible. It also recommended that countries in the process of completing Phase 1 should accelerate the process so as to complete it by the end of 2004 and the secretariat was advised to provide technical support and follow up in countries where it was considered necessary.

The RCC decided that as laboratory containment of wild poliovirus was an integral part of polio eradication, the reports on laboratory containment activities should form part of the documentation (national documentation and annual updates) that is submitted by the NCC to the RCC.

Regarding the format of the national reports on containment, it was pointed out that in view of the diverse approaches being adopted by the countries to implement the survey, it was difficult to come up with a standardized reporting format. The countries should be advised to use the quality assurance guidelines supplemented by tables to submit their reports. The RCC recommended that as with other reports submitted by the NCCs, the laboratory containment reports could also be technically reviewed by the secretariat before being considered by the RCC.

4. REVIEW OF ANNUAL UPDATE REPORTS FOR 2003

The RCC reviewed annual update reports presented by chairmen or their representatives of the NCCs from Bahrain, Djibouti, Islamic Republic of Iran, Iraq, Jordan, Kuwait, Libyan Arab Jamahiriya, Morocco, Oman, Qatar, Saudi Arabia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates and Republic of Yemen. The RCC also received a report from the NCC, Lebanon, about the case of wild poliovirus imported in January 2003.

The RCC made a few comments on the reports from Bahrain, Islamic Republic of Iran, Jordan, Kuwait, Libyan Arab Jamahiriya, Morocco, Oman, Qatar, Saudi Arabia, Syrian Arab Republic, United Arab Emirates and Tunisia. However, it was agreed to accept these reports subject to submission of a revised version taking into account the comments of the RCC which will be communicated in a letter from the chairman, RCC, to the chairmen of the respective NCCs.

The RCC made several comments on the reports from Djibouti, Sudan and Republic of Yemen, and the chairmen of the NCCs of these countries would be requested to submit a revised report keeping in view the comments of the RCC, which would be sent to them in a letter from the Chairman, RCC. In addition, the RCC considered that the epidemiological situation of polio in Sudan and Yemen was still fragile and they should be advised to pay special attention to improving routine coverage and implementing high quality SNIDs,

especially in low coverage areas and in the case of Sudan along its borders. The quality of surveillance for AFP needs to be improved in both the countries. For Sudan, there was also a need for better coordination with the operation in the south of the country.

The RCC noted with disappointment that no annual update for 2003 had been submitted by the NCC, Lebanon, despite several reminders by the secretariat, and recommended that the NCC be advised of the RCC's concern at the delay in submitting this report, which should be submitted without further delay. Meanwhile they should try to improve their routine coverage with OPV 3.

For Iraq, the annual update for 2002 was accepted. In view of the situation prevailing in the country during 2003, the annual update for 2003 was noted by the RCC. The RCC expressed concern about the overall situation regarding polio eradication activities and requested that this be conveyed to the Ministry of Health.

5. OTHER MATTERS RELATED TO THE WORK OF THE RCC

1. Format for pre-certification documentation

As requested at its previous meeting, the RCC was presented with a draft outline of a format for national documentation to be submitted by the NCCs for regional certification.

After some discussion on the need and usefulness for having countries submit such a detailed document, it was agreed that it was needed as a basis for regional certification. It would give a sense of ownership to the NCCs, demonstrate accountability and would bring together in one document, material that had been submitted to the RCC in instalments over several years. The RCC emphasized that the purpose of the proposed document was in no way to question the polio free status of the countries.

Apart from few additions (e.g. lessons learnt, contribution of polio eradication activities to development of health services and other disease control activities), the RCC agreed with the format outlined (revised outline is given in Annex 3) and looked forward to receiving the final and detailed version including dummy tables. Meanwhile, the RCC advised the secretariat to explore the possibility of having one of the NCCs preparing a report based on this format for discussion at its next meeting. It was agreed that reports would be considered individually and not as part of an 'epidemiological block'. Starting from next year, polio free countries would be invited to submit these reports

- 2. The role of the inter-agency coordination committees in the remaining endemic countries should include planning, problem solving and fund-raising for the programme.**
- 3. Routine immunization should receive primary attention in countries with poor coverage, particularly as supplemental immunization activities are phased out.**
- 4. Adequate provision should be made for funding containment activities.**

5. The RCC noted that arrangements are being made for continuing to support the national surveillance and laboratory staff for some time so that they can become engaged in other disease control or community based activities such as integrated surveillance.
6. The RCC noted that distribution of the revised versions of the annual reports by Chairmen, NCCs at the time of the meetings of the RCC was disruptive and should be discontinued. Only the versions of the reports received at the latest 3–4 weeks before the meeting should be considered. Furthermore the RCC agreed that copies of the reports could be sent to them at least 2 weeks (rather than 4 weeks) before the meeting.
7. The RCC decided that henceforth, as the number of reports to be considered at its meetings in April will increase in the coming years, the private meeting should be restricted to only half a day to allow more time for presentation and discussion of country reports. Furthermore, no formal presentations on the polio situation should be scheduled for the private meeting.
8. The RCC was concerned about the paucity of cases of VAPP being reported from the countries in the Region and requested the secretariat to draft an appropriate text for transmission to chairmen of NCCs and of the national expert groups drawing their attention to the definition of VAPP and advising them to be on the lookout for such cases.
9. It was agreed that the next meeting of the RCC would take place in the Regional Office in Cairo, Egypt, on 13–14 October 2004.

Annex 1

PROGRAMME

Saturday, 3 April 2004

- 09:00–09:30 **Opening session**
- **Introductory remarks by Dr Ali J. Sulaiman, Chairman of RCC**
 - **Address by Dr Hussein A. Gezairy, Regional Director, WHO/EMRO**
- 09:30–11:00 **Briefing of RCC members on critical issues facing polio eradication initiative**
- 11:00–13:30 **Progress in laboratory containment**
- **Global overview, Mr Chris Wolff, WHO/HQ**
 - **Progress in the Region, Dr Humayun Asghar, WHO/EMRO**
- 13:30–15:30 **Current status of national documents and annual updates (special situation of Iraq and Palestine)**
- Proposed draft format of documentation to be presented by countries just prior to regional certification**
- Suggestions for agenda items for the joint meeting of the chairs, NCC, and coordinators of laboratory containment, tentatively from 10–11 October 2004**
- Suggestions for further streamlining the work of the EM RCC in the run up to regional certification**
- Any other items to be suggested by the members of the RCC**

Sunday, 4 April 2004

- 08:30–09:00 **Registration**
- 09:00–09:30 **Opening**
- **Welcoming remarks by Dr Ali J. Sulaiman, Chairman of RCC**
 - **Adoption of agenda**

- 09:30–11:30 Overview of the present situation of polio eradication
- Global overview, Dr Roland Sutter, WHO/HQ
 - EM regional overview, Dr Faten Kamel, Dr Humayun Asghar, WHO/EMRO
 - AFR, Dr Sam Okiror, WHO/AFRO
 - SEAR, Dr N.K. Shah, WHO/SEARO
 - EUR, Prof. Margareta Böttiger, EUR /RCC
 - Discussion
- 11:30–14:00 Laboratory containment
- Update on laboratory containment with special emphasis on the progress in the EM region, Mr Chris Wolff, WHO/HQ, Dr Humayun Asghar, WHO/EMRO
 - A pilot study of quality assurance of laboratory survey (Iran, Oman and Saudi Arabia), Dr Seyed Zahraie, Iran, Dr Suliman Al-Bussaidy, Oman, Professor Talal Bakir, Saudi Arabia
- 14:00–16:00 Review of 2003 annual updates of Bahrain, Djibouti, Iraq (2002 and 2003) and Iran
- 16:00–17:00 Private meeting of the RCC members

Monday, 5 April 2004

- 08:30–10:45 Review of 2003 annual updates of Jordan, Kuwait, Lebanon, Libyan Arab Jamahiriya and Morocco
- 10:45–14:00 Review of 2003 annual updates (cont.) Oman, Qatar, Saudi Arabia, Sudan and Syrian Arab Republic
- 14:00–16:00 Review of 2003 annual updates of Tunisia, United Arab Emirates and Republic of Yemen
- 16:00–17:00 Private meeting of the RCC members

Annex 2

LIST OF PARTICIPANTS

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Annex 3

**OUTLINE OF FINAL COUNTRY REPORTS TO BE SUBMITTED BY THE
NATIONAL CERTIFICATION COMMITTEES IN THE EASTERN
MEDITERRANEAN REGION FOR REGIONAL CERTIFICATION**

The Eastern Mediterranean Regional Commission for Certification of Poliomyelitis Eradication (RCC) at its eleventh meeting held from 3–5 April 2004 approved the following outline for final country reports to be submitted by the National Certification Committees (NCCs) in the Region for submission to the RCC for regional certification.

The report to be submitted by the NCCs would be composed of items given below and will be largely descriptive (around 25–30 pages long) supported by a limited number of tables, graphs and maps and should be written from a point of view of also providing a historical record of polio eradication in the country.

Contents of the country report

1. A self-contained executive summary (3–5 pages long)

This would be attached to RCC's own report to the Global Commission for Certification. It should include a short description of the certification process in the country, relevant country background (demographic and socio economic) as it impinged on the polio eradication activities and an assessment of: the performance of AFP surveillance and case investigation activities; laboratory activities including containment of wild poliovirus and infectious material; routine and supplementary immunization activities for polio eradication and of the ability to detect and respond to an importation of wild poliovirus. Finally the NCC should comments on the sustainability of post-polio free activities and on any other area (s) of special concern.

2. Country background information

This section should include: information on the demographic situation; population density and a map showing major population centers and indicating geographically remote and relatively inaccessible areas should be attached; latest socio economic and health indicators; brief description of the organization of the health system and of the immunization services including surveillance for AFP and the role of private sector in the various polio eradication activities.

3. Description of the certification process

This section should include the constitution of the NCC and NEG, expertise represented in the committees, their methods of working, interaction with the national programme, mechanisms employed to validate the findings presented by the national programme for inclusion in the annual reports to the RCC and any other pertinent information such as constraints in NCC's functioning.

4. History of poliomyelitis in the country

This section should describe the epidemiology of polio in the country and show the progressive decline and elimination of wild poliovirus. It should include: a bar chart showing polio incidence for as many years as possible; details of the last confirmed case of wild poliovirus; summary of vaccine-associated polio cases and of polio-compatible cases (including investigation and immunization activities); details of any outbreaks and their management since eradication activities were initiated.

5. Performance of AFP surveillance

This should be a description of the development of surveillance activities with important milestones, reporting sites (routine and active) and their geographical representativeness and completeness of reporting over the preceding 10 years. AFP surveillance indicators should be in a tabular form for the preceding 10 years. This section should also include a summary description and results of supplementary surveillance activities where they have been carried out.

6. Laboratory activities

If the specimens were being processed in a polio laboratory within the country, its status should be clarified, i.e. national or regional. Mention how coordination was effected with surveillance staff including communication of results. Provide data on the workload, certification status and key indicators of performance over the past 10 years.

7. Immunization activities

The report should mention the history of polio immunization, current immunization schedule, the polio vaccines used and trace the coverage by routine polio immunization for as far back as records permit. Indicate population subgroups at high risk of poliomyelitis due to low immunization coverage and describe steps taken to raise coverage in these groups and the outcome of these efforts. This section should also list the various supplementary immunization activities (NIDs/ SNIDs /iSNIDs/ mopping up) over the last ten years with percentage of population covered at each round.

8. Updated national plan of action for responding to an importation with wild poliovirus

A detailed report should be provided on the detection and response to each importation.

9. Final report on Phase 1 of laboratory containment with an updated inventory

The report should be structured using the quality assurance guidelines supplemented by appropriate tables.

10. Lessons learnt from the polio eradication initiative related activities

This section should also highlight the contributions of national polio eradication efforts to the control and prevention of other communicable diseases and to the development of health services, especially for the under privileged and those living in underserved and remote areas.

11. Any areas of special concern such as sustainability of polio free status that needs attention both before and after global certification
12. Conclusions and recommendations